Children's Health Insurance Program: An Evaluation (1997 - 2010)

Interim Report to Congress

December 21, 2011

Sheila Hoag
Mary Harrington
Cara Orfield
Victoria Peebles
Kimberly Smith
Adam Swinburn
Matthew Hodges
Kenneth Finegold, ASPE
Sean Orzol
Wilma Robinson, ASPE

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U.S. Department of Health and Human Services,
Office of the Assistant Secretary
for Planning and Evaluation
200 Independence Ave., SW
Washington, DC 20201

Project Officers: Wilma Robinson and Rose Chu

Submitted by:
Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-2583
Telephone: (734) 794-1120
Facsimile: (734) 794-0241

Project Director: Mary Harrington

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CONTENTS

Chapter III (*Continued*)

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TABLES

FIGURES

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EXECUTIVE SUMMARY

Passed with bipartisan support as part of the Balanced Budget Act of 1997, the Children's Health Insurance Program (CHIP) recently celebrated its 14th anniversary. The goal of CHIP is to help close coverage gaps for low-income children whose families cannot afford private coverage but whose incomes are too high to qualify for Medicaid. CHIP, in conjunction with Medicaid, has helped to fuel a decline in the number of uninsured children, which has fallen from 11.4 million (15 percent) in 1997 to 8.0 million (10 percent) in 2010 (1997–2010 Current Population Survey data). Legislation reauthorizing CHIP, the Children's Health Insurance Program Reauthorization Act (CHIPRA), was signed into law on February 4, 2009, providing significant new financial support for the program and introducing various initiatives to increase enrollment, improve retention, and strengthen access and quality of care in Medicaid and CHIP.

Evidence from two prior national evaluations along with other research indicates CHIP has been successful in several areas. With expansions in the program, new investments in outreach, and enrollment simplifications, uninsured rates declined among children, both for those made newly eligible for public coverage under CHIP and for those already eligible for Medicaid (Dubay et al. 2007; Hudson and Selden 2007; Kenney and Yee 2007; Rosenbach et al. 2007; Davidoff et al. 2005; Kenney et al. 2005; Wooldridge et al. 2005; Kenney and Chang 2004). The research also indicates improvements in access to care and increases in receipt of preventive care among the children who gained public coverage (Sebelius 2011; Sebelius 2010; Rosenbach et al. 2007; Wooldridge et al. 2005; Kenney and Chang 2004). At the same time, however, evidence indicates that millions of children remain uninsured despite being eligible for Medicaid or CHIP, and many children enrolled in public coverage do not receive recommended levels of care (DeNavas et al. 2009). Moreover, uninsured rates among low-income children vary widely from State to State and across subgroups (Lynch et al. 2010).

CHIPRA directed an updated evaluation of CHIP to explore how the program has evolved since its inception and its role in covering low-income children. Findings from the evaluation are to be submitted in a report to Congress. In September 2010 a contract was awarded to Mathematica Policy Research (Mathematica) and its subcontractor, The Urban Institute, to conduct the evaluation, which is being overseen by The Office of the Assistant Secretary for Planning and Evaluation (ASPE). Using a mixture of quantitative and qualitative research methods, the evaluation will document how CHIP programs have developed, where they stand today, and their possible future direction. Congress stipulated that the evaluation include 10 States that (1) use diverse approaches to providing child health assistance, (2) represent various geographic areas (including a mixture of urban and rural areas), and (3) each contain a significant portion of uncovered children. ASPE expanded on these factors to develop a robust set of criteria for selecting the 10 States participating in the study: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. The evaluation's primary data collection efforts include case studies and surveys of the parents of enrollees and disenrollees in each of the 10 States and a survey of program administrators in every State. It will also use data from State eligibility and enrollment systems to study enrollment and retention outcomes, and will use data from other national surveys to understand how CHIP and Medicaid are perceived by low-income families with uninsured children who might be eligible, and to gauge the extent to which CHIP is reducing the share of low-income children who are uninsured.

This interim report is the first of two reports to Congress that will fulfill the congressional mandate. It documents what is known about the CHIP program as of Federal fiscal year (FFY) 2010

and previews the issues to be examined in future evaluation activities and reported in a subsequent Report to Congress to be submitted in 2013. The main data source for this report is the CHIP Annual Reporting Template System (CARTS), a comprehensive reporting system established by the Centers for Medicare & Medicaid Services (CMS) for States to report on their CHIP programs. Data from the CHIP Statistical Enrollment Data System (SEDS) are also used for the analyses of enrollment in public coverage, and data from the Current Population Survey are used to document coverage trends from 1997 to 2010. In addition, published and unpublished literature on CHIP is used to provide motivation and context for the findings. The remainder of this executive summary synthesizes the report's major findings.

CHIP programs are diverse, and program design choices continue to evolve.

Congress designed CHIP to give States more control over program design compared with Medicaid so that States might experiment with providing coverage that more closely resembled options available in the commercial insurance market (Ryan 2009). States can (1) expand their existing Medicaid program, also called a Medicaid-expansion CHIP program, (2) create a separate program, or (3) blend the two approaches to create a combination program. Table 1 summarizes characteristics of each program type; Figure 1 shows the program type by State as of 2010.

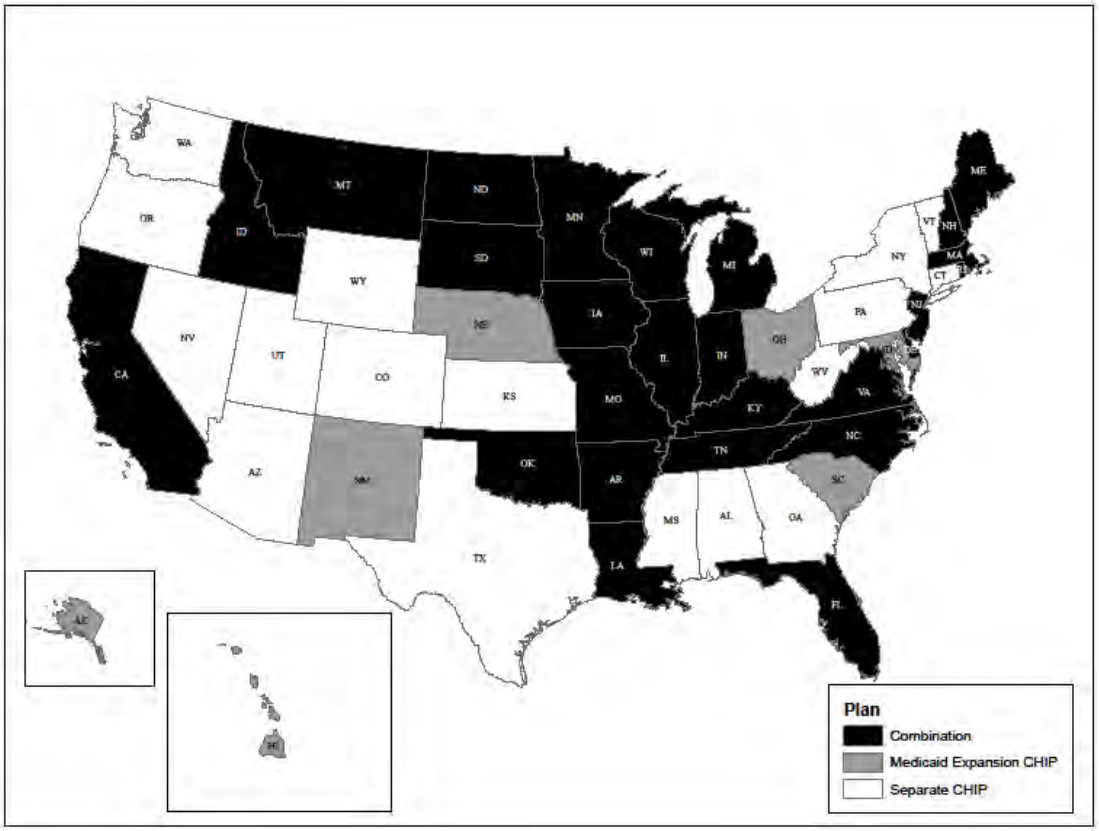
Table 1. Characteristics of CHIP Programs, FFYs 2001 and 2010

Program Type	Summary	Number of States FFY 2001	Number of States FFY 2010
Medicaid-Expansion CHIP	Required to follow all Medicaid program rules, including benefits and cost–sharing; prohibited from capping or freezing enrollment[a]	17	8
Separate CHIP	Allows increased flexibility in program design	16	17
	Benefits must be equivalent to a "benchmark" benefit package; typically a commercial plan or the State employees' health benefit package is used as the benchmark, although it can also be a benchmark equivalent package or a plan approved by the Secretary of the Department of Health and Human Services		
	Cost-sharing (premiums, copayments, and deductibles) must be nominal for children from families with incomes below 150 percent of the Federal poverty level; for families with higher incomes, cost-sharing cannot exceed 5 percent of total family income		
	Provides no Federal entitlement to coverage; States can cap or freeze enrollment at any time to limit costs and coverage		
	Option to implement waiting periods or waiting lists		
Combo	States operate both Medicaid-expansion CHIP and separate CHIP programs; each covers a different population based on income threshold	18	26

Sources: FFY 2010 CARTS reports, accessed April 25, 2011, and May 11, 2011. Certification page: "CHIP Program Type"; Mann et al. 2003; Rosenbach et al. 2003; Heberlein et al. 2011.

[a] Medicaid, and therefore Medicaid-expansion CHIP, are entitlement programs and are required to enroll all children meeting the eligibility criteria.

Figure 1. CHIP Program Type, FFY 2010



Source: Mathematica analysis of FFY 2010 CARTS data (extracted April 25, 2011, and May 11, 2011). This map shows States' responses to the question about CHIP program type.

The latest statistics show that 7.7 million children were enrolled in the program at some point in FFY 2010. As shown in Table 2, 90 percent of children enrolled in CHIP have a family income under 200 percent of the Federal poverty level (FPL), and most (76 percent) of the children enrolled in CHIP receive care through a managed care delivery system. CHIP covers children in families with income above the relevant Medicaid threshold and up to 200 percent of the FPL and beyond.[1] All but three States—North Dakota, Alaska, and Idaho—currently cover children from families with incomes at or above 200 percent FPL. Within certain limits established in the law, each State can design the CHIP benefit package and cost-sharing requirements to be consistent with public or private insurance in the State, and States can also choose the program's delivery system (managed care, fee-for-service, or primary care case management) (Rosenbach et al. 2003). Finally, States can use a portion of their administrative funds to conduct outreach for the program—a new role for States (Perry et al. 2000; Williams and Rosenbach 2007).[2]

[1] States were permitted to set their CHIP thresholds up to 50 percentage points above existing Medicaid levels; in FFY 2010, 28 states had thresholds above 200 percent FPL.

[2] Marketing efforts were not part of the Medicaid program before implementation of CHIP.

Table 2. CHIP at a Glance, FFY 2010

Children ever enrolled in CHIP during the year	7.7 million
CHIP children with family incomes below 200% of the Federal poverty level	90%
Number of children in CHIP programs in the fourth quarter of FFY 2010[a]	5.8 million
Who obtained care through managed care plan enrollment	4.4 million (76%)
Who obtained care on a fee-for-service basis	0.8 million (14%)
Who obtained care through primary care case management	0.6 million (10%)
Number of State (and DC) CHIP programs	51
Which operate Medicaid-expansion CHIP programs	8
Which operate separate CHIP programs	17
Which operate combination programs (Medicaid-expansion CHIP and separate CHIP)	26
Government spending on CHIP, FFY 2010	$11.4 billion
Federal spending on CHIP	$8.0 billion
State spending on CHIP	$3.4 billion

Sources: Centers for Medicare & Medicaid Services (CMS) 2011c; Medicaid and CHIP Payment and Access Commission (MACPAC) 2011; FFY 2010 CARTS reports; CMS CHIP Statistical Enrollment Data System (SEDS) as of February 18, 2011, verified and provided by CMS.

[a] Data are for children ever enrolled in quarter 4 of FFY 2010 accessed June 15, 2011.

Cost-sharing is allowed in CHIP to help it mirror private coverage, reduce unnecessary utilization, and support the costs of the program. As of FFY 2010, 34 States charged premiums or enrollment fees to some portion of their CHIP enrollees. States with separate CHIP and combination programs used cost-sharing more often than States with Medicaid-expansion CHIP programs. Only three (out of eight) States with Medicaid-expansion CHIP programs (Alaska, Maryland, and New Mexico) required enrollees to share in costs in some manner, versus 41 out of 43 States with separate CHIP or combination programs.

Since the enactment of CHIPRA in early 2009, a number of States have introduced policy changes to their Medicaid and CHIP programs: 11 have expanded eligibility to children from higher-income households; 17 sought approval in 2010 to introduce improvements in their enrollment and retention processes; eight States have received approval to take advantage of the new Express Lane Eligibility (ELE) option for Medicaid (four for Medicaid only and four for both Medicaid and CHIP); and 19 States have begun using Federal funds to cover legal immigrant children and/or pregnant women who have been in the country fewer than five years (Department of Health and Human Services 2010; Families USA 2010; Mathematica analysis of CARTS data 2011). In addition, 23 States offer additional coverage options for children from families whose incomes are too high to qualify for CHIP, in the form of buy-in programs (11 States), premium assistance options (eight States), or both (four States). Such programs can serve as a bridge between CHIP and private coverage options before provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) extend coverage further in 2014.

Most States have policies in place to discourage substitution of CHIP for private coverage. While some substitution is unavoidable, it is difficult to measure precisely.

Because CHIP covers uninsured children at higher income levels than Medicaid, policymakers were concerned that individuals and families, as well as employers, might drop private coverage to enroll their children in CHIP. To address this concern, Title XXI required States to implement procedures to ensure that CHIP did not displace or "crowd out" private coverage (Rosenbach et al. 2003). In FFY 2010, 47 States had at least one substitution policy in place and 42 States used at least

two different approaches. Most States impose some type of waiting period during which a child must be uninsured before becoming eligible (with reasonable exceptions). Forty-three States monitor health insurance status at the time of application and 27 report checking eligibility against another database, such as their local Blue Cross/Blue Shield insurer, State-specific databases on employer-sponsored insurance (ESI), or the State employee health insurance plan database, among others.

An extensive literature on the substitution topic has yielded widely varying estimates of how much the gains in public coverage are related to declines in private coverage. While studies differ in their methods and data sources, existing evidence indicates that some level of crowdout is unavoidable but the magnitude of substitution is lower than many expected and concerns about CHIP substituting for private coverage have lessened over time. Estimates range from as little as none to as much as 60 percent of the increase in public coverage from CHIP coming from reductions in private coverage, with more recent studies using longitudinal data sources and stronger methods finding rates ranging from 7 to 30 percent (Dague et al. 2011; Dubay and Kenney 2009; Gruber and Simon 2008; Lee et al. 2008; Schone et al. 2008; Bansak and Raphael 2007; Sommers et al. 2007; Davidoff et al. 2005; Hudson et al. 2005; Wooldridge et al. 2005; LoSasso and Buchmueller 2004; Cunningham et al. 2002; Hughes et al. 2002; Slifkin et al. 2001; Mulvihill et al. 2000; Shenkman, et al. 1999). State estimates of denials based on an applicant having access to private coverage are low, with most States reporting denial rates below 10 percent (Limpa-Amara et al. 2007; Lutzky and Hill 2001).[3] In their FFY 2010 CARTS reports, 26 States reported the percentage of applicants found to have other group insurance at the time of application; the average was 8.5 percent, with 12 States reporting figures of 3 percent or less.

The scope and nature of outreach campaigns have evolved over time; recent Federal investment through CHIPRA is helping to spur innovation by States, by providing outreach grants to increase program participation.

In the context of Medicaid and CHIP, the term "outreach" broadly describes efforts undertaken to increase knowledge of and participation in the programs. Under Medicaid, States processed applications from anyone who applied, but in CHIP, States began reaching out to find children who were uninsured and helping them to apply for coverage—a major paradigm shift that also had spillover effects for Medicaid enrollment. The analysis of State data from 2006 to 2010 that was conducted for this report finds that States continued to rely on strategic partnerships with community-based organizations (CBOs), State and local government agencies, and school districts to help reach potentially eligible populations, with a majority of States reporting these partnerships as their most effective outreach strategies. During the same period, States began adopting more technologically savvy, internet-based outreach strategies and reduced the resources they spent on mass media campaigns and community-wide enrollment events.

Conducting a successful outreach campaign is just one way States can work to maximize program participation. In addition to funding outreach campaigns, CHIPRA also identified best practices for simplifying enrollment and renewal processes and offered bonuses to States that used these strategies and achieved significant enrollment gains. As of December 2010, 15 States had received these bonus payments, totaling over $206 million. Of 13 simplification policies studied for

[3] In their review of CHIP crowd-out estimates from applicant-based studies, GAO estimates range from 0 to 17 percent.

this report, States have implemented an average of 8 simplifications per State; the number of policies adopted per State ranged from 5 to 12 by FFY 2010. From FFY 2006 to 2010, more States adopted web-based and online application submission tools, whereas the number of States offering telephone submission of applications decreased. Many States reduced burdensome documentation requirements, allowing self declaration of income, insurance status and other types of information. Variation in State adoption of simplifications is likely influenced in part by how difficult they are to implement. Adoption of ELE, for example, involves coordination with other State agencies and requires Federal approval, whereas eliminating the face-to-face interview is a fairly easy administrative change to implement.

With 4.3 million children (roughly two-thirds of all uninsured children) eligible for but not enrolled in public coverage as of 2009, outreach is still an important tool for States (Kenney et al. 2011). Coverage expansions under the Affordable Care Act will require innovative outreach strategies to educate the public on new eligibility and program guidelines. Lessons from Medicaid and CHIP about what messages are most important to communicate and which methods are most effective to reach the target populations will be important to maximize public awareness and enrollment.

Enrollment grew rapidly at the start and then more gradually as CHIP programs matured. Overall there has been a steady increase in public program enrollment; the rate of growth is influenced by economic conditions, increasing more during economic downturns.

States quickly implemented CHIP programs; enrollment tripled in the first three program years, from about 1.0 million in 1998 to 3.3 million in FFY 2000 (Wooldridge et al. 2003). The program continued to grow over the next decade, reaching a program high of 7.7 million children in FFY 2010. Despite continued program growth (in absolute numbers), the rate of growth has fluctuated over time, due in part to changes in economic conditions and State policies, including eligibility expansions and enrollment simplifications. It is also important to consider how CHIP and Medicaid work together to cover children in low-income families. During economic downturns and periods of increased unemployment, enrollment in CHIP may fall off as family incomes fall and children become eligible for Medicaid. Also, CHIP outreach efforts have helped to find and enroll millions of children in both Medicaid and CHIP. Generally, enrollment in CHIP has followed the pattern of enrollment in Medicaid—both programs increased rapidly after CHIP was implemented in October 1997 (from FFYs 1998 to 2002), after which point the rate of increase slowed, with enrollment plateauing between FFYs 2003 and 2005 before resuming a more pronounced upward trend. Enrollment growth continued between FFYs 2009 and 2010, albeit at a slower pace for CHIP than Medicaid, reflecting the greater need for public programs during economic downturns, as well as increased Federal support for children's coverage under CHIP and Medicaid through CHIPRA, the American Recovery and Reinvestment Act of 2009 (ARRA), and the Affordable Care Act.

States have made great progress in enrolling and retaining eligible children, but there is still room for improvement in program retention.

Recognizing that millions of children remain uninsured despite being eligible for public programs, recent Federal and State efforts have devised creative ways to reach these children and keep them enrolled. In February 2010, Secretary Sebelius issued the *Connecting Kids to Coverage Challenge* to encourage States and local governments, community and faith-based organizations, school districts and health centers, and DHHS partner agencies to find children eligible for public programs and keep them enrolled for as long as they qualify.

If public programs retained all children who were ever enrolled in a given year, the number of uninsured children in the United States would fall by one-third according to one study (Sommers 2007). Administrative data for 8 States participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program show between 40 and 80 percent of children remain enrolled for 18 months, depending on the State (Trenholm et al., 2011). This wide range underscores the vast differences in retention across States and the likelihood that many children leaving CHIP in at least some States may remain eligible. Some children disenroll from CHIP and Medicaid because they are no longer eligible or obtain private coverage, but many children who are still eligible are disenrolled because they do not complete their annual renewal. Discontinuities in coverage also occur due to nonseamless transitions between Medicaid and CHIP. Many children who lose coverage while still eligible reenroll after a short coverage gap (a process referred to as churning), increasing States' administrative costs without increasing overall participation rates.

States have experimented with a variety of strategies to improve retention in public coverage over the past decade. The most prevalent strategies in FFY 2010 are providing a 12-month renewal period (all 51 States), eliminating face-to-face redetermination interviews (49 States), sending renewal notices (46 States), offering continuous coverage (35 States), and using prepopulated renewal forms (32 States). As of September 2010, few States had adopted renewal policies that rely primarily on external databases for eligibility redeterminations, such as ex parte renewals (13 States); administrative renewals (3 States); and ELE (3 States).

CHIP and Medicaid have contributed to reducing the number and percentage of children without insurance.

An analysis of a consistent time series of data from the CPS indicates that the percentage of all children who were uninsured fell from 15.1 percent in 1997 to 10 percent in 2010. For CHIP's primary target population of children with family incomes below 200 percent FPL, the uninsured rate fell by more than 8 percentage points, from 24.6 percent in 1997 to 15.3 percent in 2010. The percentage of uninsured children has continued to decline despite the economic conditions of the last several years that have separated many families from their connection to employer-sponsored coverage and given families fewer resources to purchase coverage on their own, which reinforces the importance of CHIP's role in covering low-income children. Evidence of CHIP's role in reducing uninsured rates for children is in contrast to trends for low-income parents and other adults not eligible for CHIP that show stable or increasing rates of uninsurance during the time period since CHIP was enacted. While coverage gains are evident for children in all racial and ethnic groups, gains for Hispanic children have been particularly large and have contributed to reducing coverage disparities for low-income children during the CHIP era.

Available evidence suggests that the quality of care received by children in Medicaid and CHIP is improving and compares favorably to care received in private plans, but further improvements can be made.

Evidence from prior studies is mixed as to whether children with public coverage receive health care of comparable quality as those who are privately insured (Sebelius 2011). Earlier CHIP evaluations found that recent CHIP enrollees reported receiving more preventive care, had fewer unmet needs, and had better communication with providers than in the six months before enrollment (Kenney 2007; Wooldridge et al. 2005). Although access improved for racial and ethnic minority children and children with special health care needs, disparities in access to care remained (Wooldridge et al. 2005). More recent research reported that access to specialists is more difficult for publicly insured children (Bethell et al. 2011).

More publicly insured children received preventive, primary care, and dental services in FFY 2010 than had in the past. Nearly all children in the various age groups examined had a primary care visit in FFY 2010 among the States that reported using HEDIS or HEDIS-like specifications. Well-child visits were less frequently reported: about 63 percent of all enrolled children ages 3 through 6 had one in FFY 2010, although this is an improvement over FFY 2006, when on average 56 percent of enrolled children had a well-child visit in the 31 States reporting in both years. Notably, median PCP visit rates for Medicaid and CHIP are comparable to rates for commercial plans, and adolescent well-child visit rates are higher in Medicaid and CHIP than in commercial plans.

Still, children in CHIP and Medicaid are not getting as many services as the American Academy of Pediatrics recommends. For example, among States reporting using common measure specifications, most Medicaid and CHIP children of all ages had at least one visit to a primary care provider, but fewer than half of Medicaid and CHIP adolescents had a well-child visit (they should have one well-child visit annually), and only about half of infants in the first 15 months of life received six or more well-child visits (the recommended number of visits for children in this age group is nine). Notably, median PCP visit rates for Medicaid and CHIP are comparable to the median rates for commercially insured children, and rates for adolescent well-child visits are higher in Medicaid and CHIP than in commercial plans. Finally, although Healthy People 2010's goal is for 56 percent of children to have a dental visit within a year, only 40 percent of children in Medicaid received any dental service in FFY 2009 (Sebelius 2011). Recognizing this important health problem, HHS has instituted new goals for States as part of its oral health strategy to try to increase the percentage of children who receive preventive dental services and dental sealants on a permanent molar tooth.

States are a large health care purchaser for children in the United States, covering 34 percent of all children and 60 percent of low-income children in 2010 (2011 Current Population Survey Annual Social and Economic Supplement). However, States have not always had the resources or knowledge to focus on providing quality care in these programs. CHIP and Medicaid programs can improve the care delivered to children enrolled in these programs. The use of a core set of children's health care quality measures enables ongoing monitoring of the quality of care provided to children enrolled in Medicaid and CHIP, and targeted efforts to improve quality within and across States. This report indicates that the use of recommended primary care, preventive, and dental services increased over time, but that room for more improvement exists. New investments from CHIPRA will support State efforts to improve the collection, reporting, and use of child health quality measures, and enable States to begin using what they learn from the measures to improve the care provided to children in Medicaid and CHIP.

Increased caseloads and budget shortfalls top the list of challenges reported by State programs.

Annual CARTS reports include a section for States to report on the challenges and accomplishments for their programs each year. With most States still struggling to rebound from the recession that extended for most of FFYs 2008 and 2009, the economy was by far the most common and significant factor influencing Medicaid and CHIP programs in FFY 2010. Many States described similar patterns related to the economic downturn: sustained unemployment and falling wages resulting in greater demand for public coverage at the same time that economic forces reduced State revenues and created serious budget deficits. Notably, however, support for CHIP remained strong despite these budget challenges, and several States reported eligibility expansions. With limited staff resources, States looked for ways to do business more efficiently and prioritized how staff spent their time.

Many States talked about the challenge of implementing CHIPRA requirements, specifically those related to prospective payment of Federally qualified health centers and rural health clinics and expanded dental and mental health benefits; a few States also mentioned the challenge of keeping up with the Affordable Care Act legislation and its potential impact on CHIP. Several States reported declining enrollment levels as CHIP enrollees became Medicaid eligible with the loss of income. Some States reported being concerned that children were not transitioning smoothly from separate CHIP programs to Medicaid or Medicaid-expansion CHIP programs.

States report use of technology and attention to quality of care as major contributors to State efforts to improve program outcomes.

Two major themes capture many of the accomplishments reported by States in their FFY 2010 CARTS reports: (1) using technology to streamline and simplify enrollment and retention, and (2) improving quality measurement and quality of care. Although States have focused on simplification strategies for many years, current efforts are advancing the use of online applications, prepopulated renewal forms, and electronic exchange of information between different programs or agencies to reduce the burden on families. Some States implemented simplification measures and increased children's enrollment in Medicaid above targeted levels to qualify for a CHIPRA performance bonus. Several States were implementing or exploring the use of ELE and many States reported use of interagency agreements to verify income electronically and/or to verify citizenship and identity using the Social Security Administration (SSA) State Verification Exchange System (SVES).

CHIPRA included provisions to advance quality measurement and quality improvement, and some States noted accomplishments in these areas. Several States, for example, highlighted their work on the CHIPRA quality demonstration projects (a total of 33 States participate in one of these demonstrations). A few States mentioned that health plans participating in their programs had received high rankings in quality. Others noted they had added new quality measures to their standard reports. Ten States cited increased enrollment and fewer uninsured children as accomplishments. Six States mentioned participating in outreach efforts supported by grants and other outside resources. Several States mentioned coordinating with recipients of CHIPRA outreach grants.

Challenges and opportunities arising from the Affordable Care Act are starting to emerge but it is too soon to report on how State programs will be affected by these changes.

Few States discussed the implications of the Affordable Care Act in their FFY 2010 CARTS reports, but they will likely include more on this in future reports and the evaluation will also gather evidence on State experiences and perspectives through the case studies and survey of program administrators. Among the many changes introduced by the Affordable Care Act, the following have potential to affect CHIP programs more substantially:

- A new minimum Medicaid eligibility threshold for all children younger than age 19 of 133 percent FPL, including children currently eligible under a separate CHIP program, effective January 1, 2014
- New Medicaid eligibility for parents and other adults younger than 65 at income levels not exceeding 133 percent FPL, allowing parents and children to be covered under the same plan, effective January 1, 2014
- Elimination of most income disregards in Medicaid and CHIP so that income eligibility is established using a common modified adjusted gross income (MAGI) method; a

standard 5 percent disregard will be applied to everyone, raising the effective income thresholds for Medicaid and CHIP by 5 percentage points

- New options for States to cover children of public employees in CHIP if minimum agency contributions and other requirements are met

The Affordable Care Act also directed development of Affordable Insurance Exchanges (operated by States or the Federal government) through which certified health plans and subsidies would be made available to eligible individuals. The exchanges must be coordinated with Medicaid and CHIP so that eligibility for the appropriate program is established based on a single application that a person can submit online, over the telephone, by mail, or in person. In addition to distinguishing between CHIP and Medicaid populations, States will have to keep track of those who are newly eligible for Medicaid because the amount of Federal financial participation will be higher for these people. The Affordable Care Act also stipulates that CHIP enrollees be assured coverage through a qualified affordable insurance exchange plan that is certified as comparable to CHIP in the event that State programs exhaust their Federal allotments and are unable to continue enrolling children in CHIP.

In many ways the changes set in motion by the Affordable Care Act mark the beginning of a new era in coverage for low-income children and families. The reforms have the potential to streamline and simplify the process of getting coverage for millions of low-income families and to reduce some of the complexity involved in operating public coverage programs. It is still too early in the implementation process for States to know how these changes will affect their CHIP programs. Future evaluation activities will focus on documenting State experiences and gathering insights about the role of CHIP in the evolving health care landscape.

I. CONTEXT FOR AN UPDATED FEDERAL EVALUATION OF CHIP

The Children's Health Insurance Program (CHIP), a landmark initiative to help close the health insurance coverage gap for low-income children, recently celebrated its 14th anniversary. Passed with bipartisan support as part of the Balanced Budget Act of 1997, CHIP in conjunction with Medicaid has helped to fuel a decline in the number of uninsured children, whose number has fallen from 11.4 million (15.1 percent of children) in 1997 to 8.0 million (10.0 percent of children) in 2010 (analysis of data from the Current Population Survey, Annual Social and Economic Supplement, 1998-2011).

Although designed to resemble Medicaid in some ways, CHIP differs from Medicaid in several key respects. Both are joint Federal–State programs, but CHIP is smaller than Medicaid in terms of total enrollment (nearly 8 million in CHIP versus 68 million in Medicaid) and program spending ($11 billion versus $400 billion) in Federal fiscal year (FFY) 2010 (Medicaid and CHIP Payment and Access Commission [MACPAC] 2011). Medicaid targets the poorest children (along with certain poor adults), generally those with family income up to 133 percent of the Federal poverty level (FPL) (for children under age 6) or up to 100 percent of the FPL (for children ages 6 to 18).[4] CHIP picks up where a State's Medicaid eligibility thresholds end, offering coverage to children with family incomes up to 200 percent of the FPL and beyond (Wooldridge et al. 2005).[5] States have more control of the design of their CHIP programs than they do for Medicaid, and the States' share of CHIP costs is lower than for Medicaid (on average the Federal share of CHIP costs in FFY 2010 was 12 percentage points higher than it was for Medicaid) (*Federal Register* Notice 2008).[6] Although Medicaid is an entitlement program with no spending cap, CHIP was designed as a block grant program that included set Federal allotments for each State based on the number of uninsured children in a State (along with other factors), with an initial cap on Federal funding of $40 billion.[7] States also have flexibility, within parameters set by the CHIP statute, to design CHIP benefit packages and cost-sharing rules, and to control eligibility thresholds, outreach strategies, and enrollment and retention policies; in contrast, Medicaid policies are relatively rigid, prescribed by

[4] As discussed further in Chapter II, there are many exceptions to these general Medicaid eligibility rules for children: for example, States can offer Medicaid coverage to children from higher-income households by disregarding certain income or deducting certain expenses; they can also modify their Medicaid eligibility requirements through a Federally approved waiver; and they can permit children with high medical costs to spend down to Medicaid eligibility levels (National Academy of State Health Policy [Hess et al. 2011). In addition, States must cover many other populations in Medicaid, including certain poor adults and pregnant women, certain poor individuals with disabilities or who qualify for cash assistance under the Supplemental Security Income (SSI) program, and certain groups of legal permanent resident immigrants (Congressional Research Service 2010).

[5] Although intended to cover children, States could initially cover certain uninsured adults in their CHIP programs with a federally approved waiver; this has since been phased out.

[6] Section 2105(b) of the BBA Act of 1997 specifies the formula for calculating the Enhanced Federal Medical Assistance Percentages (FMAP) as follows: The "enhanced FMAP", for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent. The limit of 85 percent has not been reached by any State so far.

[7] The original CHIP allotments were based on three State factors: (1) the number of low-income children (2) the number of low-income uninsured children, and (3) health sector wages (Czajka and Jabine 2002; Families USA 2009).

Federal rules and regulations. Because of the flexibility CHIP affords, the characteristics of CHIP programs vary across States (Rosenbach et al. 2007).

CHIP has evolved considerably since its inception. States quickly implemented CHIP programs. Legislation in 1999 and 2005 made adjustments to the allotments, including additional funds for States with shortfalls, to try to counteract these problems (P.L. 106-113; Deficit Reduction Act of 2005 [P.L. 109-171]).

Because of compromises made to enact CHIP, it was set to expire in 2007 unless reauthorized by Congress. Congress gave CHIP a temporary reprieve in December 2007: the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the program and funded it through March 2009 (Kaiser Commission on Medicaid and the Uninsured 2009a). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) reauthorized CHIP and funded it through 2013. CHIPRA also provided States with new tools, new funds, and a new funding formula to use in their CHIP programs to address shortfalls in both enrollment and access to and quality of care. Further supporting CHIP, the Patient Protection and Affordable Care Act of 2010 and the Health Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) extended CHIP funding through 2015. Among other changes, the Affordable Care Act also specified a new "no wrong door policy" for applicants: beginning in 2014, CHIP must work in coordination with Medicaid and the Affordable Insurance Exchanges (a new form of subsidized coverage) to screen each child and adult who applies for coverage and enroll them in the insurance appropriate for their income (Medicaid, CHIP, or the exchange).

A. Purpose of this Report

CHIPRA also directed an updated evaluation of CHIP, with reports of evaluation findings to be submitted to Congress; this interim report is the first of two reports that will fulfill the mandate. This report has two fundamental purposes:

- To provide a comprehensive resource for Congress documenting what is known about the CHIP program as of FFY 2010, including insights about changes States have made as a result of opportunities CHIPRA introduced.
- To provide a preview of the issues that will be examined through evaluation activities and presented in the final evaluation report, due to Congress in 2013.

The evaluation comes at an important juncture for CHIP. The Affordable Care Act extended funding for CHIP through FFY 2015, but funding after that point is not assured; moreover, the Affordable Care Act stipulated that States must maintain minimum eligibility and enrollment standards (known as maintenance of effort [MOE] requirements) in CHIP (as well as in Medicaid) that are at least as generous as those in place when the legislation was enacted on March 23, 2010 (P.L. 111-148).[8] Thus, States' CHIP programs must cover children through September 2019 at

[8] The American Recovery and Reinvestment Act, passed in February 2009, first established the Medicaid MOE requirements and made them retroactive to Medicaid eligibility standards in place as of July 1, 2008; this legislation also provided Medicaid fiscal relief, in the form of enhanced Medicaid matching, through June 2011 (Kaiser Commission on Medicaid and the Uninsured 2011). The Affordable Care Act extended the Medicaid MOE requirements for adults to January 2014, when the exchanges go into effect (Kaiser Commission on Medicaid and the Uninsured 2011).

prescribed minimum eligibility levels without guaranteed financing after 2015 and risking the loss of Federal Medicaid funds if they do not comply (Kaiser Commission on Medicaid and the Uninsured 2011b). The evaluation will provide new insights about enrollment, retention, and the effect of changes authorized by CHIPRA. It will also provide early information on issues related to State implementation of relevant provisions of the Affordable Care Act. Findings will help Congress and the nation better understand CHIP and assess its value.

B. History and Evolution of CHIP

Providing health insurance coverage to children has been a pressing policy issue for decades (Cunningham and Kirby 2004). The Social Security Act Amendments of 1965 (P.L. 89-97) enacted Medicare (Title XVIII of the Social Security Act), the coverage program for the elderly, and Medicaid (Title XIX of the Social Security Act), the coverage program for the poor, including families with children and the aged, blind, or disabled. Before this legislation, health care services for the poor were provided through a patchwork of public programs, charities, and community hospitals (Kaiser Commission on Medicaid and the Uninsured 2011a; Policy Almanac 2011).[9] From its inception, Medicaid coverage was tied to receipt of Aid to Families with Dependent Children (AFDC), the nation's welfare program. AFDC recipients were automatically entitled to Medicaid benefits (Kronebusch 2001).

The growing number of uninsured, low-income children throughout the 1970s and early 1980s led to Medicaid reforms. Beginning with the Deficit Reduction Act of 1984 (P.L. 98-369), Congress passed a series of expansions throughout the decade that permitted States to offer Medicaid coverage to additional groups, including certain pregnant women, infants, and children under age 6 up to specified incomes, among others (Kaiser Commission on Medicaid and the Uninsured 2011a). Still, the gap in coverage for children continued to widen: by 1987, nearly one-quarter (24 percent) of children in families with family income less than 100 percent of the FPL were uninsured, compared with less than 5 percent of children with family incomes greater than 200 percent of the FPL (Centers for Disease Control 1987). In 1990, the Omnibus Budget Reconciliation Act (OBRA 90) (PL 101-508) sought to address this problem, expanding Medicaid coverage to all children ages 6 to 18 with family income less than 100 percent of the FPL, starting with the youngest and phasing in another age level each year until 2002, when all 18-year-olds became eligible. By 1997, the effects of the OBRA 90 legislation were apparent: 11 percent of children with income less than 100 percent of poverty were uninsured (Agency for Health Care Research 1997; Cunningham and Kirby 2004).

It was also in the 1990s that a previously overlooked trend became evident: the growing number of uninsured children with incomes *above* the FPL. Between 1977 and 1997, the percentage of children with family incomes between 100 and 200 percent of the FPL who were uninsured increased from 13.0 to 19.5 percent, due largely to declines in private insurance coverage (Cunningham and Kirby 2004). Although attempts at national health care reform had failed in 1994, there was support from Congressional leaders of both political parties to craft legislation that would help children who fell into this coverage gap. The State Children's Health Insurance Program (originally known as SCHIP, now called CHIP) passed with bipartisan support as part of the

[9] For example, Title V of the Social Security Act of 1935 provided services for mothers, infants, and children, although this was not a "coverage" program. This was the predecessor program to what is now known as the Maternal and Child Health Services block grant program.

Balanced Budget Act of 1997 and became law on August 5, 1997, becoming Title XXI of the Social Security Act (P.L. 105-33).[10] Congress appropriated $40 billion to support CHIP's first 10 years (FFYs 1998 through 2007) (Wooldridge et al. 2003).

As noted earlier, CHIP is similar to Medicaid in that both are Federal–State jointly supported programs, and the Centers for Medicare & Medicaid Services (CMS) administers both programs for the Federal government. However, Congress deliberately designed CHIP to give States more control over program design compared with Medicaid, with the hope that States might experiment with providing coverage that more closely resembled what might be available in the commercial insurance market (Ryan 2009). For example, States decide how they administer CHIP, as well as who is covered and what the benefit package will be, within Federal limits. CHIP covers children in families with income above the relevant Medicaid threshold and up to 200 percent of the FPL and beyond.[11] Title XXI also gave States flexibility in how they counted family income, permitting States to be more generous in their upper income limit for the program if desired (Rosenbach et al. 2003). Within certain limits established in the law, States could design the CHIP benefit package and cost-sharing requirements to be consistent with public or private insurance in the State, and States could also choose the program's delivery system (managed care, fee for service, or primary care case management) (Rosenbach et al. 2003). Finally, States could use a portion of their administrative funds to conduct outreach for the program—a new role for States (Perry et al. 2000; Williams and Rosenbach 2007).[12] Outreach funds were seen as vital to encouraging CHIP enrollment, but in addition, it was anticipated that CHIP outreach might have a complementary effect on Medicaid enrollment, which had fallen in the wake of welfare reform (welfare reform, passed in 1996, severed the automatic eligibility link between welfare and Medicaid enrollment) (Rosenbach et al. 2003; Nathan et al. 1999).

States quickly implemented CHIP programs; in the first three program years, enrollment tripled, from about 1.0 million in 1998 to 3.3 million in FFY 2000 (Wooldridge et al. 2003). The program has continued to grow, albeit at a slower pace, in the past decade. The latest statistics show that 7.7 million children were enrolled in the program at some point in FFY 2010. As shown in Table I.1, 90 percent of children enrolled in CHIP in 2010 have a family income under 200 percent of the FPL, and most (76 percent) of the children enrolled in CHIP receive care through a managed care delivery system. Table I.2 provides an overview of State programs and the number of children ever enrolled in CHIP in 2010, by State.

CHIP has not been a static program. Even before CHIPRA passed, Congress legislated changes to various aspects of CHIP (Figure I.1 provides a time line of key legislative changes). For example, States identified problems early on with the formula for the allotments; the formula did not consider State expenditures, leading to imbalances where some States had surplus CHIP funds while others

[10] CHIPRA renamed the program the Children's Health Insurance Program (CHIP); for clarity, we use the CHIP acronym throughout this report.

[11] States were permitted to set their CHIP thresholds up to 50 percentage points above existing Medicaid levels and in some states this resulted in thresholds above 200 percent FPL. In FFY 2010, 28 States had income thresholds above 200 percent FPL

[12] Marketing efforts were not part of the Medicaid program.

experienced shortfalls (Peterson 2006; Peterson 2009).[13] The Balanced Budget Refinement Act of 1999 revised aspects of the State allotment formulas, provided additional funding for CHIP in U.S. territories, and required an evaluation of the program. CHIP remained largely untouched until passage of the Deficit Reduction Act of 2005 [P.L. 109-171] (signed into law in February 2006), which increased funds available for CHIP to avoid State CHIP deficits. This legislation also eliminated coverage of childless adults in CHIP. States also made changes to their CHIP programs unrelated to legislative changes. For example, while many initially implemented Medicaid-expansion CHIP programs because it allowed them to quickly implement CHIP, over time more have begun administering separate CHIP and combination programs, which offer States more flexibility in program design.

Table I.1. CHIP at a Glance, FFY 2010

Children ever enrolled in CHIP during the year	7.7 million
CHIP children with family incomes below 200% of the Federal Poverty Level	90%
Number of children in CHIP programs in the fourth quarter of FFY 2010[a]	5.8 million
Who obtained care through managed care plan enrollment	4.4 million (76%)
Who obtained care on a fee-for-service basis	0.8 million (14%)
Who obtained care through primary care case management	0.6 million (10%)
Number of State (and D.C.) CHIP programs	51
Which operate Medicaid-expansion CHIP programs	8
Which operate separate CHIP programs	17
Which operate combination programs (Medicaid expansion and separate CHIP)	26
Government spending on CHIP	$11.4 billion
Federal spending on CHIP	$8.0 billion
State spending on CHIP	$3.4 billion

Sources: Centers for Medicare and Medicaid Services (CMS) 2011c, Medicaid and CHIP Payment and Access Commission (MACPAC) 2011, FFY 2010 CARTS reports, CMS CHIP Statistical Enrollment Data System (SEDS), as of February 18, 2011, verified and provided by CMS.

Notes: All data are for FFY 2010; CHIP= Children's Health Insurance Program;

[a] Data are for children ever enrolled in quarter 4 of FFY 2010 accessed June 15, 2011.

CHIP was legislated as a 10-year program; without reauthorization, CHIP was set to expire in 2007. Attempts to reauthorize the program failed in fall 2007. Congress instead extended CHIP through March 2009, funding it at $5 billion per year and appropriating some additional funds to help States with projected funding shortfalls. In January 2009 the U.S. House and Senate passed legislation to reauthorize CHIP that was signed into law on February 4, 2009. CHIPRA provided significant new financial support for the program, including $44 billion in new funding (in addition to the $25 billion already appropriated through FFY 2015), establishment of a performance bonus fund to encourage States to pursue innovations in enrolling children and keeping them enrolled, $100 million in new outreach grant funding, and the establishment of an enhanced match rate for translation and interpretation services (Kaiser Commission on Medicaid and the Uninsured 2009b; PL 111-3, Section 104). CHIPRA also provides funding to study and improve access and quality of care for children and address other issues.[14]

[13] Allotments were based on the number of low income children without health insurance (100% in FY 1998 and FY 1999, 75% in FY 2000, 50% in FY 2001- 2008) and the number of all low-income children. States argued that the original allotments were based on inaccurate data and put States that insured more low income children at a disadvantage.

[14] This included $225 million for child health quality initiatives, including developing child health quality measures and electronic health records, and $20 million for the U.S. Census Bureau to improve State-specific estimates of children, as well as funding for this CHIP evaluation (P.L. 111-3).

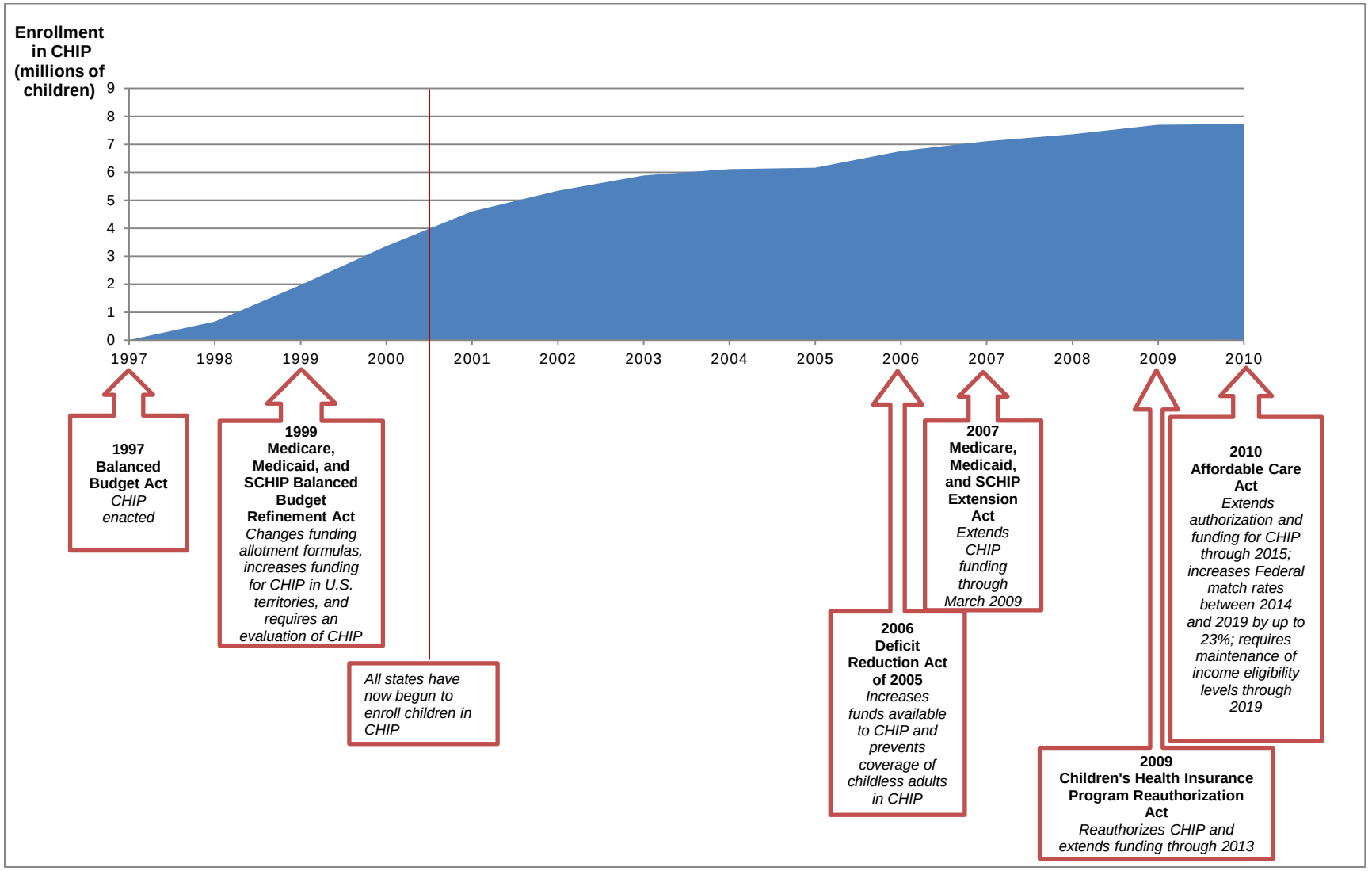
Table I.2. A Snapshot of CHIP Programs in the 50 States and District of Columbia, FFY 2010

State	Type of CHIP Program, FFY2010	Program Name	Number of Children Ever Enrolled in CHIP Programs, FFY 2010
Total			7,705,723
Alabama	Separate	ALL Kids Program	137,545
Alaska	Medicaid Exp.	Denali Kid Care	12,473
Arizona	Separate	KidsCare Program	39,589
Arkansas	Combo	ARKids First-B	100,770
California	Combo	Healthy Families Program	1,731,605
Colorado	Separate	Child Health Plan Plus (CHP+)	106,643
Connecticut	Separate	HUSKY Plan, HUSKY Part B, HUSKY Plus	21,033
Delaware	Combo	Delaware Healthy Children Program	12,852
District of Columbia	Medicaid Exp.	DC Healthy Families	8,100
Florida	Combo	Florida KidCare	403,349
Georgia	Separate	PeachCare for Kids	248,268
Hawaii	Medicaid Exp.	QUEST program	27,256
Idaho	Combo	Idaho Children's Health Insurance Program (CHIP)	42,208
Illinois	Combo	All Kids	329,104
Indiana	Combo	Hoosier Healthwise Program	141,497
Iowa	Combo	Healthy and Well Kids in Iowa (hawk-I) Program	63,985
Kansas	Separate	Healthwave	56,384
Kentucky	Combo	Kentucky Children's Health Insurance Program (KCHIP)	79,380
Louisiana	Combo	LaCHIP Program	157,012
Maine	Combo	MaineCare/CubCare Program	32,994
Maryland	Medicaid Exp.	Maryland Children's Health Program (MCHP)	118,944
Massachusetts	Combo	MassHealth Program	142,279
Michigan	Combo	MIChild Program	69,796
Minnesota	Combo	MinnesotaCare Program	5,164
Mississippi	Separate	Mississippi Children's Health Insurance Program (CHIP)	95,556
Missouri	Combo	MO HealthNet for Kids	86,261
Montana	Combo	Healthy Montana Kids	25,231
Nebraska	Medicaid Exp.	Kids Connection Program	47,922
Nevada	Separate	Nevada Check Up Program	31,554
New Hampshire	Combo	NH Healthy Kids	10,630
New Jersey	Combo	NJ FamilyCare/Kidcare	187,211
New Mexico	Medicaid Exp.	New Mexikids program	9,654
New York	Separate	Child Health Plus (CHPlus) Program	539,614
North Carolina	Combo	North Carolina Health Choice for Children Program	253,892
North Dakota	Combo	Healthy Steps Program	7,192
Ohio	Medicaid Exp.	Healthy Start Program	253,711
Oklahoma	Combo	Children's Health Insurance Program (CHIP)/SoonerCare Choice	122,874
Oregon	Separate	Oregon Health Plan/Healthy KidsConnect	64,727
Pennsylvania	Separate	Children's Health Insurance Program (CHIP)	273,221
Rhode Island	Combo	RIte Care	23,253
South Carolina	Medicaid Exp.	Healthy Connections Kids	73,438
South Dakota	Combo	Children's Health Insurance Program (CHIP)	15,872
Tennessee	Combo	CoverKids Program	81,341
Texas	Separate	Children's Health Insurance Program (CHIP)	928,483
Utah	Separate	Children's Health Insurance Program (CHIP)	62,071
Vermont	Separate	Dr. Dynasaur	7,026
Virginia	Combo	FAMIS Program	173,515
Washington	Separate	Children's Health Insurance Program (CHIP)/ Apple Health for Kids	35,894
West Virginia	Separate	Children's Health Insurance Program (CHIP)/WV CHIP	37,539
Wisconsin	Combo	BadgerCare Plus	161,469
Wyoming	Separate	KidCare CHIP Program	8,342

Sources: Centers for Medicare and Medicaid Services (CMS), CHIP Statistical Enrollment Data System (SEDS) as of February 18, 2011, verified and provided by CMS.; FFY 2010 CARTS reports, accessed May 31, 2011.

Notes: CHIP=Children's Health Insurance Program; Medicaid Exp. = Medicaid-expansion CHIP, Combo = combination program.

Figure I.1. Time Line of Major CHIP Legislation and Child Enrollment Trends in CHIP, 1997-2010



Source: Mathematica analysis of SEDS data; P.L. 105-33; P.L. 106-113; P.L. 109-171; P.L. 110-173; P.L. 111-3; P.L. 111-148.

Note: The enrollment data shown for FFYs 1998 – 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 – 2010 are annual data from CMS' SEDS as of February 18, 2011, verified and provided by CMS. Enrollment shown is children ever enrolled in the program. Deficit Reduction Act of 2005 was not signed into law until 2006. The Affordable Care Act refers to the Patient Protection Act of 2010 and the Health Care Education Act of 2010 collectively.

CHIPRA also amended the CHIP funding formula: beginning April 1, 2009, State allotments are now based on actual CHIP expenditures, instead of the prior formula, which allocated funds to each State based on the number of low-income children, the number of low-income uninsured children, and health sector wages in each State (Czajka and Jabine 2002; Families USA 2009). In addition, during FFYs 2009 and 2010, all States were scheduled to receive larger allotments than they had in the past, even if historically they did not spend all of their allotments (Families USA 2009). However, beginning in FFY 2011, CHIP allotments are based on how much States spent in FFY 2010—giving States an incentive to try to enroll and retain as many uninsured children as possible, to maximize expenditures and thus maximize their allotments (Families USA 2009). Finally, the new funding mechanism will revise State allotments every two years, based on how much of their previous year's allotments were spent, and it establishes a contingency fund for States with shortfalls.

In addition to financing changes, CHIPRA made several policy changes in CHIP. Among other changes, States now must offer dental services and mental health parity in CHIP; States have the option to cover legal immigrant children and pregnant women (who previously were prohibited from obtaining CHIP or Medicaid during their first five years in the United States); States can provide premium assistance to children and families with employer-sponsored coverage; States can no longer cover parents in CHIP; and children enrolled in CHIP must document their citizenship (as in Medicaid) (Kaiser Commission on Medicaid and the Uninsured 2009b).

C. Overview of the Federal Evaluations of CHIP

CHIP has been a dynamic program, evolving in response to legislative requirements as well as to changing State environments. CHIPRA directed an updated evaluation of CHIP to help Congress understand CHIP's role as an insurer in a time of changing coverage requirements, declines in private coverage, and economic volatility in the States. This section reviews findings from the prior CHIP evaluations and plans for the current evaluation.

1. Prior Evaluations and Key Findings

There have been two previous Congressionally mandated CHIP evaluations. The Balanced Budget Act of 1997 required States to evaluate their CHIP programs and submit reports to CMS by March 2000 (P.L. 105-33; Rosenbach et al. 2003). This legislation also stipulated that the Secretary of the Department of Health and Human Services submit a Report to Congress by December 31, 2001, based on the information in the State evaluations (Rosenbach et al. 2003). In the Balanced Budget Refinement Act of 1999, Congress mandated an independent, comprehensive study of CHIP (P.L. 106-113; Wooldridge et al. 2005). Mathematica Policy Research conducted both evaluations, the first through a contract with CMS, and the second, in partnership with the Urban Institute and the MayaTech Corporation, through a contract with Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, numerous other studies have assessed various aspects of CHIP.

Research evidence from CHIP's early years indicates the program has made great progress in several areas. With expansions in the program, new investments in outreach, and enrollment simplifications, uninsured rates declined among children, both for those made newly eligible for public coverage under CHIP and those already eligible for Medicaid (Hudson and Selden 2007; Davidoff et al. 2005; Kenney and Yee 2007; Kenney and Chang 2004; Dubay et al. 2007; Kenney et al. 2005; Rosenbach et al. 2007; Wooldridge et al. 2005). The research also indicates improvements in access to care and increases in receipt of preventive care among the children who gained public coverage (Sebelius 2011; Sebelius 2010; Rosenbach et al. 2007; Wooldridge et al. 2005; Kenney and

Chang 2004). At the same time, however, millions of children remained uninsured despite being eligible for Medicaid or CHIP, and many enrolled in public coverage did not receive recommended levels of care (DeNavas et al. 2009). Moreover, uninsured rates among low-income children varied widely from State to State and across subgroups (Lynch et al. 2010).

2. Current Evaluation and Key Methods Planned

The CHIPRA legislation mandates an updated evaluation of CHIP patterned after the previous Congressionally mandated evaluation (Wooldridge et al. 2005). In September 2010, Mathematica and its subcontractor the Urban Institute were awarded the contract to conduct this new Congressionally mandated evaluation of CHIP, which will be conducted over a three-year period. ASPE is overseeing this work.

Coming five years after completion of the previous evaluation, the current evaluation will provide new and detailed insights into how the program has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Affordable Care Act. Building on prior evaluations focused on the early years of CHIP, it will explore how States have grappled with important implementation challenges as the program matured and their experiences in enrolling, retaining, and delivering care to children in low-income families. It will place particular emphasis on understanding enrollees' experiences in obtaining care and the types of services received, as well as how CHIP compares with other public and private coverage. Using a mixture of quantitative and qualitative research methods, the evaluation will document how CHIP programs have developed, where they stand today, and their possible future direction. It will draw on new primary data collection efforts modeled after the previous evaluation, including surveys of enrollees and disenrollees in CHIP (10 States) and Medicaid (3 States), site visits and focus groups in the 10 survey States, and a survey of program administrators in every State. To analyze States' progress in enrolling and retaining children and to document effective policies and practices, the evaluation will also make use of various secondary data sources, including States' annual reports on their CHIP programs, other program data States submit to CMS, and administrative data files from State eligibility and enrollment systems. It also will tap data from other national surveys to understand how CHIP and Medicaid are perceived by low-income families with uninsured children who might be eligible and to gauge the extent to which CHIP is reducing the share of low-income children who are uninsured.

As shown in Table I.3, the evaluation has five coordinated components, with findings that will be integrated to address a large number of overlapping research questions. The research topics and questions are summarized in Table I.4. CHIPRA specified that the evaluation include 10 States that (1) use diverse approaches to providing child health assistance, (2) represent various geographic areas (including a mixture of urban and rural areas), and (3) each contain a significant portion of uncovered children. ASPE and the evaluators expanded on these three factors to develop a robust list of 17 criteria for selecting States and a set of decision rules for applying them, resulting in 10 States being recruited for the study: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. Table I.5 provides more details about how each State, and the States in combination, satisfy the 17 study criteria.[15] Together, these 10 States represent 53 percent

[15] The full study design, including a detailed discussion of the State selection process, is contained in Harrington et al. 2011, available on request from the authors.

of the nation's uninsured children and 57 percent of all children enrolled in CHIP. Evaluation findings will be synthesized in two reports to Congress. The first, this 2011 interim evaluation report, draws on findings from an analysis of State program reports and other secondary data sources (discussed below). A more comprehensive 2013 evaluation report will integrate findings and lessons from all five study components to address the full range of research questions Appendix Table A.1 provides a complete list of the research questions covered in the evaluation and indicates the questions addressed in this report versus the 2013 Report to Congress.

Table I.3. Methods Planned for Current CHIP Evaluation

Method	Purpose	Timing[a]
Survey of CHIP Enrollees and Disenrollees in 10 States and Medicaid Enrollees in 3 States	Provide information on the demographic and socioeconomic characteristics of CHIP/Medicaid children and their families; perceptions of and experiences with application and renewal processes; the health status and health care needs of CHIP/Medicaid enrollees; enrollee experiences with accessing health care; and satisfaction with the program	Feb – Dec 2012
Case Studies in 10 Survey States	Conduct site visits to interview key State and local informants, and conduct focus groups with families of enrolled and disenrolled children to understand perceptions of CHIP, barriers families might experience, the extent to which CHIPRA has changed program design or administration, and likely ramifications for CHIP and Medicaid after implementation of the Affordable Care Act	Jan – Jun 2012
Survey of CHIP Program Administrators in 50 States and the District of Columbia	Provide national context for case study findings as well as understand State preparations for implementation of the Affordable Care Act	Fall 2012
Analysis of National Survey Data	Analyze the National Survey of Children's Health (NSCH) module of the State and Local Area Integrated Telephone Survey (SLAITS), the Current Population Survey (CPS), and American Community Survey (ACS) data to estimate program participation rates, explore how low-income families with uninsured children perceive CHIP and Medicaid, and determine implications of health reform provisions	Winter 2012 – Spring 2013
Analysis of State Program Data	Analyze administrative data from State eligibility and enrollment systems to analyze enrollment and retention trends and dynamics, including transitions between CHIP and other coverage and trends in churning out of and into CHIP, and identify program features and other factors influencing these outcomes	Winter 2012 – Spring 2013

Notes: CHIP=Children's Health Insurance Program; CHIPRA=CHIP Reauthorization Act.

[a] These are the currently anticipated timing of activities; actual timing will depend on clearance of study materials by the Office of Management and Budget (OMB).

Table I.4. Summary of Key Research Topics and Questions and Methods to Assess Them

Research Topics and Key Questions	Methods				
	Survey of CHIP Enrollees and Disenrollees in 10 States and Medicaid Enrollees in 3 States	Case Studies in 10 Survey States, including Key Informant Interviews and Focus Groups	Survey of CHIP Program Admin in 50 States and the District of Columbia	Analysis of National Survey Data (SLAITS, CPS, ACS)	Analysis of State Program Data
Program Context and Design Features • What are key design features? • How and why have these features changed over time? • How do features influence key program outcomes?	X	X	X	X	X
Outreach and Enrollment • What are effective and ineffective outreach strategies for CHIP and Medicaid? • What are the trends in program enrollment? • What factors influence enrollment trends?	X	X	X	X	X
Retention and Disenrollment • What are the trends in retention, churning, and transitions between Medicaid and CHIP? • How have these trends and dynamics changed over time? • How long do children typically remain enrolled? • Why do children disenroll from CHIP?		X	X	X	X
Access, Utilization, Content of Care, and Satisfaction • What experiences do CHIP enrollees have in seeking or obtaining care? How does this compare with experiences before enrolling? • What impact does CHIP have on the type of care received, content of care, and family well-being?	X	X	X		
Relationship Between CHIP and Other Coverage • How has CHIP altered or factored into the movement of low-income children between public coverage, private coverage, and uninsurance? • Do families view CHIP as a long- or short-term coverage option?	X	X		X	
Impact on Uninsured Children • What is the participation rate in public coverage among eligible low-income children? • What are the implications of setting eligibility at higher levels to target uninsured children?		X	X	X	X
Implications for Health Reform • What factors do families consider when making decisions about health insurance options? • How are States preparing for health reform? What challenges have they encountered, and what kind of assistance do they need?	X	X			

Notes: CHIP=Children's Health Insurance Program; SLAITS=State and Local Area Integrated Telephone Survey; CPS=Current Population Survey; ACS=American Community Survey.

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Table I.5. Key Aspects of 10 States Selected for Current CHIP Evaluation

Primary Selection Criteria	Alabama	California	Florida	Louisiana	Michigan	New York	Ohio	Texas	Utah	Virginia
Program type	Separate CHIP	Combo (Separate CHIP: 82.0%)	Combo (Separate CHIP: 99.6%)	Combo (Medicaid-expansion CHIP: 97.0%)	Combo (Separate CHIP: 78.0%)	Separate CHIP	Medicaid Expansion	Separate CHIP	Separate CHIP	Combo (Separate CHIP 54.0%)
At least 50% share of uninsured children under 200% FPL	1.33%	14.57%	9.74%	1.06%	1.76%	3.15%	2.66%	16.64%	1.51%	1.86%
At least 2 of the top 10 States, highest rate of uninsured children		X	X			X	X	X		
At least 40% share of CHIP enrollees nationally	1.39%	22.71%	4.53%	2.55%	0.93%	7.71%	3.09%	10.97%	0.84%	1.94%
At least 5 States outside top 10, CHIP program size	X			X	X				X	X
At least 2 States, top and bottom quartile, Medicaid and CHIP participation rate			X (Bottom)	X (Top)	X (Top)	X (Top)		X (Bottom)	X (Bottom)	
At least 2 States that received CHIPRA bonus payment	X			X	X					
At least 2 States with ELE	X			X						
At least 2 States, SSA matching	X	X		X			X			X
At least 2 States that did not receive CHIPRA bonus payments, do not have ELE, and do not do SSA matching			X			X		X	X	
At least 2 States reporting Separate CHIP enrollment in MSIS				X					X	X
At least 2 States in which at least 20% of the population lives in a rural area	X						X			
At least 3 States in which at least 25% of the population lives in an urban area	X	X	X	X	X	X	X	X	X	X
At least one State from each of the 4 Census regions	S	W	S	S	MW	NE	MW	S	W	S
At least 7 States in top half, percentage of non-white children	X	X	X	X		X		X		X
At least 3 States in top quartile, percentage of Hispanic children		X	X			X		X		
At least 3 States in top quartile, percentage of African American children	X		X							X

Sources: Program type data: Centers for Medicare & Medicaid Services (CMS) 2011c; Uninsured rate among low-income children: Lynch et al. 2010; CHIP enrollment as of June 2009: Kaiser Family Foundation 2010; Medicaid and CHIP participation rate: Kenney et al. 2010; CHIPRA bonus payments: Insurekidsnow.gov 2011; Express Lane Eligibility information: Families USA 2010a; SSA matching information: Cohen Ross 2010; Reporting of separate CHIP data in MSIS: Matthew Hodges, Mathematica Policy Research, personal communication, November 16, 2010; Geographic data: U.S. Census Bureau 2010; Racial and ethnic data: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, 2010.

Notes: CHIP = Children's Health Insurance program; Combo=combination program; CHIPRA = CHIP Reauthorization Act; ELE = Express Lane Eligibility; FPL = Federal poverty level; SSA = Social Security Administration; X = State has this feature; For Census region, MW = Midwest; NE = Northeast; S = South; W = West;

D. Data Sources for this Report

This interim report provides a comprehensive review of the current status of the CHIP program and how it has changed since FFY 2006. It uses secondary data sources, whereas the final evaluation report will use data from primary data collection efforts that will begin in 2012. The main data source for this report is the CHIP Annual Reporting Template System (CARTS), a comprehensive reporting system established by CMS for States to report on their CHIP programs.[16] Because this evaluation of CHIP is designed to start where the previous national evaluations ended, we have analyzed the CARTS data for FFYs 2006 through 2010. Although the 2010 data provide a current picture of CHIP, data from the earlier years enable us to examine policy and program changes so that we can characterize the ongoing evolution of the program.

There are two main limitations to CARTS data. First, States can skip questions or provide different levels of information to open-ended questions; thus some data elements are not available systematically across States. Second, the wording of some questions in CARTS has changed over time and other questions have been added or eliminated, limiting our ability to characterize program changes in some areas. Where data are inconsistent or unavailable in CARTS, we used other published sources so that we could provide a complete picture of CHIP in the 50 States and the District of Columbia.

The second main data source for the report is the CHIP Statistical Enrollment Data System (SEDS). We used SEDS data for the analyses of enrollment in public coverage presented in Chapter IV. We used tested validity checks to verify the consistency of the SEDS data (described in Ellwood et al. 2003). In addition, in cases in which either Medicaid or CHIP enrollment data were missing in SEDS, we used published data on Medicaid and CHIP enrollment available through the Medicaid Statistical Information System (MSIS) State Summary Datamart. Data from the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) are used to document coverage trends from 1997 to 2010.

Finally, we use published and unpublished literature on CHIP to provide motivation and context for the findings in each chapter, based on review and synthesis of prior and ongoing CHIP research.

E. Road Map for the Report

Chapter II reviews key design features of CHIP and Chapter III describes CHIP outreach and application processes. Chapter IV reviews CHIP enrollment and retention policies and processes and describes enrollment trends in CHIP and Medicaid. Chapter V examines coverage trends and progress toward reducing uninsurance rates for low income children; Chapter VI reports on child health quality performance measures reported by States. Chapter VII concludes the report by summarizing past successes and ongoing challenges reported by States and discussing future implications of the Affordable Care Act on State CHIP programs.

[16] Section 2108 (a) of the Balanced Budget Act of 1997 (which established CHIP) also established the requirement that States assess their CHIP programs in each fiscal year and report on findings by the following January 1st. The CARTS reporting system, as it exists today using a uniform reporting system, did not begin until 2003.

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II. DESIGN FEATURES OF CHIP PROGRAMS

The Children's Health Insurance Program (CHIP) gave States many design options and as a result they have implemented diverse CHIP programs. For example, States can decide whether to operate CHIP as an expansion of Medicaid or as a separate program (or operate both types of programs for different populations); which populations to cover; how to design their benefit packages; whether to require cost-sharing; and the type of delivery system, among other choices. Moreover, program design choices continue to evolve as States elect to change their programs to suit changing State circumstances, to respond to new options afforded by the CHIP Reauthorization Act (CHIPRA), or to prepare to implement the Patient Protection and Affordable Care Act of 2010 and the Health Care Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act).

This chapter reviews CHIP program features as of federal fiscal year (FFY) 2010 and their evolution, as reported by States in their CHIP Annual Reporting Template System (CARTS) reports. The focus is primarily on changes since FFY 2006, but reference is made to 2001 for select features. Section A highlights five core CHIP program features: program type, eligibility rules, cost-sharing requirements, benefit packages, and delivery systems. Section B describes state efforts to prevent the substitution of CHIP for private coverage (crowd out) and available evidence on the extent to which crowd out occurs. Section C reviews other coverage options in CHIP, including premium assistance and buy-in programs, and Section D reviews the history of adult coverage options through CHIP, including coverage of pregnant women. Section E discusses the findings.

A. Core Design Features

1. Program Type

States have three options for the type of CHIP program they can implement: (1) expand their existing Medicaid program (also called a Medicaid-expansion CHIP program), (2) create a separate CHIP program, or (3) blend the two approaches to create a combination program. Because Medicaid-expansion CHIP programs are extensions of the States' Medicaid programs, they must follow Medicaid rules and regulations: for example, States cannot establish a waiting list in Medicaid-expansion CHIP programs, but must keep the program open for anyone who meets the eligibility requirements, as in Medicaid. They also must use the same benefit package and the same delivery system. In contrast, separate CHIP programs give States more flexibility to tailor their CHIP programs to State circumstances; for example, they can control program size with enrollment caps or waiting lists, which could make it easier for States to work within a given annual program budget (Rosenbach et al. 2003).

Table II.1 summarizes the main characteristics of each program type and the number of States that operate each type; Figure II.1 shows the program type by State as of 2010. Although 17 States operated Medicaid-expansion CHIP programs in 2001, gradually over time fewer States opted for this design (now only 8 States), with most (26) offering combination programs by 2010 and 17 offering separate CHIP programs. Most of the States that initially implemented Medicaid-expansion CHIP programs did so because they viewed such programs as more cost-effective, and easier, than developing a new administrative structure separate from Medicaid. Some of these States also believed that Medicaid-expansion CHIP programs would provide better continuity of care for children who moved between traditional Medicaid and Medicaid-expansion CHIP and would avoid confusion among providers and families that might arise due to multiple programs (Rosenbach et al.

2003). Nine of the 35 States that initially implemented Medicaid-expansion CHIP programs or Medicaid-expansion CHIP components of combination programs—Alabama, Arkansas, California, Florida, Mississippi, New York, North Dakota, Tennessee, and Texas—did so to accelerate the phase-in of older adolescent coverage for children below the Federal poverty level (FPL) that was mandated in Medicaid as part of the Omnibus Budget Reconciliation Act (OBRA 90) (Rosenbach et al. 2003).[17] Four of these States (Alabama, Mississippi, New York, and Texas) now operate only separate CHIP programs, whereas the rest have maintained combination programs.

Table II.1. Characteristics of CHIP Program Types and Number of States, by Program Type, FFYs 2001 and 2010

Program Type	Summary	Number of States as of FFY 2001	Number of States as of FFY 2010
Medicaid-expansion CHIP	Required to follow all Medicaid program rules, including benefits and cost–sharing; prohibited from capping or freezing enrollment[a]	17	8
Separate CHIP	Allows increased flexibility in program design	16	17
	Benefits must be equivalent to a "benchmark" benefit package; typically a commercial plan or the State employees' health benefit package is used as the benchmark, although it can also be a benchmark equivalent package or a plan approved by the secretary of the Department of Health and Human Services		
	Cost-sharing (premiums, copayments, and deductibles) must be nominal for children from families with incomes below 150 percent of the Federal poverty level; for families with higher incomes, cost-sharing cannot exceed 5 percent of total family income		
	Provides no Federal entitlement to coverage; States can cap or freeze enrollment at any time to limit costs and coverage		
	Option to implement waiting periods or waiting lists		
Combo	States operate both Medicaid-expansion CHIP and separate CHIP programs; each covers a different population based on income threshold	18	26

Sources: FFY 2010 CARTS reports, accessed April 25, 2011, and May 11, 2011 Certification page: "CHIP Program Type"; Mann, Rowland and Garfield 2003; Rosenbach et al. 2003; Heberlein et al. 2011.

Notes: CARTS=CHIP Annual Reporting Template System; CHIP=Children's Health Insurance Program; Combo=Combination program. Delaware did not submit a CARTS report for 2010. Data from Heberlein, et al. 2011 were used in place of CARTS report data for Delaware. South Carolina converted its separate CHIP program to Medicaid-expansion CHIP in October 2010, changing from a Combo State to a Medicaid-expansion CHIP State, and is counted as a Medicaid-expansion CHIP State in FFY 2010 (Heberlein et al. 2011).

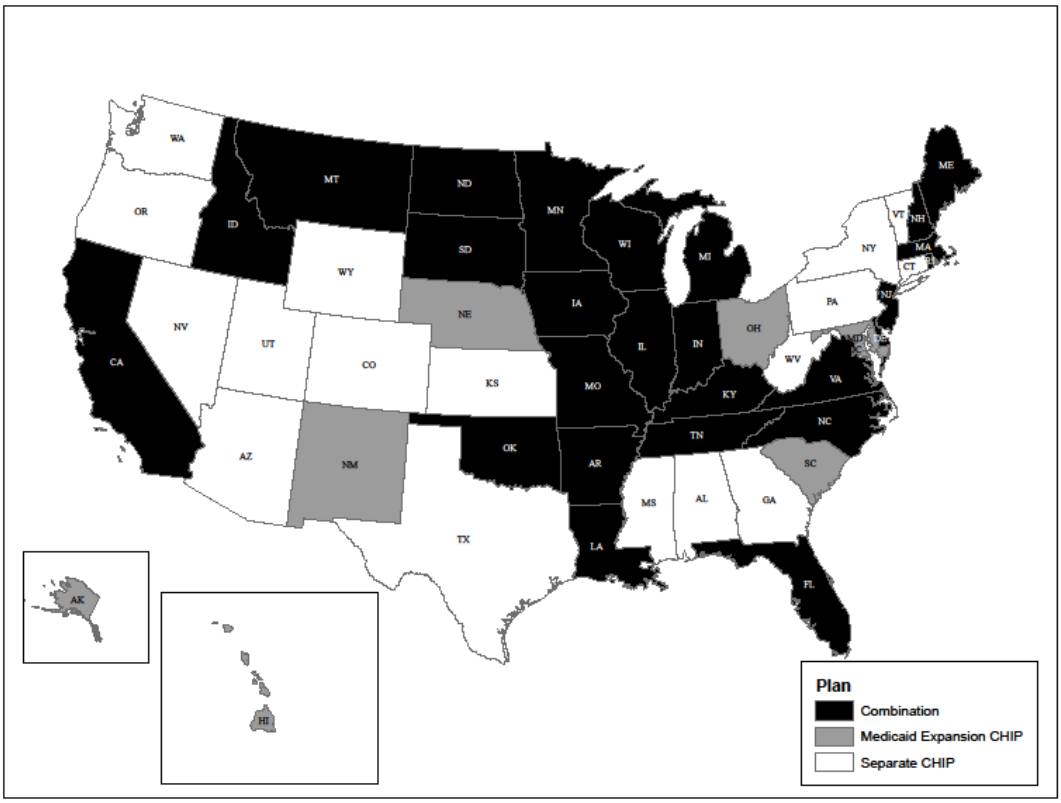
[a] Medicaid, and therefore Medicaid-expansion CHIP, are entitlement programs and are required to enroll all children meeting the eligibility criteria.

Not surprisingly, States that initially opted for a separate CHIP program indicated they wanted to take advantage of the flexibility under Title XXI to design their program according to the needs in the State: a number of these States attempted to simulate the private health insurance market in their separate CHIP programs, in terms of marketing approach, benefit package, cost-sharing structure, and provider networks, and some even designed their separate CHIP programs to resemble private

[17] As noted in Chapter 1, OBRA 90 (PL 101-508) expanded Medicaid coverage to all children ages 6 to 18 with family incomes under 100 percent of the FPL, starting with the youngest and phasing in another age level each year until 2002, when all the 18-year-olds became eligible. These States used their Medicaid-expansion CHIP programs to extend coverage to these children before Medicaid law would catch up to these coverage levels.

insurance products. Some opted for a separate program to distinguish the program from Medicaid, which they hoped would increase public support for the program (Rosenbach et al. 2003).

Figure II.1. CHIP Program Type, FFY 2010



Source: Mathematica analysis of FFY 2010 CARTS data (extracted April 25, 2011, and May 11, 2011). This map shows States responses to the question about CHIP program type.

Notes: Combo = Combination Medicaid-expansion CHIP and separate CHIP program.

[a] Delaware did not submit a CARTS report for 2010. Source for Delaware: Heberlein et al. 2011.

[b] South Carolina converted its separate CHIP program to a Medicaid-expansion CHIP program in October 2010, changing from a combination State to a Medicaid-expansion CHIP State and is counted as a Medicaid-expansion CHIP State in 2010 (Heberlein et al. 2011).

Six States have changed their program type since 2006. All of the changes were enacted before CHIPRA changes took effect (even in Montana, which implemented the change in 2010, but did so in response to voter support in 2008 for an expansion of coverage for children). The changes to program type include the following:

- Since 2007, Louisiana has operated a combination program, adding a separate CHIP component to the existing Medicaid-expansion CHIP component. The separate CHIP component was added to provide prenatal care to women otherwise ineligible for Medicaid. In its 2007 CARTS report, Louisiana noted that the main impetus for the expansion was the "… explosion of immigrant women who have little to no access to prenatal care due to the compromised safety net in post-Katrina New Orleans." In 2008, Louisiana expanded its separate CHIP program, adding children whose family incomes fell between 201 and 250 percent of the FPL, whose families must pay $50 per month (per family) plus copays to participate.

- Effective June 1, 2007, Maryland eliminated its separate CHIP component, transferring children who were eligible for it (uninsured children with family incomes from 201 to 300 percent of the FPL) to the existing Medicaid-expansion CHIP program. State administrators noted it was an administrative change only, with no visible change to applicants or participants.
- In September 2007, Missouri implemented a separate CHIP program alongside its existing Medicaid-expansion CHIP program. The Medicaid-expansion CHIP program covers families with incomes up to and including 150 percent of the FPL; the separate CHIP program covers families with incomes above 150 percent and up to 300 percent of the FPL. According to Missouri's CARTS reports, the State previously covered this group in Medicaid-expansion CHIP using a Section 1115 demonstration waiver (we discuss waivers later in this chapter), but decided to end the waiver and move the group into a separate CHIP program design. There is one benefit difference between the M- and separate CHIP programs: nonemergency medical transportation is a covered benefit in the Medicaid-expansion CHIP program, but not in the separate CHIP program.
- Montana implemented a Medicaid-expansion CHIP program in 2010 to augment its existing separate CHIP program, making it a combination State. The Medicaid-expansion CHIP program covers children ages 6 to 18 from families with incomes between 101 and 133 percent of the FPL, whereas the separate CHIP program covers children from birth through age 18 from families with incomes between 134 and 250 percent of the FPL. State officials reported in CARTS that child coverage had strong political and public support; in November 2008, Montana voters passed initiative I-155, Healthy Montana Kids. Implemented in 2010, State officials anticipated that up to 30,000 uninsured Montana children could be covered through the separate CHIP program.
- Oklahoma implemented a separate CHIP program on April 1, 2008, while continuing to offer its Medicaid-expansion CHIP program, becoming a combination CHIP State. Like Louisiana, Oklahoma's separate CHIP program initially covered only pregnant women, but in July 2010, Oklahoma expanded its separate CHIP program to offer a premium subsidy to children in families with incomes between 185 and 200 percent of the FPL who are insured through their family's insurance plan.
- South Carolina, which implemented a separate CHIP component in 2008 to become a combination program, eliminated the separate program in 2010, returning to a Medicaid-expansion CHIP only design. The separate CHIP program expanded coverage to infants (newborn to age 1) in families with incomes from 185 to 200 percent of the FPL, and children ages 1 to 18 in families with incomes between 150 and 200 percent of the FPL. The State legislature mandated the change and the Medicaid-expansion CHIP component now covers children previously eligible for the separate CHIP program.

2. Eligibility Rules

Section 2110(b) of the Social Security Act broadly defines CHIP eligibility standards, requiring States to establish standards for "targeted low-income children." The CHIP statute and CMS regulations define a targeted low-income child as one with the following characteristics:

- Has been found eligible by the State for child health assistance under the State plan;

- Has a family income at or below 200 percent of the FPL, and the income exceeds the State's Medicaid income level but is not more than 50 percentage points above the State's Medicaid applicable income level as of March 31, 1997;
- Is not eligible for Medicaid or covered under a group health plan or other creditable health insurance coverage;[18]
- Is not an inmate of a public institution nor a patient in an institution for mental disease.

The Affordable Care Act expanded the definition of a targeted low-income child to include children of State employees who are otherwise eligible for CHIP, as long as the State meets two conditions: (1) the State has consistently contributed to the cost of employee coverage since 1997; and (2) the State can demonstrate that the coverage currently available to public employees presents a financial hardship for families (P.L. 111-148, Section 10203(b)(2)(D); Centers for Medicare & Medicaid Services [CMS] 2011b).

Regulations also permit States to adopt other eligibility standards related to "geographic areas served by the plan, age, income, resources, spend downs, disposition of resources, residency, disability status, access to, or coverage under, other health coverage, and duration of eligibility" (42 CFR 457.320). Such provisions allow States to customize their programs; for example, a State can use income disregards and deductions to effectively increase the income level in CHIP more than 50 points above the State's Medicaid income level as of March 31, 1997, or use asset or resource tests to limit income eligibility in CHIP (Hess et al. 2011).

In this section we review State variation related to the following CHIP eligibility requirements: income rules; service area, residency, and citizenship requirements; and retroactive eligibility policies. Provisions related to the substitution of CHIP for private coverage and evidence from the literature on the extent to which this occurs is covered in Section B.

a. Income Eligibility Thresholds, Income Disregards, and Asset Tests

Although Federal regulations specified very narrow CHIP income limits—not more than 50 percentage points above the State's Medicaid income-eligibility threshold as of March 31, 1997, and not more than 200 percent of the FPL—a State can exceed these rules by disregarding certain income, as discussed earlier. In Medicaid-expansion CHIP programs, Medicaid rules dictate the kinds of income that can be disregarded; disregards can include work-related, child care, and child support expenses up to certain limits, or a block of income can be disregarded for all applicants (Hess et al. 2011). In contrast, States with separate CHIP programs can set their own rules regarding whether to use disregards, and if so, what can be disregarded (Hess et al. 2011).

Table II.2 shows income eligibility limits and use of income disregards in CHIP and Medicaid for 2010; for CHIP, the table also compares the income-eligibility limits in place in 2006. All but three States—North Dakota, Alaska, and Idaho—cover children from families with incomes at or above 200 percent of the FPL.

[18] This includes coverage by a State health benefits plan on the basis of a family member's employment with a public agency, even if the family member declines the coverage, although this exclusion does not apply to Medicaid-expansion CHIP programs (NASHP 2011).

Table II.2 CHIP (Title XXI) Upper Income-Eligibility Limit for Children's Coverage, FFYs 2006-2010 and Medicaid (Title XIX) Upper Income-Eligibility Limits for Children's Coverage, FFY 2010, by State

	CHIP (Title XXI)					Medicaid (Title XIX)			
		Upper Income-Eligibility Limits (as a percentage of the FPL)				Upper Income-Eligibility Limits (as a percentage of the FPL)			
State	2010 CHIP Program Type	2006, ages Birth to 18	2010, ages Birth to 18	Direction of Change in CHIP Eligibility Limit, 2006 to 2010	Income Disregards[a]	2010, ages Birth to 1	2010, ages 1 to 5	2010, ages 6 to 19	Income Disregards
States with 2010 CHIP eligibility limit below 200 percent of FPL									
North Dakota	Combo	140	160	Up	X	133	133	100	
Alaska	Medicaid exp.	175	175	Steady	X	150	150	150	X
Idaho	Combo	185	185	Steady		133	133	100	
States with 2010 CHIP eligibility limit at 200 percent of FPL									
Arizona	Separate	200	200	Steady		140	133	100	
Arkansas	Combo	200	200	Steady	X	133	133	100	X
Delaware[b]	Combo	200	200	Steady	X	185	133	100	X
Florida[c]	Combo	200	200	Steady		185	133	100	
Illinois[c, d]	Combo	200	200	Steady	X	133	133	100	
Kentucky	Combo	200	200	Steady	X	185	133	100	X
Maine[c, d]	Combo	200	200	Steady	X (Medicaid exp. only)	133	133	125	X
Michigan	Combo	200	200	Steady	X	185	150	150	X
Mississippi	Separate	200	200	Steady	X	185	133	100	X
Nebraska	Medicaid exp.	185	200	Up	X	150	133	100	X
Nevada	Separate	200	200	Steady		133	133	100	
North Carolina[c]	Combo	200	200	Steady	X	185	133	100	X
Ohio[c]	Medicaid exp.	200	200	Steady	X	150	150	150	
Oklahoma	Combo	185	200	Up	X	133	133	100	X
South Carolina	Medicaid exp.	150	200	Up	X	150	150	150	
South Dakota	Combo	200	200	Steady	X	133	133	100	X
Texas	Separate	200	200	Steady	X	185	133	100	X
Utah	Separate	200	200	Steady		133	133	100	X
Virginia[d]	Combo	200	200	Steady	X (Medicaid exp. only)	133	133	100	X
Wyoming	Separate	200	200	Steady		133	133	100	X

Table II.2 (*Continued*)

State	CHIP (Title XXI)					Medicaid (Title XIX)			
		Upper Income-Eligibility Limits (as a percentage of the FPL)				Upper Income-Eligibility Limits (as a percentage of the FPL)			
	2010 CHIP Program Type	2006, ages Birth to 18	2010, ages Birth to 18	Direction of Change in CHIP Eligibility Limit, 2006 to 2010	Income Disregards[a]	2010, ages Birth to 1	2010, ages 1 to 5	2010, ages 6 to 19	Income Disregards
States with 2010 CHIP eligibility limit above 200 percent and below 250 percent of FPL									
New Mexico[e]	Medicaid exp.	235	235	Steady	X	185	185	185	X
Georgia[d]	Separate	235	235	Steady	X	200	133	100	
Kansas	Separate	200	241	Up		150	133	100	
States with 2010 CHIP eligibility limit at 250 percent of FPL									
California	Combo	250	250	Steady	X (separate CHIP only)	200	133	100	
Colorado	Separate	200	250	Up	X	133	133	100	
Indiana	Combo	200	250	Up	X (Medicaid exp. only)	200	133	100	X
Louisiana	Combo	200	250	Up	X (Medicaid exp. only)	133	133	100	X
Montana	Combo	150	250	Up	X	133	133	100	X
Rhode Island[f]	Combo	250	250	Steady	X	185	133	100	X
Tennessee[c, g]	Combo	200	250	Up	X (Medicaid exp. only)	185	133	100	
West Virginia	Separate	200	250	Up		150	133	100	X
States with 2010 CHIP eligibility limit above 250 percent and below 300 percent of FPL									
Minnesota[c, h]	Combo	275	275	Steady	X (Medicaid exp. only)	275	275	275	X
States with 2010 CHIP eligibility limit at 300 percent of FPL									
Alabama	Separate	200	300	Up	X	133	133	100	X
Connecticut[c]	Separate	300	300	Steady		185	185	185	
District of Columbia	Medicaid exp.	200	300	Up	X	185	133	100	X

Table II.2 (*Continued*)

State	CHIP (Title XXI)					Medicaid (Title XIX)			
		Upper Income-Eligibility Limits (as a percentage of the FPL)				Upper Income-Eligibility Limits (as a percentage of the FPL)			
	2010 CHIP Program Type	2006, ages Birth to 18	2010, ages Birth to 18	Direction of Change in CHIP Eligibility Limit, 2006 to 2010	Income Disregards[a]	2010, ages Birth to 1	2010, ages 1 to 5	2010, ages 6 to 19	Income Disregards
Hawaii	Medicaid exp.	200	300	Up	X	185	133	100	
Iowa	Combo	200	300	Up	X (Medicaid exp. only)	133	133	100	X
Maryland[i]	Medicaid exp.	300	300	Steady	X	185	133	100	X
Massachusetts	Combo	300	300	Steady		185	133	114	
Missouri	Combo	300	300	Steady		185	133	100	X
New Hampshire[c]	Combo	300	300	Steady	X	185	185	185	X
Pennsylvania[c, j]	Separate	200	300	Steady	X	185	133	100	X
Oregon[c, k]	Separate	185	300	Up		133	133	100	X
Vermont[l]	Separate	300	300	Steady	X	225	225	225	
Washington	Separate	250	300	Up	X	200	200	200	
Wisconsin[c, m]	Combo	185	300	Up	X	300	185	100	
States with 2010 CHIP eligibility limit above 300 percent of FPL									
New Jersey[c, d]	Combo	350	350	Steady	X	185	133	100	X
New York[c]	Separate	250	400	Up		200	133	100	X

Sources: FFY 2010 CARTS reports, accessed April 18, 2011, and May 11, 2011, Section 1, Question 1: "Eligibility" and "Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?"; Heberlein et al. 2011, Centers for Medicare and Medicaid (CMS) 2007, 2009a, 2009b.

Notes: CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FPL = Federal poverty level; Medicaid exp. = Medicaid-expansion CHIP; Combo = combination program; X = State uses income disregards for specified program. Medicaid data as of January 1, 2011. The income eligibility levels noted may refer to gross or net income depending on the State. Income-eligibility levels listed are for Medicaid (Title XIX), where States receive standard Medicaid matching payments.

[a] CHIP income disregards are reported for both Medicaid-expansion CHIP and separate CHIP programs. We have noted when Combo States report income disregards for only one component of their programs.

[b] Delaware did not submit a CARTS report in FFY 2010. In January 2011, Delaware reported the same upper income-eligibility levels to Kaiser Family Foundation's State Health Facts (2011a) web site as was reported in the State's 2009 CARTS report, which is what is reported here.

[c] Connecticut, Florida, Illinois, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown to buy into Medicaid/CHIP.

[d] Infants born to mothers enrolled in Medicaid in Georgia, Illinois, Maine, New Jersey, and Virginia are covered up to 200% of the FPL in Medicaid. In Georgia, Maine, and New Jersey, infants born to non–Medicaid-covered mothers are covered to 185% of the FPL, and in Illinois and Virginia to 133% of the FPL.

[e] New Mexico reports income eligibility limits of 234 in the State's FFY 2010 CARTS report. However, according to Heberlein et al. (2011), its income-eligibility limit is 235. Income disregards were not reported in the State's FFY 2010 reports. Data reported here are from New Mexico's FFY 2009 CARTS report.

Table II.2 (*Continued*)

[f] Rhode Island reports income eligibility only for children ages 6 to 16 and children ages 17 or 18. According to Heberlein et al. (2011), Rhode Island covers children from birth to age 5 with incomes up to 250%of the FPL through its separate CHIP program as well. Rhode Island covers children ages 1 to 7 with family incomes up to 133% of the FPL with Title XIX funding, and covers children ages 8 through their 19th birthday with incomes up to 100% of the FPL with Title XIX funding.

[g] Tennessee did not submit a CARTS report for 2006. According to the State's State Plan Letter, the upper income-eligibility limit is 200% of the FPL (CMS 2007).

[h] Minnesota reports a 280% of the FPL income-eligibility limit for infants under Medicaid-expansion CHIP. Other age groups in Minnesota are covered under regular Medicaid with eligibility up to 275%of the FPL. In Minnesota, the infant category under Medicaid (Title XIX) includes children up to age 2, with income eligibility up to 275% of the FPL.

[i] Maryland reports income eligibility limits of 200 in the State's 2010 CARTS report. The State Plan Fact Sheet and Heberlein et al. (2011) both report 300 % of the FPL (CMS 2009a).

[j] Income disregards were not reported in Pennsylvania's FFY 2010 CARTS report. Data reported here are from the State's FFY 2009 CARTS report.

[k] Oregon increased the income-eligibility limit from 185 to 200% of the FPL and added an option for a private insurance benefit for those above 200% through 300% of FPL, as reported in its FFY 2010 CARTS report.

[l] In Vermont, Title XIX funding covers uninsured children in families with incomes at or below 225% of the FPL; uninsured children in families with incomes between 226% and 300% of the FPL are covered via Title XXI funding under a separate CHIP program. Underinsured children are covered in Medicaid through Title XIX funding up to 300% of the FPL.

[m] Wisconsin's FFY 2010 CARTS reports a 300%percent of the FPL income-eligibility limit through separate CHIP for all age groups except infants. According to Heberlein et al. (2011), its infant income-eligibility limit is also 300% of the FPL, but is administered through the Medicaid-expansion CHIP program.

Moreover, through the use of income disregards, 25 States now have an upper income-eligibility limit for children from families with incomes at or above 250 percent of the FPL—twice the number as had these limits in 2006. New Jersey and New York offer the highest upper income-eligibility thresholds for CHIP, offering coverage to children with family incomes up to 350 percent and 400 percent of the FPL, respectively.

Most States (30) held their income limits steady from FFYs 2006 to 2010 in both Medicaid-expansion CHIP and separate CHIP programs; no States cut eligibility below 2006 levels (although California had expanded to 300 percent of the FPL in 2008, but returned to an upper limit of 250 percent in 2009). Another 21 States increased their upper eligibility limits from 2006 to 2010; six States increased their upper income limits by 100 percentage points in this period: Alabama, District of Columbia, Hawaii, Iowa, Montana, Pennsylvania, and Washington. Among the 20 States with increases, slightly more than half—11 of the 20 States—made the expansions post-CHIPRA (Table II.3). New York had the largest change, increasing its upper income-eligibility limit from 250 to 400 percent of the FPL.

Table II.3. States that Reported Post-CHIPRA Eligibility Expansions to Children based on Family Income, February 2009 to September 2010

State	Children Newly Covered by the Expansion (by family income, as a percentage of the Federal poverty level)
Alabama	200–300
Colorado	205–250
Iowa	200–300
Kansas	200–241
Montana	175–250
Nebraska	185–200
New York	250–400
North Dakota	140–160
Oklahoma	185–200
Oregon	185–300
Wisconsin	250–300

Sources: FFY 2008–2010 CARTS reports, accessed April 18, May 11, and October 7, 2011; CMS 2011d.

Notes: CARTS=CHIP Annual Reporting Template System; CHIPRA=CHIP Reauthorization Act.

States with separate CHIP-only or combination programs generally had higher eligibility limits than States with only Medicaid-expansion CHIP programs; in 2010, the median income limit was 250 percent of the FPL in separate CHIP or combination programs, compared with 217 percent of the FPL in Medicaid-expansion CHIP-only programs. Of the 8 States with only Medicaid-expansion CHIP programs, 3 have eligibility thresholds above 250 percent of the FPL (38 percent). In contrast, 22 of the 43 States with separate CHIP-only and combination programs set income eligibility at or above 250 percent of the FPL (51 percent).

States also can count—or not count—a family's assets, such as a car, house, or savings account, when making an eligibility determination for public insurance (that is, having certain assets can preclude a child from being eligible, even if he or she meets all of the other eligibility criteria). Title XXI does not address asset tests, allowing States the flexibility to determine whether to use asset tests in determining eligibility. However, in the early years of CHIP, States were strongly encouraged not to use asset tests in order to simplify eligibility determination and facilitate program enrollment. As of 2001, five States required asset tests: Arkansas, Indiana, North Dakota, Oregon, and Texas (Rosenbach et al. 2003). By FFY 2010, four States—Arkansas, Missouri, South Carolina, and Texas—used an asset test in CHIP.

b. Service Area, Residency, and Citizenship Requirements

The CHIP regulations permit States to define the service area and residency requirements for the program (Rosenbach et al. 2003). All CHIP programs are currently operated Statewide, although initially Florida offered its program in only 60 of 67 counties, and it did not go completely Statewide until January 2011 (Rosenbach et al. 2003; Healthcare Finance News 2010). Regarding residency, CHIP programs must abide by Federal law, which defines residency in terms of being present in a State with intent to remain; as of August 24, 2001, Medicaid rules specifically prohibit durational residency requirements (42 CFR § 435.403(j)(1); Rosenbach et al. 2003).

Citizenship requirements for enrollment in CHIP have changed over time. At the time CHIP was implemented, Federal law prohibited otherwise-eligible legal immigrants from enrolling in CHIP (or Medicaid) for the first five years they reside in the United States, although States could use State-only funds to cover some low-income immigrants (Kaiser Commission on Medicaid and the Uninsured 2008). In addition, undocumented and temporary immigrants generally have been prohibited from enrolling in Medicaid or CHIP since the programs began (Kaiser Commission on Medicaid and the Uninsured 2008). However, until 2006 there was no requirement that applicants or enrollees prove their U.S. citizenship.

In 2006, the Deficit Reduction Act required Medicaid programs—including Medicaid-expansion CHIP programs—to verify the citizenship status of applicants beginning in July 2006. Although the requirement did not extend to separate CHIP programs, there were implications for CHIP applicants in States using joint applications (such that CHIP applicants would also be required to provide citizenship documentation). There were also concerns that in both Medicaid and CHIP enrollment might drop as a result of this requirement (Hoag 2007). Moreover, the simplifications and improved coordination between CHIP and Medicaid appeared to be jeopardized (Hoag 2007). States reported enrollment declines in Medicaid and CHIP when the requirement went into effect, as well as increased administrative costs associated with citizenship verification (U.S. Government Accountability Office 2007; Summer 2009).

CHIPRA extended the citizenship documentation requirement to all CHIP applicants in 2009, but also introduced a new option to ease the additional paperwork burden for families and States by allowing and encouraging data matching with the Social Security Administration (SSA). In 2010, 33 States and the District of Columbia used the data-matching process available through SSA to verify citizenship for children (U.S. Department of Health and Human Services 2010). CHIPRA also removed the five-year ban for legal immigrant children and pregnant women, a rule that prohibited these groups from enrolling in Medicaid and CHIP for their first five years of residency. States can now decide whether to expand coverage to legal immigrant children, pregnant women, or both, and whether to implement the expansion only in Medicaid or in Medicaid and CHIP (Sullivan 2010). According to States' FFY 2010 CARTS reports, 19 States cover lawfully residing immigrant children and/or pregnant women in their CHIP programs (see Table II.4).

Table II.4. CHIP Coverage of Lawfully Residing Immigrant Children and or Pregnant Women, FFY 2010

State	Covering Lawfully Residing Immigrant Children and or Pregnant Women in CHIP as of FFY 2010	Not Covering Lawfully Residing Immigrant Children and or Pregnant Women in CHIP as of FFY 2010
Medicaid-Expansion CHIP States		
Alaska		X
District of Columbia	X	
Hawaii	X	
Maryland	X	
Nebraska		X
New Mexico	X	
Ohio		X
South Carolina		X
Separate CHIP States		
Alabama		X
Arizona		X
Colorado		X
Connecticut	X	
Georgia		X
Kansas		X
Mississippi		X
Nevada		X
New York	X	
Oregon	X	
Pennsylvania	X	
Texas		X
Utah		X
Vermont		X
Washington	X	
West Virginia		X
Wyoming		X
Combination States		
Arkansas		X
California	X	
Delaware		X
Florida		X
Idaho		X
Illinois		X
Indiana		X
Iowa	X	
Kentucky		X
Louisiana		X
Maine	X	
Massachusetts	X	
Michigan		X
Minnesota	X	
Missouri		X
Montana	X	
New Hampshire		X
New Jersey	X	
North Carolina		X
North Dakota		X
Oklahoma		X
Rhode Island	X	
South Dakota		X
Tennessee		X
Virginia	X	
Wisconsin	X	

Sources: FFY 2009 and FFY 2010 CARTS reports, accessed September 15, 2011; Section 1, Question 9: "Have you made changes to any of the following policy or program areas during the reporting period?: Expansion to 'Lawfully Residing' children," or "Expansion to 'Lawfully Residing' pregnant women," and U.S. Department of Health and Human Services n.d.

Note: CHIP=Children's Health Insurance Program; CARTS=CHIP Annual Reporting Template System; N-number. According to Nebraska's FFY 2010 CARTS report, the State had not expanded coverage to lawfully residing immigrant children in FFY 2010, but it has submitted a State plan amendment that is awaiting approval from CMS.

c. Retroactive Eligibility

As part of the eligibility determination process in Medicaid, when a child is determined eligible for Medicaid the State must also determine whether the child would have been eligible during the three months before the date of application, if the child had applied. If the child appears to have been eligible and received Medicaid-covered services during any of those months, Medicaid will pay for any bills that remain unpaid. This procedure is known as retroactive eligibility. In addition to assisting families with unpaid medical bills, retroactive eligibility offers some protection to providers against uncompensated care provided to uninsured low-income children (Rosenbach et al. 2003).

Although Medicaid-expansion CHIP programs must offer three months of retroactive eligibility (following Medicaid rules), Title XXI did not require separate CHIP programs to offer retroactive eligibility and, initially, most did not—only six States did so as of 2001 (Rosenbach et al. 2003). However, in the past five years, the trend has been toward more separate CHIP programs offering retroactive eligibility (Table II.5). Of the States with separate CHIP programs or separate CHIP components of combination programs, 21 States offer retroactive eligibility for some populations covered by the program (whereas 22 States do not offer any retroactive coverage in separate CHIP). The period of retroactive coverage varies from as long as three months, as the Medicaid program requires (Arkansas, Idaho, Maine, Minnesota, Vermont, and Washington), to a shorter period, such as up to two weeks (Illinois). Six States specifically target newborn children for retroactive coverage (Alabama, California, Mississippi, Nevada, Pennsylvania, and Virginia), often providing coverage retroactively to the child's date of birth (if families apply within a certain period). Of the 21 States that offer retroactive coverage, most have been doing so for the full five-year period; exceptions include California (which introduced retroactive eligibility in 2008), Louisiana (in 2007), and Maine (in 2010).

3. Cost-Sharing Requirements

Sharing in the cost of care is a common feature in ESI and other private coverage. Cost-sharing is allowed in CHIP to help it mirror private coverage, reduce unnecessary utilization, and support the costs of the program. In all CHIP programs, lower-income families are not permitted to have greater cost-sharing burdens than higher-income families, cumulative annual cost-sharing cannot exceed 5 percent of a family's annual income, and States cannot require cost-sharing for well-child or well-baby services (P.L. 105-33, Section 2103). Medicaid-expansion CHIP programs must follow Medicaid rules regarding cost-sharing (which stipulate that families with incomes over 100 percent of the FPL can share in costs, and families over 150 percent of the FPL can be charged premiums [CMS 2006]), whereas separate CHIP programs are not bound by Medicaid restrictions (P.L. 105-33, Section 2103).

There are three main types of cost-sharing:

- **Premiums** are payments that families must pay at enrollment and periodically to continue to receive insurance coverage. Premiums can be paid monthly, quarterly, or annually and are permitted in Medicaid-expansion CHIP for beneficiaries with incomes over 150 percent of the FPL and for all separate CHIP beneficiaries. Some States charge an enrollment fee rather than a premium; the difference is that an enrollment fee must be paid before the child is covered, whereas with premiums, States can offer grace periods that permit the child to remain enrolled if the premium payment is late. Beginning in 2009, CHIPRA required that separate CHIP programs that charge premiums must permit a 30-day grace period before coverage is terminated (P.L. 111-3, Section 504(a).

Table II.5. Retroactive Eligibility in Separate CHIP and Combination Programs, FFYs 2006 -2010

State	2006	2007	2008	2009	2010	For Whom	How Long
Total	19	20	21	21	21		
Alabama	X	X	X	X	X	Newborns	Within 60 days after birth, retroactive to date of birth (DOB)
Arkansas	X	X	X	X	X	All eligibles	Up to 3 months
California			X	X	X	Infants enrolled in the Access to Infant Mothers Program	Within 30 days of birth, retroactive to DOB
Connecticut	X	X	X	X	X	Newborns	Within 30 days of birth, retroactive to DOB
Georgia	X	X	X	X	X	All eligibles	First day of the month of application
Idaho	X	X	X	X	X	All eligibles	Up to 3 months
Illinois	X	X	X	X	X	Children entering separate CHIP for the first time	Up to 2 weeks
Indiana	X	X	X	X	X	NR	First day of the month of application
Louisiana		X	X	X			
Maine					X	All eligibles	3 months
Massachusetts	X	X	X	X	X	All children	10 days before application
Minnesota	X	X	X	X	X	NR	3 months
Mississippi	X	X	X	X	X	Newborns	Within 31 days of birth, retroactive to DOB
Nevada	X	X	X	X	X	Newborns	As of the month of the infant's birth
Oregon	X	X	X	X	X	All eligibles	Based upon the date stamped on the client's application package
Pennsylvania	X	X	X	X	X	Children disenrolling from Medicaid to CHIP and newborns	Children may be retroactively enrolled to avoid a lapse in coverage Newborns begin coverage either the first day of the month following birth or DOB
South Dakota	X	X	X	X	X		Up to the first day of the third month before application
Utah	X	X	X	X	X	All eligibles	4 days
Vermont	X	X	X	X	X	All eligibles	Up to 3 months
Virginia	X	X	X	X	X	Newborns	Within 3 months of birth, retroactive to DOB
Washington	X	X	X	X	X	NR	Up to 3 months, or one month earlier than conception (unborn)
West Virginia	X	X	X	X	X	NR	First day of month of application for enrollees up to 200% of FPL; 201 to 250% begins the first of the month following receipt of the first premium payment

Source: FFYs 2006-2010 CARTS reports, accessed May 19, 2011, Section 1: "Is retroactive eligibility available? If Yes, for Whom and How Long?"; Rosenbaum and Markus 2002.

Notes: The table summarizes results for separate CHIP States, and separate CHIP components of combination States. Twenty-one (of a total of 43) States that operate separate CHIP or combination programs did not offer retroactive eligibility in 2010. Medicaid-expansion CHIP States are not shown on this table, as Medicaid and Medicaid-expansion CHIP programs are required to provide three months of retroactive coverage (Rosenbaum and Markus 2002); CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FPL = Federal poverty level; X = eligible in the year indicated.

- **Deductibles** are a specific amount that a family must pay out of pocket before the insurance plan begins to pay for any services. Deductibles are permitted in Medicaid-expansion CHIP for children in families with incomes over 100 percent of the FPL and for all children in separate CHIP programs, if States choose to implement them.
- **Copayments and coinsurance** are charges that families pay when they use a service. A copayment is a specific dollar amount, whereas coinsurance is a percentage of the cost of the service. Copayments and coinsurance are often charged for office visits or prescription drugs; they cannot be charged for well-child and well-baby services.

As of FFY 2010, 34 States charged premiums or enrollment fees to some portion of their CHIP enrollees, whereas 17 States did not impose any premiums or enrollment fees (Table II.6). Twenty-eight States require monthly premium payments, 2 require quarterly payments, and 4 require annual payments. Of the programs with annual payments, 3 States—Colorado, North Carolina, and Texas—charge enrollment fees instead of premiums. Colorado and North Carolina cap this enrollment fee for families with two or more children; Texas charges a per-child fee that varies with the family's income level.

Whether collected monthly, quarterly, or annually, most States set premiums as a flat amount per child per month, based on the family's income. The exceptions are Minnesota and Missouri, which sets payments as a percentage of income. Premiums typically are charged for families with higher income levels, although nine States—Alabama, Arizona, California, Delaware, Florida, Georgia, Minnesota, Nevada, and Utah—charge premiums for families with incomes between 101 and 150 percent of the FPL. New York and New Jersey, which have the highest income-eligibility limits in the nation, begin charging premiums to families with incomes over 200 percent of the FPL. Rhode Island was the only Medicaid-expansion CHIP program to require premiums. The premium was tiered for those with incomes over 150 percent of the FPL, and fees ranged from $61 to $92 monthly. Of the 30 separate CHIP and combination programs that imposed premiums in 2010, all but one (Vermont) tiered the fees based on family income.

Thirty-one States charge either copayments (30 States) or co-insurance (one State) in their CHIP programs. Copayments for generic prescriptions are generally $5 or less, though New Jersey and Utah both charge copayments on a sliding scale that can go as high as $10, depending on income. Louisiana, which charges coinsurance rather than using copayments (the only State to do so), requires participants to pay 50 percent of the cost of the prescription. Copayments for a primary care office visit range from $2 to $20; Louisiana charges coinsurance of 10 percent of the cost of the visit. Only three States—Louisiana, Utah, and Wisconsin, all separate CHIP programs—impose deductibles.

Table II.6. FFY 2010 CHIP Premiums at Selected Income Levels and Cost-Sharing

State	Program Type	Premium Amount per Child / Family Cap by family income level[a,b]						Direction of Premium Change Since 2006	Deductible Required (If Yes, report rate)	Copayments or Co-Insurance[d]		
		101% FPL	151% FPL	201% FPL[c]	251% FPL[c]	301% FPL[c]	351% FPL[c]			Copayments or Co-Insurance Required	Cost of Generic Prescription[e]	Cost of Primary Care Office Visit[e]
Monthly Payments												
Arizona	Separate	$10 / $15	$20 / $60	$50 / $70	--	--	--	Up	No	No	--	--
California[f]	Combo	$4 / $14	$13 / $48	$21 / $72	$21 / $72	--	--	Up	No	Yes	$5	$5
Connecticut	Separate	$0	$0	$0	$38 / $60	$38 / $60	--	Up	No	Yes	$3	$5
Delaware[g, h]	Combo	$10	$15	$25	--	--	--	Steady	No	Yes	NR	NR
Florida[h]	Combo	$15	$20	$20	--	--	--	Steady	No	Yes	$5	$5
Georgia[i]	Separate	$10 / $15	$20 / $40	$29 / $58	--	--	--	Steady	No	No	--	--
Idaho[j]	Combo	$0	$15	--	--	--	--	Steady	No	Yes	NR	NR
Illinois	Combo	$0	$15 / $40	$15 / $40	--	--	--	Steady	No	Yes	$2-$3	$2-$5
Indiana[j]	Combo	$0	$22 / $33	$42 / $53	$53 / $70	--	--	Up	No	Yes	$3	$0
Iowa	Combo	$0	$10 / $20	$20 / $40	$20 / $40	$20 / $40	--	Up	No	Yes	NR	NR
Kansas[h]	Separate	$0	$20	$50	--	--	--	Steady	No	No	--	--
Louisiana[j, k]	Combo	$0	$0	$50	$50	--	--	Steady	30% of negotiated rate	Yes	50% of cost	10% of cost
Maine	Combo	$0	$8 / $16	$32 / $64	--	--	--	Steady	No	No	--	--
Maryland[h]	Medicaid exp.	--	--	$55	$67	--	--	Up	No	No	--	--
Massachusetts	Combo	$0	$12 / $36	$20 / $60	$28 / $84	$28 / $84	--	Steady	No	No	--	--
Michigan[h]	Combo	0	$10	$10	--	--	--	Up	No	No	--	--
Minnesota[r]	Combo	$4	$28/ 8% of income	$57/ 8% of income	$93/ 8% of income	--	--	Up	No	No	--	--
Missouri[j, l]	Combo	0	4% of income	4% of income	4% of income	4% of income	--	Up	No	No		
New Hampshire	Combo	0	0	$32 / $128	$32 / $128	$54 / $162	--	Up	No	Yes	$0-$5	$0-$10
New Jersey[h, j]	Combo	0	0	$40	$79	133	133	Up	No	Yes	$0-$10	$0-$10
New York	Separate	0	0	$9 / $27	$30 / $90	$45 / $135	$60 / $180	Up	No	No		

Table II.6 (*Continued*)

State	Program Type	Premium Amount per Child / Family Cap by family income level[a,b]						Direction of Premium Change Since 2006	Deductible Required (If Yes, report rate)	Copayments or Co-Insurance[d]		
		101% FPL	151% FPL	201% FPL[c]	251% FPL[c]	301% FPL[c]	351% FPL[c]			Copayments or Co-Insurance Required	Cost of Generic Prescription[e]	Cost of Primary Care Office Visit[e]
Oklahoma[m]	Combo	0	0	$67 / $181	--	--	--	Up	No	Yes	NR	NR
Pennsylvania[j]	Separate	0	0	$29 / $50	$40 / $70	$124 / $256	--	Up	No	Yes	$0-$6	$0-$5
Rhode Island[h]	Combo	0	$61	$92	$92	--	--	Steady	No	Yes	NR	NR
Vermont[h]	Separate	$0	$0	$0	$60	$60	--	Down	No	No	--	--
Washington[n]	Separate	0	0	$20 / $40	$30 / $60	$30 / $60	--	Down	No	No	--	--
West Virginia	Separate	0	0	$35 / $71	$35 / $71	--	--	Up	No	Yes	$0	$5-$20
Wisconsin[o]	Combo	0	0	$10 / $10	$34 / $98	$34 / $98	--	Down	Difference between person's monthly income and the Medicaid income limit	Yes	NR	NR
Quarterly Payments												
Nevada[n]	Separate	$25	$50	$80	----	----	----	Up	No	No	--	--
Utah[n, q]	Separate	$30	$75	$75	----	----	----	Up	100-150% FPL: $36/family151 -200% FPL: $1,500/family	Yes	$1-$10	$3-$20
Annual Payments												
Alabama[n]	Separate	$50 / $150	$100 / $300	$100 / $300	$100 / $300	$100 / $300	----	Steady	No	Yes	$1-$2	$3-$5
Colorado[p]	Separate	$0	$25 / $35	$25 / $35	$25 / $35	----	----	Steady	No	Yes	$1-$3	$2-$5
North Carolina[p]	Combo	$0	$50 / $100	$50 / $100	----	----	----	Up	No	Yes	$1	$0-$5
Texas[p]	Separate	$0	$35	$50	----	----	----	Up	No	Yes	$0-$5	$3-$10
No Payments												
Alaska	Medicaid exp.	--	--	--	--	--	--	Steady	No	Yes	NR	NR
Arkansas	Combo	--	--	--	--	--	--	Steady	No	Yes	$5	$10

Table II.6 (*Continued*)

State	Program Type	Premium Amount per Child / Family Cap by family income level[a,b]						Direction of Premium Change Since 2006	Deductible Required (If Yes, report rate)	Copayments or Co-Insurance[d]		
		101% FPL	151% FPL	201% FPL[c]	251% FPL[c]	301% FPL[c]	351% FPL[c]			Copayments or Co-Insurance Required	Cost of Generic Prescription[e]	Cost of Primary Care Office Visit[e]
District of Columbia	Medicaid exp.	--	--	--	--	--	--	Steady	No	No	--	--
Hawaii	Medicaid exp.	--	--	--	--	--	--	Steady	No	No	--	--
Kentucky	Combo	--	--	--	--	--	--	Down	No	Yes	$1	$2
Mississippi	Separate	--	--	--	--	--	--	Steady	No	Yes	$0	$5
Montana	Combo	--	--	--	--	--	--	Steady	No	Yes	$3	$3
Nebraska	Medicaid exp.	--	--	--	--	--	--	Steady	No	No	--	--
New Mexico	Medicaid exp.	--	--	--	--	--	--	Steady	No	Yes	NR	NR
North Dakota	Combo	--	--	--	--	--	--	Steady	No	Yes	$2	$0
Ohio	Medicaid exp.	--	--	--	--	--	--	Steady	No	No	--	--
Oregon	Separate	--	--	--	--	--	--	Steady	No	No	--	--
South Carolina	Medicaid exp.	--	--	--	--	--	--	Steady	No	No	--	--
South Dakota	Combo	--	--	--	--	--	--	Steady	No	No		
Tennessee	Combo	--	--	--	--	--	--	Steady	No	Yes	$1-$5	$5-$15
Virginia	Combo	--	--	--	--	--	--	Steady	No	Yes	$2-$5	$2-$5
Wyoming	Separate	--	--	--	--	--	--	Steady	No	Yes	$3-$5	$5-$10

Sources: FFY 2010 CARTS reports, accessed April 21, 2011, and May 13, 2011; Section 1, Question 1 "Does your program require premiums or an enrollment fee?", "Does your program impose copayments or coinsurance?", "Does your program impose deductibles?" State plan information obtained from the Centers for Medicare and Medicaid (CMS) 2011d;. Wisconsin DHS, 2011.

Notes: CHIP=Children's Health Insurance Program; CARTS=CHIP Annual Reporting Template Survey; ER = emergency room; FPL = Federal poverty level; Medicaid exp = Medicaid-expansion CHIP, Separate = separate CHIP, Combo=combination program; NR = not reported.

[a] Within the table, the first premium figure represents the per-child premium amount and the second premium figure represents the maximum premium amount a family would be responsible for paying within the specific income range. Many States cap total premiums per family to reduce the burden on larger families. If a State did not report a family cap, the number reported is the premium amount per child, with the exceptions listed in footnote (h).

[b] If a particular income bracket is outside the bounds of a State's income eligibility limits, or if a State does not charge premiums to enrollees, the premium amount is listed as "--".

[c] States with an upper income-eligibility limit one percentage point below the income limit shown in each column have their premium amounts included. For example, for States with an upper income-eligibility limit of 200% of FPL, the 201% FPL column lists the premium obligation of a family at 200% of FPL. This applies to the upper income-eligibility limit for the following States: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin.

[d] Copayments and co-insurance are two separate options States can implement. CARTS does not solicit information that would allow for separate analysis. The detailed copayment and co-insurance price information was drawn from CMS State plan information (CMS 2011d).

Table II.6 (*Continued*)

[e] If a State was not included in the CMS State plan information, or it did not provide information on copayment amounts for generic prescriptions or primary care office visits, the State is designated as not reported (NR).

[f] Premium amounts vary depending on the type of plan chosen in California.

[g] Delaware did not submit a CARTS report in FFY 2010. These figures are from its FFY 2009 CARTS report.

[h] Figures displayed represent monthly family premiums for Delaware, Florida, Kansas, Louisiana, Maryland, Michigan, New Jersey, Rhode Island and Vermont. Premiums for Maryland are effective April 1, 2011.

[i] Premiums are not required for children ages birth through 5 years in Georgia.

[j] Premiums cannot exceed 5% of family income in Idaho, Indiana, Louisiana, Missouri, New Jersey, or Pennsylvania.

[k] In Louisiana, the deductible amounts according to the CMS State plan information are as follows: inpatient-$200 deductible for mental health/substance abuse services; ER-$150 deductible (waived if admitted); Other-30% of negotiated rate for home health.

[l] In Missouri, premiums for families with gross incomes above 185% up to and including 225% of the FPL are 4% of monthly income between 150% and 185% of the FPL plus 8% of monthly income between 185% and 225% of the FPL. Premiums for families with gross incomes above 225% up to and including 300% of the FPL are 4% of monthly income between 150% and 185% of the FPL plus 8% of monthly income between 185% and 225% of the FPL plus 14% of monthly income between 225% and 300% of the FPL.

[m] Oklahoma: Insure Oklahoma Populations Only (populations from 185 to 200% of the FPL). Members pay the lesser option of 4% of total household annual income or the set premium amounts listed.

[n] Premiums are not required for American Indian/Alaskan Native children in Washington, Nevada, Utah, and Alabama.

[o] According to the Wisconsin Medicaid web site, the deductible program is only for people who have high medical bills and meet all Medicaid rules but whose income is too high to qualify for Medicaid. It applies to pregnant women, children younger than 19, and elderly or disabled adults.

[p] Fees listed for Colorado, North Carolina, and Texas are annual enrollment fees, not premiums.

[q] Utah tiers deductible rates based on income. For families with incomes between 101 and 150% of the FPL, the rate is $36 per family. For families with incomes between 151 and 200% of the FPL, the rate is $500 per person and $1,500 per family.

[r] Premiums are reported for the MinnesotaCare program. Enrollees with family incomes below 150% of the FPL pay the minimum premium of $4 per enrollee per month. Enrollees with family incomes above 150 percent of FPL pay premiums on a sliding scale (Minnesota Health Care Programs Manual Letter #42 2011). Minnesota did not report premiums in its FFY 2010 CARTS report. Premiums reported in this table are for a family of three, with one child enrolled in MinnesotaCare (Heberlein et al. 2011).

As expected given CHIP rules, States with separate CHIP and combination programs used cost-sharing more often than States with Medicaid-expansion CHIP programs in 2010. Only 3 (out of 8) States with Medicaid-expansion CHIP programs (Alaska, Maryland, and New Mexico) require enrollees to share in costs in some manner, versus 41 States out of 43 with separate CHIP or combination programs. From 2006 to 2010, a number of other trends also are evident:

- **More States are using copayment-based cost-sharing and charging premiums than in the past.** Five States—Idaho, Oklahoma, Pennsylvania, Rhode Island, and Tennessee—have added copayments since 2006. In total, 30 States required copayments for CHIP enrollees in FFY 2010 (only one State, Louisiana, uses coinsurance). The number of States charging premiums also increased, from 31 States in 2006 to 34 in 2010. Louisiana, Oklahoma, Pennsylvania, and West Virginia added premiums in their separate CHIP programs; Kentucky removed premiums in its separate CHIP program; and Massachusetts, Rhode Island, and Wisconsin (all are combination States) removed premiums in one component of their program but maintained them in the other component (Massachusetts and Wisconsin removed them in Medicaid-expansion CHIP but left them in separate CHIP; Rhode Island removed them from separate CHIP but kept them in Medicaid-expansion CHIP.

- **More than half of the States that require premiums cap the amount a family must pay.** Twenty States offer a family cap on the premiums that a family must pay, so that families with more children are not charged on a per-child basis but rather a maximum is set. Fourteen of the 34 States that charge a premium (or enrollment fee) do not use a family cap; families in these States pay a set amount per child enrolled, regardless of the number of children.

- **Three States now impose deductibles, a new occurrence since 2006.** In 2006, no States reported using deductibles. As of 2010, Louisiana, Utah, and Wisconsin's separate CHIP programs reported using deductibles. Louisiana expanded coverage to those with income between 201 and 250 percent of the FPL in 2008; only those in this upper income group must pay a deductible. In 2007, Utah re-benchmarked CHIP benefits to State employees' coverage, which resulted in deductibles (and copayments) for some services. Wisconsin began charging deductibles in 2010 for some dental services for those with income more than 200 percent of the FPL.

- **There have been few changes to cost-sharing since CHIPRA's implementation.** While not shown in the table, 4 States eliminated premiums in the period since CHIPRA was implemented (Hawaii and Maryland in their Medicaid-expansion CHIP programs, Kentucky and Oklahoma in their separate CHIP programs). Four States added copayments (California and Oklahoma in their separate CHIP programs, Rhode Island in both its M- and separate CHIP programs, and Wisconsin in its Medicaid-expansion CHIP program), while one (North Dakota in its Medicaid-expansion CHIP program) eliminated copayments. Finally, Wisconsin added deductibles in its separate CHIP program. To help States understand the rules regarding cost-sharing after passage of the Affordable Care Act, CMS issued guidance in a State Health Official letter on February 25, 2011 to clarify the treatment of State premium increases under the Affordable Care Act relative to maintenance of effort (MOE) requirements (Center for Medicaid, CHIP and Survey & Certification 2011). This guidance included four clarifications: (1) that States that had explicit language in their State plan as of March 23, 2010 to automatically increase premiums on a regular basis could continue to do so in accordance with the approved State plan; (2) that States are permitted within certain rules to adjust premiums

for inflation; (3) that States can adopt new premiums if they are applied to new Medicaid coverage provided after July 1, 2008 or for CHIP, after March 23, 2010; and (4) that copayments are not conditions of eligibility, and that increases in copayments are not considered to be a violation of the MOE requirements.

4. Benefit Package Requirements

Federal CHIP regulations specify how a State may design its CHIP benefit package. Medicaid-expansion programs must offer all mandatory Medicaid services—such as inpatient and outpatient hospital services, physician visits, age-appropriate preventive screening services,[19] lab services, x-ray services, family planning, and so on—and may offer additional optional benefits beyond that if they choose.[20] Appendix Table A.2 describes these mandatory and optional benefits for Medicaid-expansion CHIP (and Medicaid) programs. As the table shows, most States offer many optional benefits for their Medicaid and Medicaid-expansion CHIP enrollees: for example, 50 States offer clinic services, skilled nursing facility services for those younger than 21, occupational and physical therapy, and prescription drugs, among other optional services.

States administering separate CHIP programs may offer a benchmark package, a benchmark-equivalent package, or a Secretary-approved package. There are three types of benchmark packages: the Blue Cross and Blue Shield standard option available to Federal employees, a plan available to State employees, and the health maintenance organization (HMO) plan in their State with the largest commercial, non-Medicaid enrollment. States may also design a benchmark-equivalent package that covers services comparable to the benchmark packages. If a State chooses to implement a benefit package not tied to one of these benchmarks, it must receive approval from the Secretary of the U.S. Department of Health and Human Services (HHS) (Davenport 2007). As shown in Appendix Table A.3, most separate CHIP programs (24 of 43 separate CHIP or separate CHIP components of combination programs) offer Secretary-approved coverage; 10 States offer benchmark coverage equivalent to State employee coverage; and 2 States offer benchmark-equivalent coverage to the HMO with the largest commercial enrollment in the State. All separate CHIP benefit packages are required to cover inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care (including age-appropriate immunizations and preventive and screening services comparable to those offered by Medicaid).[21]

To improve access to certain services, CHIPRA implemented two new benefit changes in separate CHIP programs: (1) a requirement that separate CHIP programs provide dental coverage; and (2) a requirement that separate CHIP programs offer parity for mental health and substance abuse benefits (that is, ensuring that the financial and treatment limits for mental health and

[19] These mandated screening services are known as early and periodic screening, diagnostic, and treatment (EPSDT) services, Medicaid's comprehensive and preventive child health program for individuals younger than 21. Defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation, EPSDT includes periodic screening and vision, dental, and hearing services (https://www.cms.gov/medicaidearlyperiodicscrn/).

[20] These benefits are defined in Federal regulations and cover specific items, provider types, and service types; however, amount, duration, and scope may vary by State (MACPAC 2011).

[21] Separate CHIP programs are not required to cover EPSDT services as Medicaid-expansion CHIP programs must, but must cover comparable preventive and screening services. Differences between Medicaid-expansion CHIP-covered EPSDT services and comparable Separate CHIP services tend to be minimal (MACPAC 2011).

substance abuse services are equal to limits for medical and surgical services) (P.L. 111-3, Section 501-502). Before CHIPRA, Medicaid-expansion CHIP programs were required to cover dental services in accordance with Medicaid rules, but separate CHIP programs were not required to cover them, although most did (Kaiser Commission on Medicaid and the Uninsured and Center for Children and Families 2010). However, separate CHIP program benefits for dental care typically covered a less comprehensive set of services than Medicaid/Medicaid-expansion CHIP and often capped dental benefits at low levels (Kaiser Commission on Medicaid and the Uninsured and Center for Children and Families 2010). Under CHIPRA, States with separate CHIP must offer comprehensive dental services; if desired, States can use a benchmark dental plan to meet the requirements, including the Federal employees' health benefits plan, the State employees' dental plan, or coverage offered through the largest commercial plan in the State (P.L. 111-3, Section 501(a)). CHIPRA also introduced other dental options: separate CHIP programs can offer dental-only coverage to children who would otherwise qualify for CHIP but who have private coverage and do not have access to (or sufficient) dental benefits (P.L. 111-3, Section 501, (b)). Finally, there is a requirement in CHIPRA to educate new parents about the importance of oral health (P.L. 111-3, Section 501(c)).

The review of CARTS data found that dental benefits expanded between 2006 and 2010, in some cases before CHIPRA was enacted. For example, three States that had previously eliminated dental coverage began offering dental benefits again in 2005 (Georgia) or 2006 (Delaware and Texas). Ten States mentioned in their 2009 and 2010 CARTS reports that they increased dental benefits or lifted caps on previously limited services; of those, only two States specifically mention that they made the changes in response to CHIPRA. (Appendix Table A.3 provides more detail on benefit changes noted in CARTS between 2006 and 2010 in separate CHIP States.)

For mental health services, CHIPRA required that separate CHIP programs comply with mental health parity requirements passed in 2008.[22] Medicaid programs—and thus Medicaid-expansion CHIP programs—were already subject to these parity requirements. Eleven States—Florida, Indiana, Iowa, Mississippi, Montana, New York, Pennsylvania, Tennessee, Washington, West Virginia, and Wyoming—reported expansions of mental health or substance abuse benefits in their separate CHIP programs in 2009 and 2010. Eight of those States (all but Indiana, Montana, and Washington) specifically mentioned that the changes were made to comply with CHIPRA requirements.

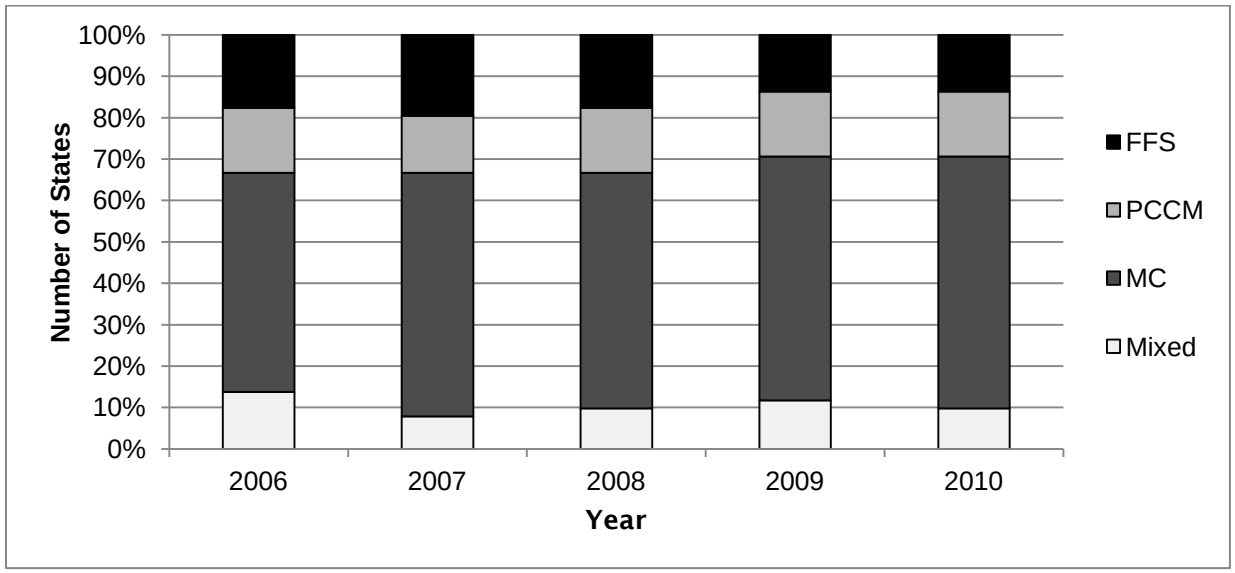
States also reported other benefit changes in 2010: for example, Colorado lifted its cap on covering hearing aids, West Virginia added vision benefits for CHIP enrollees with incomes between 201 and 250 percent of the FPL, Indiana added telemedicine, and Minnesota now covers American Sign Language interpreter services.

[22] The 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Parity Act) requires all large group health plans that currently provide mental health and/or substance abuse services to offer the same level of coverage for these services as for physical health services. This also applies to cost-sharing and treatment limits, which cannot be more restrictive for mental health services than for physical health services (Parisi and Bruno 2010).

5. Type of Delivery System

Like other health insurance products, CHIP programs offer coverage through three types of delivery systems: (1) an FFS system, in which the provider bills for each service and members have open access to services without a gatekeeper or medical home; (2) a primary care case management (PCCM) system, in which a provider is paid a capitated fee for serving as a medical home or gatekeeper for services, but all services are reimbursed outside the capitated arrangement; or (3) managed care, in which health plans pay providers a flat monthly capitation rate per enrollee for all or a defined set of services. Following national trends in the commercial sector, States continued moving toward managed care arrangements and away from FFS systems for CHIP (and Medicaid).[23] Figure II.3 shows the number of States by dominant delivery system.[24] The number of States reporting managed care as the dominant delivery system increased from 27 to 31 States in the period; States with a PCCM-dominant system remained constant over the period; States reporting FFS as the dominant delivery system declined slightly, from 9 to 7 States in this period; and mixed delivery systems declined from 7 to 5 States. Appendix Table A.4 provides State-level detail on CHIP delivery systems from 2006 to 2010.

Figure II.3. Dominant Delivery Systems of CHIP Programs, 2006 to 2010



Source: Mathematica analysis of Q1 FFY 2006, Q1 FFY 2007, Q1 FFY 2008, Q1 FFY 2009, and Q1 FFY 2010 Statistical Enrollment Data System (SEDS) data, accessed June 15, 2011.

[23] Over the past 15 years, managed care—defined as either enrollment in an HMO or preferred provider organization (PPO)—has become the dominant form of health care; 58 percent of those with ESI are enrolled in PPOs, followed by 19 percent in HMOs (National Conference of State Legislatures 2011).

[24] A dominant delivery system was defined as one that enrolled at least two-thirds of CHIP enrollees; otherwise, the delivery system was considered a mixed system.

B. Substitution of CHIP for Private Coverage (Crowd Out)

Because CHIP covers uninsured children at higher income levels than Medicaid, policymakers were concerned that individuals and families, as well as employers, might drop private coverage to enroll their children in CHIP. For families, the incentives to drop private coverage for CHIP are potentially lower costs in CHIP compared with private coverage, and the potential for more comprehensive benefits. For employers, the incentives would be cost savings from eliminating or reducing their contributions to dependent coverage policies for their low-wage workers. To address this concern, Title XXI required States to implement procedures to ensure that CHIP did not displace or "crowd out" private coverage (Rosenbach et al. 2003). CHIP regulations specify that the State plan must include a description of reasonable procedures to ensure that substitution does not occur, although the regulations do not specify what those procedures must be (42 CFR 457.805).[25]

1. State Policies to Prevent Substitution

Although the requirement to monitor substitution has been in place since CHIP's inception, CMS began asking States to report on specific substitution-prevention policies in 2008.[26] Table II.7 summarizes the information on crowd out policies reported by States in their 2008, 2009 and 2010 CARTS reports. In FFY 2010, 47 States reported having at least one substitution policy in place and 42 States used at least two different approaches to try to prevent crowd out. Common strategies used to prevent crowd out include imposing a waiting period during which the child must be uninsured before they can be enrolled in CHIP, and designing cost sharing features so that they are similar to features in private coverage options. The most frequently reported substitution policies were monitoring insurance status at the time of application and imposing waiting periods between terminating private coverage and enrolling in CHIP. Some States indicate they employ "other policies to prevent substitution," such as providing premium assistance for private or employer-sponsored insurance, and more extensive monitoring of insurance status at times other than application using database matching and reports from health care providers and other agencies.

Compared with what States reported in FFY 2001, in FFY 2010 10 more States conducted database matches and half as many States (9 versus 18) used cost sharing as a method for deterring substitution (FFY 2001 data not shown). Roughly the same number of States had waiting periods and monitored insurance status at the time of application in FFYs 2001 and 2010. In FFY 2010, 4 States (the District of Columbia, Hawaii, Nebraska and Ohio) reported not having any substitution policy in place and 3 States (Pennsylvania, Utah and Washington) were employing all 5 methods CARTS asks about. Notably, while the total number of policies States used remained steady at 131 in FFYs 2008 to 2010, States seem to still be experimenting with their substitution policies, with 15 States changing one or more method in the period: 7 States stopped using a strategy and 7 added something new during this period (one State added and dropped a policy for a net change of zero). For example, Alaska and South Carolina dropped waiting period requirements in 2010, and Iowa, Kansas, Minnesota, and Oklahoma implemented them in either 2009 or 2010. Figure II.2 provides

[25] States with premium assistance programs must administer specific crowd-out procedures in accordance with 42 C.F.R. 457.810, but those without premium assistance programs have discretion to determine their own reasonable crowd-out procedures.

[26] The 1997 CHIP legislation also required States to report on their substitution policies in an evaluation report that was due to CMS in March 2000.

more detail on current State waiting period policies. Among the 41 States with a waiting period in 2010, slightly more than half (23 States) used waiting periods of four months or fewer; 16 States have a waiting period of six months; and only 2 States—Kansas and Louisiana—require a period of uninsurance of more than six months. The median length of waiting periods, among States that used them, decreased from six months in 2008 (when 39 States used a waiting period) to four months in 2010 (when 41 States used a waiting period). States that monitored health insurance status at the time of application required, at a minimum, that applicants report their current health insurance status. Many States also asked applicants to provide information about coverage during a specified time period prior to the date of application as well as reasons for termination of employer-based or private coverage if applicable.

States are permitted to offer exemptions to waiting period requirements for circumstances such as involuntary job loss or coverage that is not affordable. The most common exemptions reported by States in FFY 2010 are due to involuntary separation from employment (81 percent), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) benefits ending (53 percent), employer dropping coverage (50 percent), or death/divorce (44 percent). Twenty-nine States also offered other reasons they will exempt a child from the waiting period requirements, including loss of coverage due to disability (six States), domestic violence (three States), or loss of Medicaid or CHIP coverage (three States), among other reasons listed. Iowa and Kansas adopted waiting periods in their CHIP programs that apply to new expansion groups only.

More than half of States utilize some form of database matching to determine if an applicant is already covered by another form of insurance. States with separate CHIP programs are asked to report on the databases to which they match (14 Medicaid-expansion CHIP programs also report matching to a database, but they are not asked to specify the databases they use). Many States are using similar databases: 10 States reported that they use a contractor's database (Health Management Systems), 6 States match with data from their local Blue Cross/Blue Shield insurer, 4 States mentioned State-specific databases on employer-sponsored insurance (ESI), and 2 States reported that they check against the State employee health insurance plan database, among others. North Dakota works with Blue Cross Blue Shield of North Dakota (BCBSND), the major health care carrier in the State, to compare CHIP applicants to BCBSND enrollment files. BCBSND informs the State of the matches it finds, and the State initiates an investigation. Because this approach involves establishing data sharing partnerships, States with one or two dominant health insurance carriers may have a distinct advantage over those with many small carriers or a large self-insured population. The quality of a State's matching procedure also depends upon the quality of the data files and the algorithms used to match records. Some States report using a quality assurance process to ensure the accuracy of matches. States that do not perform matches must rely on the accuracy of applicants' self-reported insurance status or, in some cases, periodic case audits.

Table II.7. CHIP Substitution and Crowd–Out Policies, by State, FFYs 2008–2010

State	2010 Program Type	Upper Income Limit ($)	Does the State's CHIP Program…															Total Number of Policies by Year		
			Monitor Health Insurance Status at the Time of Application? [a]			Impose a Waiting Period Between Terminating Private Coverage and Enrolling in CHIP? (length of waiting period, in months)			Match Prospective Enrollees to a Database That Details Private Insurance Status?			Impose Cost-Sharing in Approximation to the Cost of Private Coverage?			Have Other Policies to Prevent Substitution? [b]					
			2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010
TOTAL			44	45	43	39	40	41	26	26	27	8	9	9	13	11	11	131	131	131
Alabama	S	300	X	X	X	3	3	3	X	X	X							3	3	3
Alaska	M.	175	X	X		12	12		X	X	X					X		3	4	1
Arizona	S	200	X	X	X	3	3	3										2	2	2
Arkansas[c]	C	200	X	X	X	6	6	6										2	2	2
California	C	250	X	X	X	3	3	3	X	X	X							3	3	3
Colorado[d]	S	250	X	X	X	3	3	3							X			3	2	2
Connecticut	S	300	X	X	X	2	2	2	X									3	2	2
Delaware[e]	C	200	X	X	X	6	6	6			--			--			--	2	2	2
District of Columbia[f]	M	300																0	0	0
Florida	C	200	X	X	X	6	2	2	X	X	X	X	X		X	X	X	5	5	4
Georgia	S	235	X	X	X	6	6	6			X							2	2	3
Hawaii	M	300																0	0	0
Idaho	C	185	X	X	X	6	6	6	X	X	X							3	3	3
Illinois	C	200	X	X											X	X	X	2	2	1
Indiana	C	250	X	X	X	3	3	3				X	X	X				3	3	3
Iowa[g]	C	300	X	X	X		1	1	X	X	X				X			3	3	3
Kansas[g]	S	241	X	X	X			8										1	1	2
Kentucky	C	200	X	X	X	6	6	6										2	2	2
Louisiana	C	250	X	X	X	12	12	12	X	X	X	X	X	X				4	4	4
Maine	C	200	X	X	X	3	3	3	X	X	X							3	3	3
Maryland	M	300	X	X	X	6	6	6	X	X	X							3	3	3
Massachusetts	C	300	X	X	X	6	6	6	X	X	X				X	X	X	4	4	4
Michigan	C	200	X	X	X	6	6	6	X	X	X							3	3	3
Minnesota[c]	C	275			X			4										0	0	2
Mississippi	S	200	X	X	X													1	1	1
Missouri	C	300	X	X	X	6	6	6				X	X	X				3	3	3
Montana	C	250	X	X	X	1	1	3	X	X	X							3	3	3
Nebraska[f]	M	200																0	0	0
Nevada	S	200	X	X	X	6	6	6	X	X	X				X	X	X	4	4	4
New Hampshire	C	300	X	X	X	6	6	6				X	X	X				3	3	3

Table II.7 (*Continued*)

State	2010 Program Type	Upper Income Limit ($)	Does the State's CHIP Program…															Total Number of Policies by Year		
			Monitor Health Insurance Status at the Time of Application? [a]			Impose a Waiting Period Between Terminating Private Coverage and Enrolling in CHIP? (length of waiting period, in months)			Match Prospective Enrollees to a Database That Details Private Insurance Status?			Impose Cost-Sharing in Approximation to the Cost of Private Coverage?			Have Other Policies to Prevent Substitution? [b]					
			2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010	2008	2009	2010
New Jersey	C	350	X	X	X	3	3	3		X	X							2	3	3
New Mexico	M	235	X	X	X	6	6	6										2	2	2
New York [h]	S	400	X	X	X	6	6	6	X	X	X							3	3	3
North Carolina	C	200													X	X	X	1	1	1
North Dakota	C	160	X	X	X	6	6	6	X	X	X							3	3	3
Ohio	M	200							X	X								1	1	0
Oklahoma [i]	C	200	X	X	X			6			X				X			2	1	3
Oregon	S	300	X	X	X	6	6	2										2	2	2
Pennsylvania	S	300	X	X	X	6	6	6	X	X	X	X	X	X	X	X	X	5	5	5
Rhode Island	C	250	X	X	X				X	X	X	X	X	X	X	X	X	4	4	4
South Carolina [j]	M	200	X	X		3	3		X	X	X							3	3	1
South Dakota	C	200	X	X	X	3	3	3										2	2	2
Tennessee	C	250	X	X	X	3	3	3	X	X	X							3	3	3
Texas	S	200	X	X	X	3	3	3										2	2	2
Utah [k]	S	200	X	X	X	3	3	3	X	X	X	X	X	X	X	X	X	5	5	5
Vermont	S	300	X	X	X	1	1	1					X	X	X	X	X	3	4	4
Virginia	C	200	X	X	X	4	4	4										2	2	2
Washington	S	300	X	X	X	4	4	4	X	X	X			X			X	3	3	5
West Virginia [l]	S	250	X	X	X	6	6	3	X	X	X				X	X	X	4	4	4
Wisconsin	C	300	X	X	X	3	3	3	X	X	X							3	3	3
Wyoming	S	200	X	X	X	1	1	1	X	X	X							3	3	3

Sources: Heberlein et al. 2010; FFYs 2008-2009-2010 CARTS reports, accessed May 9, 2011, Section 1, Question 1: "Eligibility" and "Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)? "Section I: "Does your program match prospective enrollees to a database that details private insurance status?", and "Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?"; and 2008-2009-2010 CARTS, Section III, B. Substitution of coverage: "Do you have substitution prevention policies in place? If yes, indicate if you have the following policies: Imposing waiting periods between terminating private coverage and enrolling in CHIP; Imposing cost sharing in approximation to the cost of private coverage; Monitoring health insurance status at the time of application; other, please explain."

Notes: CARTS=CHIP Annual Reporting Template System; CHIP=Children's Health Insurance Program; M=Medicaid-expansion CHIP program; S=separate CHIP program; C=combination program; X = policy in place in State/year; "—" = nonresponse provided by State.

[a] Some States did not select yes for 'Monitoring health insurance status at the time of application' in CARTS reports, however, because the State reports a waiting period, we assume health insurance status is monitored at the time of application.

[b] These "other" policies included providing premium assistance for private or employer-sponsored insurance, more extensive monitoring of insurance status using matches of applicants and enrollees to insurance carrier databases, and reports from health care providers and other agencies.

Table II.7 (*Continued*)

[c] The waiting period applies only to those covered under the 1115 waiver in Arkansas and Minnesota.

[d] Colorado did not report a waiting period in its FFY 2010 CARTS report, but Heberlein et al. (2011) report that the State had a three-month waiting period as of January 2011 and the State's 2009 report also reports a three-month waiting period.

[e] Delaware did not submit a CARTS report for FFY 2010. Heberlein et al. (2011) reports a 6 month waiting period for the State in 2010, and because the State reports a waiting period, we assume health insurance status is monitored at the time of application.

[f] The District of Columbia and Nebraska answer 'No' to the question 'Do you have substitution prevention policies in place?' for all years 2008-2010.

[g] Iowa and Kansas adopted waiting periods in their CHIP programs that apply to new expansion groups.

[h] New York did not report the length of its waiting period in 2008 CARTS. Data obtained from New York State plan amendment #12 (Arnold 2009).

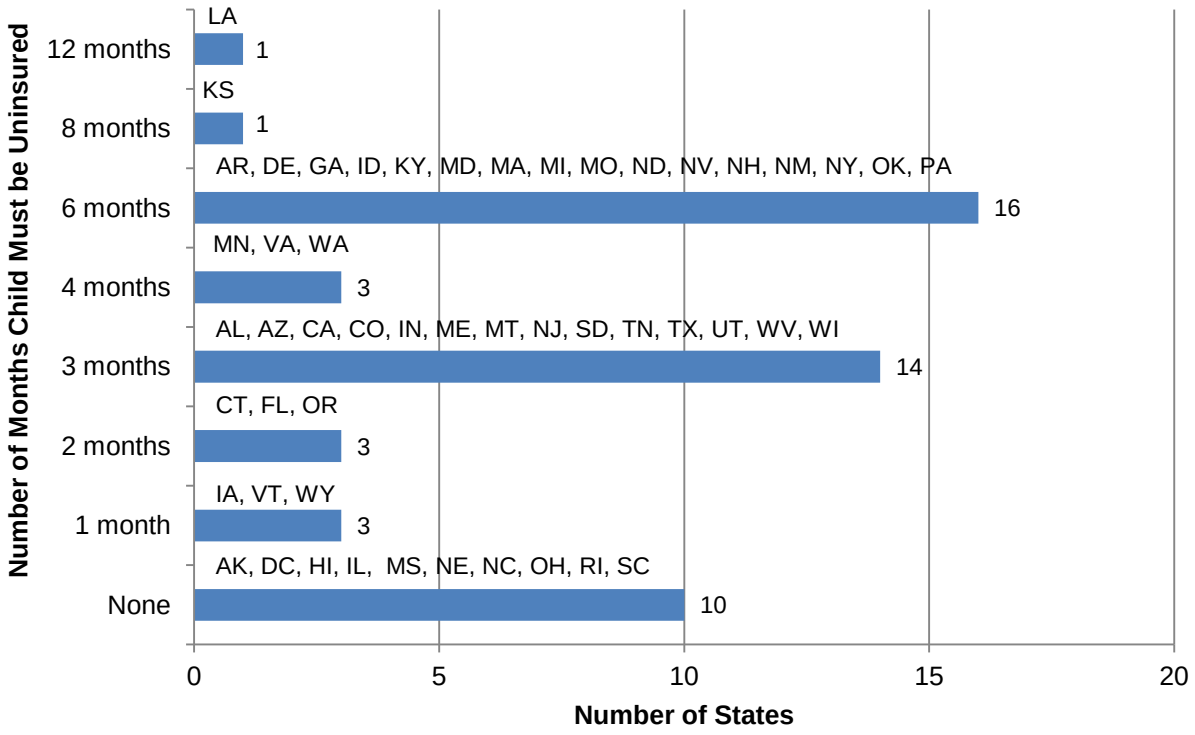
[i] Oklahoma has a six-month waiting period in its Insure Oklahoma premium assistance program.

[j] South Carolina eliminated its waiting period when the State replaced its separate CHIP program with a CHIP-funded Medicaid expansion.

[k] Utah did not report the length of its waiting period in 2008 CARTS. Data obtained from Utah's current State plan fact sheet (CMS 2009b).

[l] West Virginia decreased its waiting period from 12 months for those over 200% of the FPL and 6 months for those under 200% of the FPL to 3 months for all applicants.

Figure II.2. Length of Time a Child Is Required to Be Uninsured Before Enrollment in CHIP, 2010



Sources: 2010 CARTS reports, accessed May 9, 2011; Heberlein et al. 2011.

2. Literature on Substitution of CHIP for Private Coverage

There is a large literature on the topic of substitution, yielding a wide range of estimates. The earliest studies focused on Medicaid expansions that began in the late 1980s; more recent studies, the focus here, have examined substitution in CHIP. One reason that estimates vary so widely is that substitution is difficult to measure and the methods for doing so differ in important ways. This also makes it difficult to compare findings across studies. Ideally, substitution estimates would reflect changes in private coverage that are directly related to CHIP, but it is not possible to observe this directly in any data source or to distinguish it from changes due to factors other than substitution. Demographic and socioeconomic characteristics of the population, regional factors, the economic environment, State insurance laws and regulations, and other public and private sector policies all influence the availability, affordability and take-up of private coverage and, therefore, substitution rates. Another reason estimates vary from one study to another is because they use different data sources and/or define substitution in different ways.

Many studies have used the CPS, a cross-sectional survey that measures insurance status by asking if the person was ever covered during the previous year by any of about a dozen different types of coverage. Other studies use longitudinal surveys that measures insurance status for the same person at multiple points in time. In all of these surveys, people can report more than one type of coverage; many report both public and private insurance. Generally, the evidence on substitution comes from three types of studies: (1) population-based, (2) enrollee-based, and (3) applicant-based (GAO 2009; Limpa-Amara et al. 2007). Table II.8 compares basic features of methods used in these studies.

While studies differ in their methods and data sources, existing evidence indicates that some level of crowdout is unavoidable but the magnitude of substitution is lower than many expected and in general concerns about CHIP substituting for private coverage have lessened over time. Population-based studies estimate substitution rates for the program overall, typically to inform policy at the national level. Using survey data and exploiting differences in the timing of eligibility expansions or in the groups targeted by the expansions, they estimate how well CHIP is targeted to low-income uninsured children while controlling for things other than substitution that could be influencing coverage outcomes. Estimates of substitution rates from population-based studies range from none to as much as 60 percent of the increase in public coverage from CHIP coming from reductions in private coverage (Dubay and Kenney 2009; Gruber and Simon 2008; Lee et al. 2008; Bansak and Raphael 2007; Davidoff et al. 2005; Hudson et al. 2005; LoSasso and Buchmueller 2004; Cunningham et al. 2002). More recent studies using longitudinal data sources and improved methods for handling cases with both public and private coverage (discussed further below) estimate substitution rates ranging from 7 to 30 percent.

Table II.8. Comparison of Three Types of Substitution Studies

	Population-Based Studies	Enrollee-Based Studies	Applicant-Based Studies
Population Focus	National	Multistate or State-specific	State-specific
Purpose	Estimate the overall rate of substitution to inform future public policy	Evaluate extent to which enrollees dropped private coverage before applying, and reasons for dropping coverage	Provide ongoing feedback to States to ensure appropriate anti-substitution provisions are in place
Definition of Substitution	Among all children who were eligible for CHIP, the percentage who dropped private coverage or declined to take up available private coverage, with no exceptions for good cause	Among those recently enrolled in CHIP, the percentage who dropped private coverage and reasons for dropping coverage; may also estimate those who had access to private coverage while enrolled in CHIP	Among those who applied for CHIP, the percentage who were denied coverage because they dropped or intended to drop private coverage, with various exceptions for good cause
Data Source	Population-based surveys	Recent enrollee surveys	State application and other administrative data
Estimation Method	Multivariate analysis of the effects of CHIP eligibility on insurance status, controlling for secular trends, child and family characteristics, and State program features	Descriptive analysis of self-reported pre-CHIP insurance status and access to employer coverage among parents and children in family	Descriptive analysis of applicant characteristics from administrative records
Results	0 to 60 percent	0.7 to 20 percent	0 to 17 percent

Source: Adapted from Limpa-Amara et al. (2007).

Enrollee-based studies define substitution as the proportion of children enrolled in CHIP who had private coverage before enrolling. Estimates from these studies range from 0.7 to 19.9 percent (Dague et al. 2011; Hughes et al. 2002; Mulvihill et al. 2000; Schone et al. 2008; Shenkman et al. 1999; Slifkin et al. 2001; Sommers et al. 2007; Wooldridge et al. 2005). In their estimates of substitution, enrollment-based studies typically take into account the reasons for changes in private coverage, not counting involuntary losses of coverage (Limpa-Amara et al. 2007). They do not typically include cases where people forego taking up available private coverage after enrolling. One exception to this is the prior, congressionally mandated CHIP evaluation, which found that 28 to 36 percent of the parents of CHIP enrollees surveyed had employment-based coverage five months after enrolling the child in CHIP, suggesting that some children would have had private coverage in the absence of the program (Wooldridge et al. 2005).

A third approach to measuring substitution uses State-specific information on applicants for public coverage to estimate substitution prevented because applicants with access to private coverage were not permitted to enroll. While not a direct measure of crowd-out, these applicant-based studies provide estimates on potential substitution of private coverage due to CHIP. In general, estimates of denial due to access to private coverage are low, with most States reporting a denial rate of less than 10 percent (Limpa-Amara et al. 2007; Lutzky and Hill 2001).[27] In the analysis of FFY 2010 CHIP annual reports (CARTS) conducted for this report, 26 States reported the percentage of applicants found to have other group insurance at the time of application; the average was 8.5 percent and 12 States reported figures of 3 percent or less. In addition, four States reported that they track the percentage of applicants with access to private health insurance, with reported figures ranging from 0.41 percent to 28.1 percent. While all States monitor insurance status at the time of application, the tracking and reporting of this information in CARTS is not consistent among States, limiting conclusions that can be drawn from these reports.

Research is inconclusive as to whether enforcing a waiting period successful deters substitution. A study done by the National Bureau of Economic Research found "little evidence that waiting periods reduce crowd-out" (Gruber and Simon 2007). This counters a different study that found waiting periods significantly affect both take up and substitution; they estimate that a 5-month waiting period would "essentially eliminate crowd-out" but that it would also reduce the take-up rate by more than 50 percent (LoSasso and Buchmueller 2004). Other studies have also shown that waiting periods reduce CHIP enrollment and may discourage some eligible children from applying (Bansak and Raphael 2007; Wolfe and Scrivner 2005: Kronesbusch and Elbel 2004).

C. Other Options in CHIP to Expand Coverage to Children

Although CHIP provides direct coverage to those eligible for the program, CHIP programs can be designed to support a continuum of coverage options for families with incomes too high to qualify for CHIP. Here we discuss two options available to States to help such families: buy-in programs and premium assistance.

1. Buy-in programs

Buy-in programs allow families with incomes too high to qualify for CHIP or Medicaid to purchase coverage for their children, with the family paying either the full cost of their coverage or a part of it in States that offer subsidies. Because they do not use any Federal CHIP or Medicaid funds, buy-in programs do not operate under CHIP or Medicaid rules, but States generally structure them to mirror their CHIP or Medicaid programs, which simplifies administration and minimizes confusion about program differences (Center for Children and Families 2009a).

Most States with buy-in programs do not set an upper income-eligibility level, but charge premiums that are higher than those charged in CHIP—often the full cost of covering the child, although some States (for example, Illinois and Ohio) offer a sliding scale that varies with family income. States can also set other rules regarding eligibility for buy-in programs beyond income rules. In some cases, buy-in programs were developed specifically to help families with children who are

[27] In their review of CHIP crowd-out estimates from applicant-based studies, GAO estimates range from 0 to 17 percent.

difficult to insure, such as a child with disabilities with limited options for affordable private coverage (Comeau 2010). For example, the buy-in programs in Massachusetts and Minnesota are both limited to children who meet the disability criteria for Supplemental Security Income (SSI), and Massachusetts offers subsidies to families so that they can participate (the highest-income group pays $64 per month) (Heberlein et al. 2011; Comeau 2010). Other States have eligibility rules related to public coverage: for example, in Maine, children are eligible only if they have been enrolled previously in Medicaid or CHIP, and can only be enrolled for up to 18 months (Heberlein et al. 2011).

Eight States introduced CHIP or Medicaid buy-in programs for children between 2005 and 2010, bringing the total number of States offering these programs to 15. In 9 of the 15 States offering buy-in programs in 2010, children had to be uninsured for between 2 and 12 months before they could enroll. The remaining 6 States had no waiting period. In 2010, premiums ranged from $0 (for the lowest-income group in Massachusetts) to $581 per month (for the highest-income group in Ohio). In return for these premiums, children tended to receive the same benefit packages as children in CHIP or Medicaid, although in some States (Massachusetts, Oregon, and Wisconsin), the benefit package was less generous than that offered to CHIP enrollees. For families with incomes between 200 and 400 percent of the FPL, buy-in premiums may represent a relatively high proportion of family income. Perhaps partly as a result of this, take-up of buy-in programs is fairly low: the number of children enrolled in CHIP buy-in programs in some States is only about 10 percent of the eligible uninsured population (Kenney et al. 2008). (Appendix Table A.5 provides State-level detail on buy-in programs.)

As Heberlein et al. (2011) note, until new coverage provisions of the Affordable Care Act take effect in 2014, these buy-in programs could play a significant role in helping children with existing health conditions obtain coverage. Although the Affordable Care Act bans insurers in the small-group and individual insurance markets from denying coverage to children with existing conditions as of September 23, 2010, insurers have responded in many States by ceasing to offer any new child-only plans (Heberlein et al. 2011).

2. Premium assistance programs

States can establish premium assistance programs in CHIP or Medicaid, whereby States use CHIP funds, Medicaid funds, or both to subsidize the cost of private health insurance—such as ESI—for eligible individuals, rather than providing direct coverage through CHIP or Medicaid (Title 42, Chapter 7, Subchapter XIX, U.S.C. §§1396e-1, subchapter XIX, and Title 42, Chapter 7, Subchapter XXI, §§1397bb (c)(3)). Those eligible for premium assistance programs include children eligible for CHIP who have access to employer-sponsored coverage but who need help paying premiums, but also can include adults.

Although premium assistance programs were available before CHIPRA, CHIPRA provided new options for States, including the ability to provide a subsidy to children and parents if the cost of doing so does not exceed the cost of covering the family in CHIP, and the ability to subsidize ESI for Medicaid- and CHIP-eligible children and their parents if the employer's contribution is at least 40 percent of the total premium cost, enrollment in the program is voluntary, and the ESI meets certain criteria (P.L. 111-3, Section 301(a); U.S. Government Accountability Office 2010). States that offer premium assistance under new CHIPRA rules must assure that those enrolled receive the full range of CHIP or Medicaid benefits, even if the ESI does not cover those benefits (through the use of wraparound benefits, if necessary). CHIPRA also introduced limits on enrollee cost sharing (P.L. 111-3, Section 301 (a)(1)(E), Title III; U.S. Government Accountability Office 2010).

CARTS data on premium assistance programs in CHIP indicate that 12 States offered premium assistance in FFY 2010, either to children (3 States), adults (3 States), or both (6 States).[28] This is an increase from the 6 States that reported offering premium assistance in CHIP in FFY 2006. All of the programs currently operating predated CHIPRA enactment. State web sites indicate that some premium assistance programs are currently closed to new enrollment: for example, New Mexico's web site indicates that the programs for both children and adults have been closed to new enrollment since September 2010 (Insure New Mexico 2011). (Appendix Table A.6 provides more information on premium assistance programs.)

D. Adult Coverage Options

1. Demonstration programs for adults

Section 1115 of the Social Security Act permits the Federal government to approve demonstration programs allowing States to modify their public coverage programs in ways that are not otherwise allowed under CHIP statutory provisions (Kaiser Commission on Medicaid and the Uninsured 2009d). Although Medicaid Section 1115 waivers had been used to expand coverage to lower-income uninsured children and adults, in the early years of CHIP the focus of CHIP 1115 demonstrations primarily was on expansion to adults. In 2000, new research found that covering parents benefited their children (Ku and Broaddus 2000). CMS issued guidelines that permitted States to apply for Section 1115 demonstration waivers in their CHIP programs to expand coverage to parents and pregnant women (Kaiser Commission on Medicaid and the Uninsured 2009d; Families USA 2009). Beginning in 2001, States were also permitted to use Section 1115 demonstration programs to cover childless adults (Kaiser Commission on Medicaid and the Uninsured 2009d). Besides improving children's enrollment and health outcomes, States used waivers so that entire families could be covered by one plan, and thus have one system to navigate; and in some cases, the demonstration programs helped States spend their full CHIP allotments that would have otherwise gone unspent (Kaiser Commission on Medicaid and the Uninsured 2009d).

Beginning in 2006, the Federal government began phasing out adult coverage in CHIP: the Deficit Reduction Act of 2005 banned future waivers for coverage of childless adults in CHIP, and in 2007 CMS stopped renewing all CHIP adult coverage waivers (Kaiser Commission on Medicaid and the Uninsured 2009d). CHIPRA further prohibits any new waivers of the CHIP statute to cover parents with CHIP funds; the eight States with waivers in place in 2009 were permitted to continue their programs through the end of FFY 2011 (Center for Children and Families 2009b). Waivers in three States covering childless adults—Idaho, Michigan, and New Mexico—were also prohibited by CHIPRA; those in Idaho and Michigan ended in 2009, but New Mexico's will end when its waiver expires in November 2011. As of FFY 2010, seven States reported in CARTS some type of adult coverage through Section 1115 waiver authority in CHIP, covering nearly 275,000 adults (see Table II.9).

[28] Another 3 states offer premium assistance through their Medicaid programs only.

Table II.9. Adult Coverage Waivers as of FFY 2010

State	Pregnant Women	Parents	Childless Adults	Enrollment as Reported for FFY 2010
Arkansas		X to 200% of the FPL		7,135
Colorado	X to 250% of the FPL			3,790
Idaho		X between 25 and 185% of the FPL		343
Nevada	X between 125 and 185% of the FPL	X to 200% of the FPL		10
New Jersey		X between 27 and 200% of the FPL		204,044
New Mexico		X between 30 and 200% of the FPL	X to 200% of the FPL	55,748
Virginia	X between 133 to 200% of the FPL			3,242

Sources: FFY 2010 CARTS reports; Baumrucker 2008; Center for Children and Families 2009b.

Notes: CARTS=CHIP Annual Reporting Template System. While CHIPRA prohibited coverage of childless adults in CHIP, New Mexico's program will end when its current waiver expires in November 2011, per Nevada's FFY 2010 CARTS report; X = State has program for this population.

2. Coverage of Pregnant Women

Even before CHIPRA, CHIP programs could (and did) cover pregnant women. In Medicaid-expansion CHIP programs, States had to follow Medicaid rules, which include mandatory coverage of pregnant women with incomes up to 133 percent of the FPL, and optional coverage up to 185 percent of the FPL. In 2002, the Federal government revised the definition of *child* in the CHIP program to include the period from conception to birth (*Federal Register* Notice 2002). This change permitted States with Medicaid-expansion CHIP programs to create a separate CHIP program just to cover targeted low-income pregnant women; this was known as the unborn child option, because the rules covered the fetus and the only care provided was prenatal and maternity care. Finally, States could apply, as described earlier, for a Section 1115 waiver to cover pregnant women.

Under CHIPRA, States have a new option for coverage of pregnant women in CHIP by amending their State plans for CHIP. In the new option, States can provide coverage for pregnant women that includes prenatal care, delivery care, and 60 days of postpartum care under CHIP as long as they already cover pregnant women in Medicaid with incomes up to 185 percent of the FPL (P.L. 111-3, section 111). If they opt for this amendment, they must also provide CHIP coverage to children with family income up to 200 percent of the FPL (P.L. 111-3, section 111). CHIPRA also precludes applying waiting periods or cost-sharing in coverage for pregnant women. The intention in CHIPRA was that submitting a State plan amendment would be easier than applying for a Section 1115 waiver (as well as not subjecting the State to budget neutrality or renewal rules), and that more pregnant women would be covered, which in turn would offer their children a healthier start (Families USA July 2010).

At the time CHIPRA was implemented, 37 States and the District of Columbia met the State option requirements and were thus *eligible* to apply for a CHIP State plan amendment to further

expand coverage for pregnant women (Families USA July 2010). In all, 18 States covered pregnant women through CHIP as of FFY 2010, and as of September 2011, two additional States (New Jersey and Rhode Island) had been approved for the State plan option to cover pregnant women in CHIP (CMS 2011d).

E. Discussion

Even before passage of CHIPRA, States modified their CHIP programs to suit changing State circumstances, including expanding coverage to new groups and implementation of innovative approaches to bridge coverage for those with higher incomes, such as buy-in and premium assistance options. CHIPRA encouraged States to make further coverage expansions and many have done so: 19 States now cover lawfully residing immigrant children and/or pregnant women, 11 States have expanded eligibility to children of families with higher incomes than were previously eligible, 11 States have expanded mental health and substance abuse services, 10 States increased dental benefits or removed caps on dental services, and 2 States have approved State plan amendments to take advantage of the new option afforded by CHIPRA to cover pregnant women. These changes are not trivial and were made despite State budget crises and an economic recession, a time of fewer resources and greater need for coverage.

There was a slight uptick in the number of States using copayment-based cost-sharing and charging premiums over the past five years, not surprising given State resource constraints and increasing health care costs. However, cost-sharing has not increased in the aggregate since CHIPRA's implementation. Rising health care costs have undoubtedly also led to the slight increase in the use of managed care delivery systems in CHIP over fee-for-service (FFS) systems. In addition, 23 States offer additional coverage options for children from families whose incomes are too high to qualify for CHIP in the form of buy-in programs (11 States), premium assistance options (8 States), or both (4 States). Such programs can serve as a bridge between CHIP and private coverage options before provisions of the Affordable Care Act extend coverage further in 2014.

States remain vigilant about program eligibility, particularly as it relates to a child's uninsured status, with most States imposing some type of waiting period during which a child must be uninsured before becoming eligible (with reasonable exceptions), though the median length of the waiting period has decreased from six months in 2008 to four months in 2010. Consensus has emerged around the idea that some degree of substitution is unavoidable, though its existence is difficult to measure precisely. Although State policies to prevent substitution are intended to maximize CHIP's impact on uninsurance rates, they may also deter some of the eligible uninsured population from applying and lead others to become uninsured in order to meet waiting period restrictions. The CHIP Reauthorization Act (CHIPRA) gives States additional tools to leverage private coverage options available to low-income families, which may reduce substitution of CHIP for private coverage.

Economic challenges remain, with State funds and administrative resources constrained by the weak economy at the same time that demand for the program is increasing. In addition, new requirements associated with CHIPRA and the Affordable Care Act will require States to take on new coordination and implementation roles. Future evaluation efforts will further our understanding of State efforts in these areas.

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III. OUTREACH STRATEGIES AND APPLICATION PROCESSES

In the context of Medicaid and the Children's Health Insurance Program (CHIP), the term outreach broadly describes efforts undertaken to increase knowledge of and participation in the programs. Under Medicaid, States processed applications from anyone who applied, but in CHIP States began reaching out to find children who were uninsured and helped them to apply for coverage—a huge paradigm shift that also had spillover effects for Medicaid enrollment. Conducting a successful outreach campaign is just one way States can work to maximize program participation: simplifying enrollment (and renewal) processes is considered a vital step toward increasing enrollment and minimizing administrative burdens on program staff.

This chapter reviews State reports on outreach, application, and enrollment procedures, and progress toward some of the best practices in these three areas, including those encouraged by the CHIP Reauthorization Act (CHIPRA). Section B analyzes the evolution of State outreach strategies and methods used to measure their effectiveness, and Section C discusses application processes and administrative simplifications undertaken by States since federal fiscal year (FFY) 2006. In Section D, findings are discussed.

A. Background and Motivation

Before CHIP was established in 1997, little effort had been made to actively market Medicaid to potentially eligible populations (Perry et al. 2000). The legislation authorizing CHIP provided funding for States to initiate outreach campaigns dedicated to building awareness of CHIP, but also awareness of Medicaid. Although outreach was not part of the Medicaid program, at the time CHIP was implemented there was growing evidence that many children were eligible for, but not enrolled in, Medicaid (Lewis et al. 1997). Thus, outreach in CHIP could benefit Medicaid enrollment, as well as eligible families (some families might find they had children eligible for both programs, because of the variations in income thresholds by age). Because States were given freedom to develop custom outreach campaigns, they responded by implementing creative outreach strategies that helped build program name recognition, educated families about eligibility criteria and program features, and motivated eligible families to enroll (Rosenbach et al. 2007). Previous evaluations found that outreach campaigns during the implementation phase of CHIP tried to build broad awareness by using mass media to broadcast their messages; as CHIP matured and general knowledge of the program grew, States narrowed their campaigns to target specific geographic and demographic populations with low enrollment (Rosenbach et al. 2007).

CHIPRA renewed the emphasis on maximizing CHIP and Medicaid participation by authorizing competitive grants and other incentives to strengthen State outreach efforts. This included $100 million in grants for outreach and enrollment efforts through September 2013. During the first grant cycle, $40 million was awarded to 69 grantees across 42 States in September 2009. Grant recipients from a second $40 million cycle, which included 39 State agencies, community health centers, school-based organizations, and nonprofit groups in 23 States, were announced in August 2011 (Department of Health and Human Services 2011). Another $10 million

was awarded to 41 tribal health provider grantees in 19 States in April 2010, and the remaining $10 million in CHIPRA outreach grants is being used to fund a national enrollment campaign.[29]

CHIPRA also instituted performance bonus incentives to States for adopting policies that streamline enrollment and renewal procedures. These simplifications attempt to increase program efficiencies and reduce burdensome requirements that sometimes prevent families from applying or renewing coverage for their children. To qualify for the bonuses, States must have implemented at least five of eight possible administrative simplification policies specified in CHIPRA; States also had to succeed in enrolling children above specified target levels (both discussed later in this chapter). Beyond the activities that qualify for performance bonuses, States can also choose to expand the menu of options for submitting an application and allow self-declaration of income, citizenship, and insured status (rather than requiring documentation).

B. CHIP Outreach Strategies

Despite the increased emphasis placed on conducting outreach in recent years, evidence on which outreach strategies are most effective at reaching and enrolling eligible children and families is still lacking. Measuring the impact of outreach strategies is challenging due to the difficulty of disentangling the impact of a specific outreach initiative from the impact of other factors that might simultaneously influence enrollment (Rosenbach et al. 2007). Determining successful strategies across different locations or populations is also difficult, and extrapolating research findings across States is often not possible. Outreach effectiveness literature provides some evidence of the impact of outreach programs. CHIP Annual Reporting Template (CARTS) reports provide additional insight on what States believe to be effective outreach practices, although the information presented in CARTS usually is anecdotal, rather than evidence-based. To date, no States have conducted rigorous evaluations of the effectiveness of their outreach programs.

1. Most Effective Outreach Strategies

States must report annually in CARTS on their most effective outreach strategies and the methods used to assess effectiveness. Because CARTS uses an open-ended question for reporting, States are able to highlight as many or as few aspects of their outreach strategies as they desire (and the length and number of responses varied greatly across States). Figure III.1 highlights some examples of State outreach strategies (highlighted States are from among the 10 selected for further study in the evaluation). Table III.1 shows which outreach methods States reported as most effective in 2006 and 2010. Several themes emerged from this analysis.

Partnerships with community-based organizations (CBOs) were the most frequently cited effective outreach strategy by States during both 2006 and 2010. These partnerships generally entailed CBOs working closely with CHIP program administrators, distributing on-site promotional CHIP literature, and/or providing applications materials and application assistance for clients. States noted that CBO partnerships were effective due to the prominence and trust such organizations have in the communities targeted by CHIP, thereby enabling them to establish and maintain strong relationships with families. The number of States reporting use of strategic

[29] In addition to these opportunities, the Affordable Care Act authorized another $40 million in funding to support outreach and enrollment, available through 2015; requests for proposals for the Affordable Care Act outreach grants have not yet been released.

partnerships with CBOs declined from 35 in 2006 to 31 in 2010; however, this type of partnership remains the most common outreach strategy mentioned by States in CARTS. This slight decline might be associated with the increase in the use of more automated strategies in later years (discussed next).

Figure III.1. State Outreach Strategies in Action

Alabama partnered with sports marketing groups during televised sports broadcasts and with tents outside sporting events to promote CHIP outreach and enrollment in FFY 2010.

California partnered with CBOs, such as schools, faith-based institutions, social service agencies, and health care providers, to reach uninsured children and to promote program retention.

Florida conducted an "Act Out for Health" CHIP commercial competition among middle and high school students. Winning submissions aired on TV and/or radio in FFY 2006.

Louisiana conducted an "Outreach Blitz" campaign in urban and rural areas in FFY 2007. CHIP outreach workers blanketed specific areas with door-to-door and business-to-business outreach efforts, distributing applications and materials.

New York established a Children's Cabinet in FFY 2007 to bring together State agencies to focus on children's health insurance and early education; in addition, the State offered information on CHIP eligibility and enrollment at voluntary tax assistance sites.

Ohio offers the Ohio Benefit Bank, a web-enabled, counselor-assisted program that helps low- and moderate-income residents identify available benefits while filing their income taxes.

Texas held special phone-in enrollment events on local news broadcasts and the Spanish-language channel Univision in FFY 2009.

Utah outreach staff went on an eight-week statewide tour in 2007 in a newly designed CHIP van. They stopped at schools, boys' and girls' clubs, grocery stores, community centers, and so on to sign up as many youth as possible.

Virginia distributed flyers to 900 schools across the State and attended strategic events for school nurses and personnel.

Wisconsin focused its outreach methods on offering technical assistance to local community organizations in FFY 2010.

Sources: FFY 2006, 2007, 2008, 2009, and 2010 CARTS data, downloaded on May 10, 2011. This figure summarizes responses to CARTS Section III.A: 1. "How have you redirected/changed your outreach strategies during the reporting period?" and 2. "What methods have you found most effective in reaching low-income, uninsured children (e.g., TV, school outreach, word-of-mouth)?"

Table III.1. Most Effective CHIP Outreach Methods for Reaching Low-Income, Uninsured Children, FFYs 2006-2010

	Strategic Partnerships: Community-Based Organizations		Strategic Partnerships: School-Based (i.e., "Back to School" Enrollment Drives)		Strategic Partnerships: State and Local Government		Internet- or Electronic-Based Strategies		Print Marketing Materials		Mass Media Advertising		Application Assistance Trainings: Providers Clinics, Hospitals, Social Workers		Enrollment Events	
	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010
TOTAL	35	31	29	29	16	20	12	20	18	18	18	15	7	7	11	6
Alabama	X	X	X	X	X	X		X		X	X					X
Alaska	X					X			X	X		X				
Arizona	X						X		X		X					
Arkansas	X	X		X	X				X							
California	X	X	X	X				X								
Colorado	X	X	X				X									
Connecticut	X		X		X				X				X			
Delaware	X		X								X				X	
District of Columbia	X		X			X			X		X	X	X		X	
Florida	X	X	X	X	X		X	X		X	X	X				
Georgia		X	X	X	X					X						
Hawaii	X	X	X	X		X		X		X		X		X	X	X
Idaho			X	X						X						
Illinois	X	X					X	X			X					
Indiana	X		X			X	X		X	X	X					
Iowa	X	X	X	X	X	X			X		X	X			X	
Kansas			X								X				X	
Kentucky	X	X		X		X						X				
Louisiana		X	X	X		X				X	X			X		
Maine								X								
Maryland																
Massachusetts	X	X				X		X	X	X			X	X		
Michigan			X				X								X	
Minnesota		X														
Mississippi	X	X			X	X	X	X								
Missouri	X	X	X	X	X	X		X	X							
Montana	X			X					X		X	X				
Nebraska	X	X	X	X				X	X						X	
Nevada	X	X	X	X	X			X			X					X
New Hampshire	X	X	X	X										X		

Table III.1 (*Continued*)

	Strategic Partnerships: Community-Based Organizations		Strategic Partnerships: School-Based (i.e., "Back to School" Enrollment Drives)		Strategic Partnerships: State and Local Government		Internet- or Electronic-Based Strategies		Print Marketing Materials		Mass Media Advertising		Application Assistance Trainings: Providers Clinics, Hospitals, Social Workers		Enrollment Events	
	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010
New Jersey	X	X	X	X		X							X		X	X
New Mexico			X	X				X		X		X			X	
New York	X	X		X		X	X				X			X		X
North Carolina	X	X	X	X	X	X				X						
North Dakota	X		X	X	X	X					X	X				
Ohio					X											
Oklahoma		X		X		X										
Oregon	X		X	X				X	X	X		X				
Pennsylvania	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
Rhode Island	X	X														
South Carolina	X								X							
South Dakota	X	X		X			X	X	X	X			X			
Tennessee		X		X		X				X		X		X		
Texas		X					X	X				X				
Utah	X			X				X		X	X	X				
Vermont			X	X												
Virginia			X	X	X	X			X	X	X	X		X	X	
Washington	X	X	X		X			X	X							
West Virginia	X	X						X								
Wisconsin		X														
Wyoming	X	X	X	X	X	X	X	X	X	X	X		X			

Sources: FFY 2006 and FFY 2010 CARTS reports accessed May 10, 2011, Section III: Assessment of State Plan and Program Operation. A. Outreach. 2. "What methods have you found most effective in reaching low-income, uninsured children (e.g., TV, school outreach, word-of-mouth)?"

Notes: CHIP=Children's Health Insurance Program; CARTS=CHIP Annual Reporting Template System. The CARTS questionnaire does not explicitly ask States to report on their current outreach campaigns. States are asked to describe their most effective outreach methods, meaning responses to this question might not be comprehensive. The questions in 2006 and 2010 CARTS regarding outreach strategies are open-ended, causing the number of outreach strategies highlighted by States in each question to vary widely. This table represents an analysis of the most common outreach strategies and trends.

From 2006 to 2010, States increased their use of internet outreach strategies and reduced their reliance on traditional mass media advertising. The number of States reporting internet-based strategies as one of their most effective outreach methods increased from 12 in 2006 to 20 in 2010; the number of States reporting mass media advertising as one of their most effective strategies declined from 18 to 15 over the same time frame. Internet-based outreach includes posting advertisements through popular search engine web sites such as Google or Yahoo!, creating or improving program websites, and providing web-based resources (such as online applications or frequently asked question [FAQ] pages). Internet-based outreach was often highlighted as a substitute for more traditional radio, television, or billboard advertising. This type of outreach is less expensive than traditional mass media campaigns and was perceived by some States to be more effective, although these reports appear more anecdotal than based on evidence. Although not all States reported why they believed it was more effective, some specifically mentioned that they could monitor the number of hits to the web site and saw a substantial number of daily hits (for example, Hawaii averaged 1,050 hits per day in FFY 2010). Missouri officials noted that they had seen a substantial increase in web applications in FFY 2010; they believe that this method is useful at reaching a more diverse group of applicants who might not otherwise apply. Florida officials mentioned that a 2009 survey found that nearly a third of families got information on the CHIP program via the internet, the third most commonly reported method of getting program information (after obtaining information from friends and their child's school).

The perceived effectiveness of school-based partnerships remained consistently high. Establishing partnerships with schools has always been seen as an effective way of reaching the eligible but uninsured population. Twenty-nine States reported working with public schools as a main method for reaching potentially eligible families. In addition to school-based outreach, five States highlighted their efforts to connect with younger uninsured children and their families through Head Start or child care programs. Among the most popular school-based outreach efforts were States' annual back-to-school enrollment drives, efforts originally conceived of and sponsored by the Robert Wood Johnson Foundation's Covering Kids and Families campaign as a way to inform parents of the availability of low-cost or free health care coverage for uninsured children. The enrollment drives occur in August and September, and often entail enrollment fairs, media blitzes, and sending literature home to parents. Additional school-based outreach includes distributing promotional materials at public schools, advertising CHIP through literature for the free or reduced-price lunch program, offering in-person application assistance for families at school, and providing CHIP information at school wellness checkups.

Partnering with State and local government agencies grew from 2006 to 2010. The number of States reporting use of strategic partnerships with government agencies increased from 16 in 2006 to 20 in 2010. This entailed such efforts as offering enrollment assistance at county health department facilities and Department of Labor job fairs, printing information about public insurance options on unemployment checks, and/or establishing Express Lane Eligibility (ELE) across other means-tested programs. Many States highlighted the importance of these partnerships as ways to connect with traditionally hard-to-reach populations, such as minorities, rural families, and immigrants.

Eleven States mentioned facing a reduction in their outreach budgets in 2010, mainly due to State budget constraints in challenging economic times. When faced with constrained budgets, outreach is generally one of the first items cut from a State's CHIP budget. Outreach can seem less essential than other aspects of the program and successful outreach efforts can result in enrollment growth, which might not be desired during times of fiscal stress (Kaiser Commission on

Medicaid and the Uninsured 2006). In response to tighter outreach budgets, States mentioned the continued importance of strong partnerships with CBOs and government agencies to cover gaps in outreach and application assistance. States also highlighted the movement toward offering more online resources as a substitute for more traditional (but expensive) telephone hotlines, mass media advertising and other print promotional materials. In addition, States reported the continued importance of word-of-mouth advertising to bring CHIP enrollees to the program. Although not a formal outreach strategy and extremely difficult to quantify, States saw value in family, friends, and neighborhood networks sharing information about CHIP. The evidence from previous CHIP evaluations support these State anecdotes: researchers analyzed the 2001 National Survey of Children with Special Health Care Needs and found that low-income families reported that the most-often reported source of information about CHIP or Medicaid was a friend or family, reported by 27.9 percent of respondents (Kenney et al. 2004).

At the same time, CHIPRA recognized the importance of outreach funding and authorized $100 million to support outreach efforts. Among the 11 States that mentioned a reduction in outreach budgets in 2010, none were recipients of those outreach grants (although one State in this group, Washington, received an outreach grant in the second cycle of outreach grant awards in FFY 2011).

2. Outreach Effectiveness Literature

Evidence from previous research positively links specific outreach campaigns and some administrative simplifications to increases in enrollment.[30] Keeping outreach campaigns local and personal appears to be effective. Initiatives that have led to documented spikes in enrollment were diverse and very environment-specific, such as a hospital-initiated advertising campaign or a faith-based initiative (Irvin et al. 2006). CBOs such as schools, community health centers, health plans, and local religious organizations play a key role in conducting outreach and enrollment because they are able to capitalize on families' existing relationships and trust, and they can provide vital assistance in helping families overcome application and enrollment barriers (Wachino and Weiss 2009). Additionally, a 2003 case study concluded that person-to-person outreach efforts might be the most effective outreach strategy, particularly when done in partnership with public health or other agencies with a community presence (Ringold et al. 2003).

The literature presents mixed evidence with regard to large-scale marketing strategies, such as radio, television, and print media advertisements. In some instances, media campaigns were linked to an increase in telephone calls to toll-free lines, but other locations found no significant effects of these campaigns (Rosenbach et al. 2007). Differences in the type, duration, and frequency of the campaigns could have contributed to differences in the effectiveness of this strategy. Direct marketing might be an effective strategy if the target audience is narrow and carefully selected (Ringold et al. 2003).

At the State level, the evidence is scarce, but some studies have identified a link between application simplifications and gains in enrollment. A CMS-sponsored CHIP evaluation that used quantitative methods to identify enrollment spikes at the State and local levels and explored the

[30] The three studies discussed in this section present solid evidence on the effectiveness of particular outreach strategies. Each study utilized different methods and a different sampling frame. Although the results are not in contradiction, they draw different conclusions, demonstrating the lack of systematic evidence available.

potential causes using qualitative methods reported that certain simplifications, such as creation of a web site or the implementation of a web-based application, were associated with large gains in enrollment (Rosenbach et al. 2007). A 2009 qualitative study reported that State officials believed keeping application and renewal procedures simple helps to promote enrollment of eligible children (Wachino and Weiss 2009). Some of the other enrollment simplification processes, such as ELE, are too new to have evidence-based research published in the literature.

3. Measurement of Outreach Effectiveness

The extent to which States study and assess outreach effectiveness varies, as described in their CARTS reports. (However, only 34 States directly addressed the measurement question in FFY 2010 CARTS; see Table III.2.) The most common method reported for measuring outreach effectiveness was to track application, enrollment, and retention numbers (18 of 34 States). Other methods reported were tracking call volume to telephone hotlines (8 of 34 States) and conducting surveys and focus groups (7 of 34 States). Three States indicated that they do not measure the effectiveness of their outreach campaigns. However, 17 States did not report if or how they measure outreach effectiveness, likely because measuring the effectiveness of outreach campaigns is difficult and costly.

Table III.2. Methods States Reported Using to Measure Outreach Effectiveness in FFY 2010

Method for Measuring Outreach Effectiveness	Number of States Mentioning (N = 34)
Tracking application, enrollment, and retention numbers	18
Volume of calls to telephone hotline	8
Surveys, focus groups, or listening sessions	7
Track origin of application	6
Client reported at application[a]	4
Hits to web site	4
Attendance at presentation/enrollment events	4
Anecdotal feedback from partner organizations and participants	3
Effectiveness of outreach not measured	3
Other	3

Sources: FFY 2010 CARTS data, accessed on May 10, 2011; Section III.A.2: "What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, and word-of-mouth)? How have you measured effectiveness?"

Notes: Numbers reflect the number of States reporting each measurement strategy. Thirty-four States responded to the second part of this question; States could give more than one response. States that responded to the question included Alabama, California, Colorado, the District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wyoming. States not responding (or responding *not applicable*) included Arizona, Arkansas, Connecticut, Georgia, Illinois, Kansas, Maryland, Michigan, Minnesota, New Mexico, North Dakota, Rhode Island, South Carolina, Washington, and Wisconsin; CARTS = CHIP Annual Reporting Template System; FFY = Federal fiscal year; N = number.

[a] Some States have a question on their CHIP application that asks applicants how they heard about the program.

Most States perceive a positive association between outreach campaigns and enrollment, but no States presented rigorous evidence of their effectiveness. States were asked to estimate the number of children that have been enrolled in Medicaid as a result of CHIP outreach activities and enrollment simplifications. States noted that many variables contribute to Medicaid enrollment, including changes in program eligibility thresholds, CHIP and Medicaid outreach campaigns, and

enrollment/retention simplifications. Increased awareness of the program overall (potentially due to CHIP outreach) coupled with more financially eligible families in the State (due to eligibility changes and the economic downturn) were both seen as probable causes for reported increases in Medicaid enrollment in 2010 (publicly available information indicates growing Medicaid enrollment through the first half of 2010, particularly among children; data from the second half of the year are not yet available [Kaiser Commission on Medicaid and the Uninsured 2011c]). However, States were unable to quantify the number of new enrollees that were directly attributable to CHIP outreach efforts.

Eight States tracked how their enrollment or application counts fluctuated in response to particular outreach campaigns (such as a spike in enrollment after a back-to-school campaign or an increase in call volume after a radio advertisement). For example, Oregon reported an increase in applications, web site visits, and telephone calls after distributing materials at schools; New York tracked the number of referrals received after specific outreach events. Nine States reported tracking and comparing year-over-year patterns. Comparing trends across years can be problematic, however, because the number of children eligible for Medicaid/CHIP varies over time. An increase in enrollment in 2010, for example, might have been the result of poor economic conditions (such as business closures or relocations) rather than a particularly effective outreach campaign.

In an era of increased fiscal challenges for States, focusing outreach efforts on the most effective methods is increasingly important. Although States track broad enrollment and retention numbers, many questions remain regarding the effectiveness of specific CHIP outreach activities across geographic locations and diverse populations. Distinguishing the impact of a specific outreach initiative from the impact of other factors (such as demographic or programmatic changes) that influenced enrollment at the same time continues to be a challenge.

C. CHIP Application Processes and Procedures

Even using proven outreach methods, public coverage programs can struggle to maximize coverage if their application and/or renewal processes are overwhelming for clients. Reducing barriers to enrollment and renewal is considered a vital step toward increasing enrollment in CHIP and Medicaid and minimizing administrative burdens on program staff (Edwards et al. 2009). Barriers to enrollment can be grouped into three main categories: application process barriers, burdensome documentation requirements, and eligibility determination inefficiencies. In this section, we discuss administrative simplification policies and trends in adoption of these policies for enrollment based on FFY 2006–2010 CARTS reports.[31]

Making the application process easier for applicants has positive implications for both enrollees and program administrators. Enrollees benefit by being able to submit their applications more quickly and easily, and program administrators benefit by having applications that are easier to process. States face common challenges in their efforts to adopt administrative simplification policies; moreover, they must balance those efforts with program integrity requirements to ensure that only those eligible for programs can enroll. In a 2009 report studying eight States, system constraints—such as computer mainframe systems and limited automation and electronic exchange capabilities—were of primary concern for States attempting to simplify their policies (Edwards et al. 2009). Organizational and structural constraints were also problems; policies that involve data

[31] Renewal policies are discussed in Chapter IV.

sharing across multiple agencies can require complex coordination and communication, and raise issues related to program integrity, privacy and confidentiality. Finally, States must balance the use of technological innovations against the needs of the target population, which still must meet the needs of those with disabilities, low literacy or a preferred language other than English, or who might not have easy access to the needed technology (for example, internet access). Some families will continue to require personal assistance with enrollment and renewal processes that technology cannot replace.

1. Enrollment Simplification Policies

CHIPRA established performance bonuses for States that increased Medicaid enrollment above a specified target and that implemented at least five of eight specific administrative policies that were considered best practices for simplifying enrollment and renewal processes.[32] These policies include (1) eliminating the face-to-face interview requirement, (2) eliminating an assets test requirement, (3) offering ELE, (4) offering continuous eligibility, (5) using the same application and renewal process for CHIP and Medicaid, (6) using administrative or ex parte renewal, (7) offering presumptive eligibility, and (8) offering a premium assistance option. As of December 2010, 15 States were awarded bonuses in either 2009 or 2010 for meeting these requirements and for increasing their Medicaid enrollment above the state specific targets, as shown in Table III.3.[33] In FFY 2010 for example, these 15 states together increased Medicaid enrollment by over 874,000 children.

CARTS data show the extent to which States have adopted certain administrative simplification policies (which include five of the performance bonus measures).[34] Table III.4 summarizes these data. Of the 13 potential administrative simplification policies studied, the average (and median) number of policies adopted by States in FFY 2010 was 8. All States had adopted at least some of the policies by FFY 2010; the number of policies adopted per State ranged from a low of 5 in the District of Columbia to a high of 12 policies in New Jersey. The one simplification all States offer is making the application available on the State web site (although only in 34 States can an applicant submit the form online). There is variation across States, some of which can be attributed to how easy (or difficult) a particular policy is to implement. For example, some policies, such as elimination of the face-to-face interview requirement, are fairly simple and reduce the States' administrative cost and staffing requirements. Other policies, however, such as adoption of ELE or joint applications, require significant investment of State resources or even a State plan amendment. (Appendix Tables A.7 and A.8 provide State-level detail.)

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[32] State enrollment targets are set each year (beginning in FFY 2009) by applying the formula set out in CHIPRA to State enrollment data. CMS calculates the target for each State based on its child enrollment in Medicaid in 2007, adjusted each year by the State's child population growth and a standard enrollment growth factor that is specified in CHIPRA and that changes over time. The standard enrollment growth factor, which is the same for all States, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate—starting at 4.0 percent but dropping to 3.5, 3.0, and ultimately 2.0 percent (Kaiser Commission on Medicaid and the Uninsured 2009b).

[33] CARTS asks about these data elements in two separate areas: States are asked to report on their programs generally, and then it asks specifically asks about the eight performance bonus measures. In some cases, the data were internally inconsistent, and the data specifically on the eight performance bonus measures were inconsistent with published reports; for example, some States indicated they had an ELE program in place when CMS information on approved ELE programs differed, whereas some States that received bonuses had not completed all of the section or reported data inconsistent with published reports. Because of data quality concerns about these elements in CARTS, we report only on States that received bonuses.

[34] Policies included in the five-of-eight performance bonus awards are denoted with an asterisk.

2. Trends in Application and Enrollment Procedures from FFY 2006 to FFY 2010

All but two States had eliminated the face-to-face interview requirement in 2010. Eliminating the face-to-face interview is seen as an important step toward destigmatizing CHIP and easing the application process. Four States required a face-to-face interview in 2006 (the District of Columbia Medicaid-expansion CHIP, Kentucky Medicaid-expansion CHIP, Mississippi separate CHIP, and Tennessee Medicaid-expansion CHIP). Kentucky has alternately required and not required face-to-face interviews: the State had eliminated them in the early part of the decade, but later reversed these changes when the State budget was under stress and policy changed to restrict new enrollment (Wooldridge et al. 2010). Beginning in FFY 2009, Kentucky reported in CARTS that the interviews were no longer required. The District of Columbia (in its Medicaid-expansion CHIP program only) also eliminated the face-to-face interview by FFY 2007, leaving Mississippi and Tennessee as the only States requiring face-to-face interviews.

Most States with separate CHIP programs offered a joint application with Medicaid. Offering joint applications for Medicaid and separate CHIP makes coordination of eligibility between the two programs easier and helps to streamline eligibility determination. The number of States offering joint applications remained the same in 2006 and 2010, with 37 of the 43 States that offer separate CHIP programs utilizing joint applications with Medicaid.

By 2010, fewer States offered applicants the ability to apply over the telephone, but more States made applications available online and accepted online applications. The number of States accepting applications by telephone dropped from 19 in 2006 to 14 in 2010, with more separate CHIP than Medicaid-expansion CHIP programs continuing to offer this service. Although convenient for the applicant, accepting applications over the telephone is labor-intensive for the CHIP administrative office. The decrease in the use of telephone applications is occurring simultaneously with the increase in availability of application forms online (with the ability to download, print, and mail) as well as the ability to apply to the program online. Although popular in 2006, web-based application forms were ubiquitous by 2010, with every State offering the application form online by 2010.[35] Although the ability to submit the application online is not as widespread as the ability to download and print the application from the internet, the number of States offering online submission also increased—from 19 States in 2006 to 34 in 2010.

[35] Vermont did not report its application as available online in 2010, but further investigation showed that this option was available.

Table III.3. FFYs 2009 and 2010 CHIPRA Performance Bonus Awards

State	Program Features								Enrollment Target[a]		FFY 2009 Bonus Payment Amount (if applicable	FFY 2010 Bonus Payment Amount
	Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-Person Interview	Same Appl. and Renewal Form	Auto/Admin Renewal	PE	Express Lane	Premium Assistance Subsidies	Additional Enrollment Above 2010 Baseline (N)	% Increase in Enrollment over 2010 Baseline		
Alabama	X	X	X	X	X				132,999	36	$36,752,546	$54,965,407
Alaska	X	X	X	X	X				7,553	12	$707,253	$4,408,789
Colorado		X	X	X		X		X	37,359	14	NA	$13,671,043
Illinois	X	X	X	X	X	X			106,047	8	$9,460,312	$14,962,171
Iowa	X	X	X	X		X			27,729	14	NA	$6,760,901
Kansas	X	X	X	X		X			14,809	9	$1,220,479	$2,578,099
Louisiana	X	X	X	X	X				36,857	6	$1,548,387	$3,555,853
Maryland		X	X	X	X		X		43,152	10	NA	$10,549,086
Michigan	X	X	X	X		X			93,113	10	$4.721.855	$9,268,552
New Jersey		X	X	X	X	X	X		44,387	9	$3.131.195	$8,788,959
New Mexico	X	X	X	X	X	X			37,094	13	$5.365.601	$8,533,431
Ohio	X	X	X	X		X			92,503	9	NA	$12,376,346
Oregon	X	X	X	X	X				40,373	20	$1,603,336	$15,055,255
Washington	X	X	X	X				X	74,815	14	$7,861,411	$17,607,725
Wisconsin		X	X	X	X			X	85,557	23		$23,076,127
										Total Bonus Payments	$59,153,724	$206,157,744

Source: Insurekidsnow.gov 2011. FFY 2010 bonus payment information is current as of December 2010.

Notes: States that exceed their enrollment target by more than 10 percent qualify for a "Tier 2" performance bonus payment, in which additional enrollment is rewarded at a higher rate; X denotes State utilizes this feature; FFY = Federal fiscal year; PE = presumptive eligibility; N = number; NA = not available.

[a] The enrollment target is a baseline level of Medicaid child enrollment that is calculated based on a formula that accounts for population growth and for increases in enrollment during an economic recession. States that exceed their enrollment target have increased enrollment above what would have been expected without expanded outreach efforts.

Table III.4. Administrative Simplification Policies and State Adoption Status, FFY 2010

Policy	Description	Medicaid-Expansion CHIP (N = 8)	Separate CHIP (N = 17)	Combination (N = 26)	Number of States (N = 51)
Policies in place to address application process barriers					
Eliminated face-to-face interview requirement*	Adoption of an enrollment process that does not require a face-to-face interview	8	16	25	49
Joint application*	Adoption of common forms and uniform procedures in CHIP and Medicaid	NA	15	22	37
Methods for accessing and submitting application	Applications can be accessed online	8	17	26	51
	Applications can be submitted online	3	12	19	34
	Applications can be submitted over the phone	1	6	7	14
Policies in place to address onerous documentation requirements					
Eliminated asset test or administrative verification of assets*	Adoption of an enrollment process that does not require an assets test or administrative verification of assets	7	16	24	47
Reduced income documentation burden	Self-declaration (with or without internal verification) permitted for verifying:				
	Income[a]	2	6	7	15
	Citizenship[a]	1	8	13	22
	Insured status[a]	5	13	24	42
	Residency[a]	6	16	22	44
	Income disregards[a]	1	9	12	22
Policies in place to address ease eligibility determinations					
Presumptive eligibility*	Health care providers, CBOs, schools, and so on are permitted to screen and presumptively enroll children who appear eligible	2	3	11 (4 in Medicaid-expansion CHIP only; 1 in separate CHIP only)	16
Express Lane Eligibility*	State uses data and findings from other programs and databases to facilitate enrollment	1	3	3 (1 in Medicaid-expansion CHIP only)	7

Sources: FFY 2010 CARTS data, accessed on June 2, 2011, Section I questions "Does your program require a face-to-face interview during initial application?"; "Does your program require an assets test?"; "Is a joint application (i.e. the same, single application) used for your Medicaid and separate health program?"; "Please check all the methods of application utilized by your State"; "Indicate what documentation is required at initial application"; and "Is presumptive eligibility provided for children?" In addition, in Section III.C, "Does the State provide presumptive eligibility to children who appear to be eligible for Medicaid and CHIP to enroll pending a full determination of eligibility?" and "Are you utilizing the Express Lane option in making eligibility determinations and/or renewals for both Medicaid and CHIP?" Heberlein et al. 2011.

Notes: CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; Combo = combination program; N = number; NA = not available. Delaware did not submit a 2010 CARTS report as of June 30, 2011. Data from Delaware were determined from the State website and Heberlein et al. 2011.

* Denotes a policy as part of the five-of-eight performance bonus program.

[a] CARTS does not separate this question by program type.

State take-up of presumptive eligibility and ELE continues to grow. Presumptive eligibility allows children to obtain access to Medicaid or CHIP services without having to wait for their application to be fully processed. Typically enrollment through this route offers a set period of coverage until full eligibility is determined, and occurs at a provider location (such as a hospital emergency room or a Federally qualified health center); it benefits the child by providing coverage before the application is fully processed and the provider receives payment in lieu of charity care. Use of presumptive eligibility increased from 11 States in 2006 to 16 in 2010. ELE allows States to rely on findings from other programs to verify eligibility for CHIP. ELE was not explicitly available to States before the CHIPRA legislation in 2009 (although some States already had similar processes in place, they just were not labeled officially as express lane, nor did they require a State plan amendment to implement). Three States had an approved State plan amendment to utilize ELE in 2009; by 2011, this number has grown to eight, and several more States have submitted but not yet received approval for State plan amendments authorizing this option.

More than half of States permit applicants to self-report key eligibility details such as insured status or residency, but most require documentation on income and citizenship. States have begun to report the use of internal verifications, a more vigorous tool used in combination with self-declaration. States can decide how applicants can report on four key eligibility determinants: income (and income disregards if they are used), citizenship, insured status, and residency. They can allow applicants to self-declare these items; permit self-declaration, but have agency staff conduct follow-up processes to document these items (known as internal verification); or they can require applicants to provide the documentation at application. Self-declaration, with or without internal verification, is less burdensome on the applicant, whereas providing documentation is more burdensome to the applicant. The number of States allowing applicants to self-declare (with or without internal verification) income did not vary much in the period (14 States in 2007 and 15 in 2010); and most of the States reporting using internal verification on income in 2010 were States that had been self-declaration States without requiring internal verification in 2007 (Table III.5). Allowing self-declaration (with or without internal verification) of citizenship and insured status increased in this period. Forty-two States (up from 36) allowed self-declaration of insured status in 2010, and 22 (up from 14) allowed self-declaration of citizenship. CHIPRA mandated that States document citizenship of CHIP applicants, although States can take on that burden by data-matching with SSA information. In FFY 2010, States were also asked about the required documentation for use of income disregards; of the 40 States that responded, more than half permit self-declaration, with most of the self-declaration group of States not also performing internal verification.

Table III.5. Documentation Methods Reported by States, FFYs 2007 and 2010

	Self-Declaration					
	Without Internal Verification		With Internal Verification		Documentation Required	
Documentation Type	2007 (N = 50)[a]	2010 (N = 51)	2007 (N = 50)	2010 (N = 51)	2007 (N = 50)	2010 (N = 51)
Income Documentation	14	7	N/A	8	36	36
Citizenship Documentation	14	4	N/A	18	36	29
Documentation of Insured Status[b]	36	25	N/A	17	13	9
Residency Documentation	N/A	38	N/A	6	N/A	7
Documented Use of Income Disregards[c]	N/A	15	N/A	7	N/A	18

Source: FFY 2010 CARTS reports accessed June 2, 2011, Section 1, "Indicate what documentation is required at initial application."

Notes: CARTS=CHIP Annual Reporting Template System, N = number; N/A = not asked.

[a] In FFY 2007, Oklahoma did not report on any of the documentation verification questions, thus N = 50 in 2007.

[b] In FFY 2007, DC did not report on the documentation of insured status question, thus N=49 for this question in FFY 2007.

[c] Only 40 States answered the documented use of income disregards question in FFY 2010, thus N=40 for this question.

D. Discussion

States are using many of the best practices for enrollment and application processes that CHIPRA has encouraged, but there is opportunity for further adoption of these processes. For example, only 14 States offer presumptive eligibility in their separate CHIP programs. Only 15 States permit self-declaration of income and only 22 permit self-declaration of citizenship. Given concerns about program integrity, States may be reluctant to implement these types of simplifications, although new options that ease State administration while supporting program integrity—such as data matching with the Social Security Administration for citizenship verification, which became available in 2010—likely will encourage more States to adopt such simplifications.

Although all States are investing in outreach activities to try to enroll more eligible children, the most recent evidence indicates that 4.3 million children (roughly two-thirds of all uninsured children) are eligible for but not enrolled in Medicaid or CHIP as of 2009 (Kenney et al. 2011). Thus, understanding more about best outreach practices for CHIP and Medicaid remains relevant. Moreover, there is substantial State-to-State variation in participation rates in CHIP and Medicaid, which range from 62.9 percent in Nevada to 97.0 percent in Washington, D.C. (the U.S. average participation rate is 84.8 percent), with three large States—Texas, California, and Florida—accounting for nearly 40 percent of the 4.3 million eligible but uninsured children in the nation, (Kenney et al. 2011). States could benefit from more evidence about what works best in which environments and how to implement those best practices. Many States are using practices long supported by the literature—partnering with CBOs and schools, for example. They are also increasing the use of internet-based outreach, in part because it is easier for the States and cheaper than expensive marketing campaigns, but most lack hard evidence that it has worked to increase CHIP enrollment or how to target it to reach the intended audience.

Some States identified outreach—and outreach budgets—as an area of ongoing concern, but most States have benefitted from new investments in outreach by the Federal government, which might help prepare them for implementation of the Affordable Care Act. To prepare for an influx of newly eligible enrollees, the Affordable Care Act requires all States to use an integrated, web-based

enrollment system for CHIP, Medicaid, and the exchanges by 2014 (healthcare.gov 2011). In addition, coverage expansions under the Affordable Care Act will require innovative outreach strategies to educate the public on new eligibility and program guidelines. Lessons learned from CHIP about effective outreach will provide relevant information for States planning new outreach campaigns under health reform.

IV. ENROLLMENT AND RETENTION POLICIES AND PRACTICES

The Children's Health Insurance Program (CHIP) and Medicaid play critical roles in providing health insurance coverage to children from low-income households. Enrollment in both programs has grown since CHIP was first implemented in 1998, but roughly half of all children enrolled in CHIP lose coverage at the renewal period (Southern Institute on Children and Families 2009). Most enrollment losses occur at the time of renewal and are due to administrative issues rather than ineligibility or transitions to private coverage. Retaining eligible children in Medicaid and CHIP has, therefore, become a central strategy in reducing the number of uninsured children in the United States.

Since the inception of CHIP, States have been given the flexibility to implement a wide range of strategies to reduce unnecessary disenrollment. Some of these strategies are similar to those used to increase enrollment, such as simplifying administrative procedures, coordinating processes between CHIP and Medicaid, and conducting outreach efforts to educate families about the application and renewal processes; others, such as offering continuous coverage and grace periods for premium payments, are targeted more at retention. Although State adoption of such measures has increased significantly over time, recent legislation explicitly supports further adoption and has also introduced new measures to streamline administrative processes (Heberlein et al. 2011). For example, the CHIP Reauthorization Act (CHIPRA) added incentives for States to streamline renewal procedures through its performance bonus system and permitted the use of Express Lane Eligibility (ELE) processes for renewal. The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) includes State requirements that will further streamline renewal processes and enhance coordination across public programs, such as eliminating the need for multiple eligibility determinations across public programs through use of shared administrative databases. Also, in February 2010, Secretary Sebelius issued the *Connecting Kids to Coverage Challenge* to encourage States and local governments, community and faith-based organizations, school districts and health centers, and Department of Health and Human Services (DHHS) partner agencies to find children eligible for public programs and keep them enrolled for as long as they qualify.

This Chapter presents trends in CHIP and Medicaid enrollment since the implementation of CHIP in federal fiscal year (FFY) 1998 and describes the extent to which States have adopted various policies to increase program retention. Section B presents trends in public coverage using annual ever-enrolled counts for Medicaid and CHIP from the Statistical Enrollment Data System (SEDS). In the few cases in which SEDS quarterly data were not available for Medicaid, we used data in the Medicaid Statistical Information System (MSIS) State Summary Datamart, a source of publicly available Medicaid enrollment data.[36] Section C focuses on retention, using data from the CHIP Annual Reporting Template System (CARTS) to assess trends in the adoption of retention strategies between 2006 and 2010. To ensure a complete and accurate picture of renewal practices adopted by States in these years, we used other secondary data sources to verify and supplement CARTS data, most notably data from the survey of State officials conducted by the Kaiser

[36] The MSIS enrollment data are subject to validation edits that test whether individual data fields are within appropriate ranges and then distributional quality checks to evaluate the reasonableness of the information across data elements and quarters; these data are available at http://msis.cms.hhs.gov (CMS 2011).

Commission on Medicaid and the Uninsured and Georgetown University in 2010. Section D discusses the findings.

A. Background and Motivation

Enrollment of children in both CHIP and Medicaid has increased continually since CHIP was created in 1997, and CHIP and Medicaid now cover about one-third of all U.S. children and 59 percent of low-income children (Heberlein et al. 2011). Although expansions of public coverage have helped decrease the rate of uninsurance among children, keeping eligible children enrolled in CHIP and Medicaid is an ongoing challenge. A large percentage of children eligible for CHIP experience uninsurance spells or disenroll entirely (Sommers 2007, 2005; Wooldridge et al. 2005). In 2006, an estimated one-third of all uninsured children had been enrolled in Medicaid or CHIP during the previous year and more than 40 percent of uninsured children eligible for public coverage were enrolled in CHIP or Medicaid within the previous year (Sommers 2007). Administrative data for 8 States participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program show between 40 and 80 percent of children remain enrolled for 18 months, depending on the State (Trenholm et al., 2011). This wide range underscores the vast differences in retention across States and the likelihood that many children leaving CHIP in at least some States may remain eligible. Some children leave public programs because they are no longer eligible or have obtained another source of coverage, but many are disenrolled for administrative or procedural reasons. This is reflected in high rates of churning within public coverage. In a five-State study, Fairbrother et al. (2007) found that roughly half of eligible children leaving public coverage returned in two or three months.

Coverage instability within public health insurance programs is a major concern to States for several reasons. Studies have shown that children who are uninsured for even short periods have reduced access to care and report more unmet health care needs than those with continuous coverage (Olson et al. 2005; Aiken et al. 2004). In addition, the enrollment and reenrollment of the same eligible children introduces inefficiencies and unnecessary administrative costs into public programs without increasing program participation rates (Irvin et al. 2001). Finally, eligible children who disenroll from public programs tend to join the pool of uninsured children rather than transition to private coverage (Trenholm et al. 2008; Wooldridge et al. 2005). Retention of eligible children in public coverage is, therefore, central to efforts to reduce uninsurance rates among children in the United States.

Most children who disenroll but remain eligible for CHIP lose their coverage when their policies go up for renewal, often by not initiating or completing the renewal process (Cassidy 2011; Cohen et al. 2008). Misconceptions about eligibility, confusion about the renewal processes, and complicated administrative procedures imposed by States are often cited as key reasons for renewal failures by recent disenrollees (Boozang et al. 2006; Shulman et al. 2006). In States that charge premiums, missed payments are another major reason for disenrollment. Unnecessary disruptions in coverage can also occur when children transfer from one public program to another. Children who leave CHIP and qualify for Medicaid often experience uninsurance spells due to nonseamless transitions to Medicaid, particularly in States with separate CHIP programs (Merrill and Rosenbach 2006; Sommers 2005; Wooldridge et al. 2005).

B. Enrollment in Public Coverage

Combined enrollment in CHIP and Medicaid reached a historical high of 42 million children ever enrolled in public coverage in FFY 2010, following a 12-year upward trend in both programs

(Figure IV.1).[37] Medicaid is the dominant source of health insurance for low-income children, covering more than 34 million children or 82 percent of all publicly insured children in FFY 2010. The majority of CHIP enrollees are in separate CHIP programs, which have covered between 70 and 75 percent of those annually enrolled in CHIP since FFY 2001 (Table IV.1).[38]

Table IV.1. Trends in CHIP Enrollment: Number of Children Ever Enrolled, FFYs 1998 to 2010

Federal Fiscal Year	Number of Children Ever Enrolled in CHIP	Increase Over Previous Year		Enrollment by Program Type		Percentage of Total Enrollment	
		Number	Percentage	Medicaid-Expansion CHIP	Separate CHIP	Medicaid-Expansion CHIP	Separate CHIP
1998	660,351	--	--	324,637	335,714	49.2	50.8
1999	1,966,716	1,306,365	197.8	743,651	1,223,065	37.8	62.2
2000	3,358,417	1,391,701	70.8	1,037,751	2,320,666	30.9	69.1
2001	4,597,614	1,239,197	36.9	1,184,875	3,412,739	25.8	74.2
2002	5,336,508	738,894	16.1	1,317,908	4,018,600	24.7	75.3
2003	5,883,155	546,647	10.2	1,508,279	4,374,876	25.6	74.4
2004	6,111,038	227,883	3.9	1,723,182	4,387,856	28.2	71.8
2005	6,159,844	48,806	0.8	1,738,270	4,421,574	28.2	71.8
2006	6,755,199	595,355	9.7	2,031,183	4,724,016	30.1	69.9
2007	7,105,986	350,787	5.2	2,002,194	5,103,792	28.2	71.8
2008	7,355,746	249,760	3.5	2,088,984	5,266,762	28.4	71.6
2009	7,695,264	339,518	4.6	2,179,130	5,516,134	28.3	71.7
2010	7,705,723	10,459	0.1	2,165,950	5,539,773	28.1	71.9

Source: Mathematica analysis of CMS' CHIP Statistical Enrollment Data System (SEDS).

Notes: The enrollment data shown for FFYs 1998 – 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 – 2010 are annual data from CMS' SEDS as of February 18, 2011, verified and provided by CMS. In cases where States did not report annual ever-enrolled data, Mathematica used ever-enrolled data from the quarter with the highest enrollment that year to approximate annual enrollment (Ellwood et al. 2003). See Appendix Tables A.9 and A.10 for cases where annual enrollment was approximated using SEDS quarterly data. Enrollment data were not available in SEDS for New York's Medicaid-expansion CHIP program in 2002, 2003, and 2005.

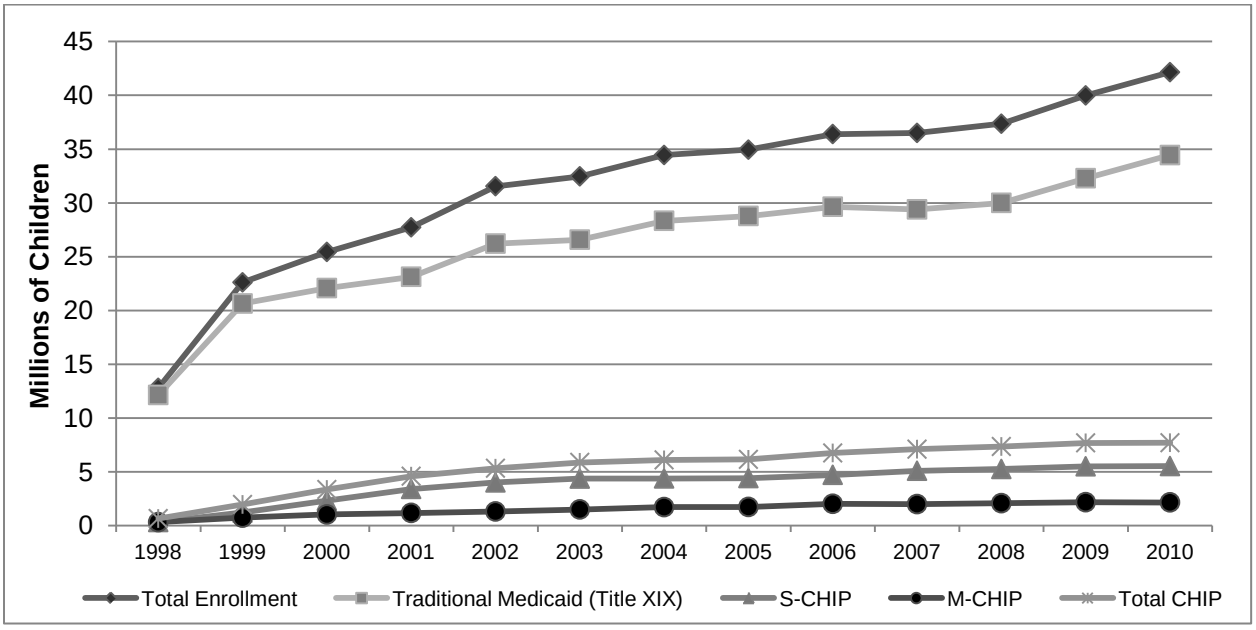
Figure IV.1 shows that enrollment in both Medicaid and CHIP increased rapidly between FFY 1998 and 2003. Much of the growth during the early years of CHIP (FFYs 1998 to 2001) has been attributed to intense outreach efforts at the national, State, and local levels, which increased awareness of public health insurance programs among children eligible for both Medicaid and CHIP (Rosenbach et al. 2007). In addition, Title XXI mandated that States with separate CHIP programs screen all CHIP applicants for eligibility for traditional Medicaid and to enroll those found eligible in the program. The "screen and enroll" provision supported growth in the Medicaid program and overall enrollment in public coverage. Moreover, many States adopted the more streamlined and simplified eligibility determination and enrollment processes implemented under CHIP for their Medicaid programs (Rosenbach et al 2007).

[37] Children in CHIP-financed coverage, including those in Medicaid-expansion CHIP programs, are counted separately from children in traditional (Title XIX) Medicaid.

[38] The share of total CHIP enrollment in Medicaid expansion programs was higher in the first two years of the program, when States were still in the process of implementing and ramping up separate programs.

Following this initial rapid enrollment growth, the rate of increase in CHIP enrollment declined between FFY 2003 and 2005, with enrollment plateauing at about 6 million enrollees (Figure IV.2). This period of relatively flat CHIP enrollment coincides with a downturn in the economy, beginning in 2001, that put pressure on State budgets and led some States to reduce outreach in order to maintain eligibility levels and benefits (Smith et al. 2010). Although the economic situation started to improve in FFY 2004, States emerged from the recession with tight budgets that prevented many from expanding public coverage (Holahan 2010). As fiscal conditions improved over the next couple of years, many States began to restore funding for outreach and to expand CHIP eligibility levels. In addition, many States continued to make efforts to simplify and increase efficiencies in their application processes, as well as to improve retention procedures (Edwards et al. 2010).

Figure IV.1. Trends in CHIP Enrollment, by Program Type, 1998-2010



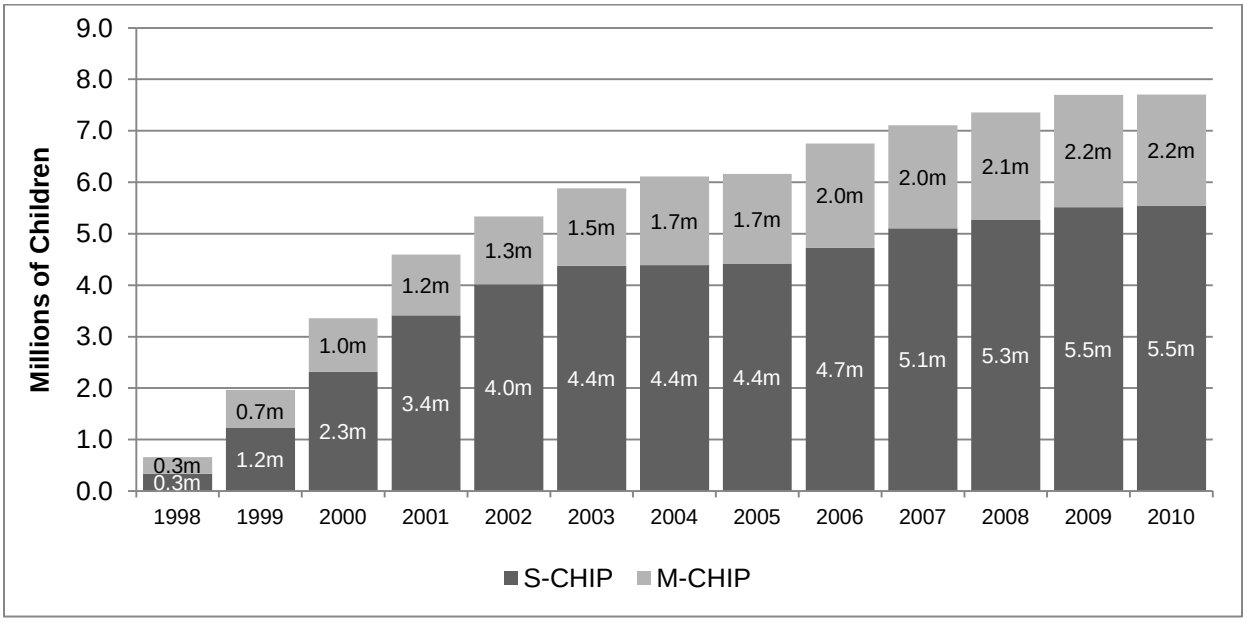
Source: Mathematica analysis of CMS' CHIP Statistical Enrollment Data System (SEDS)

Notes: The enrollment data shown for FFYs 1998 – 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 – 2010 are annual data from CMS' SEDS as of February 18, 2011, verified and provided by CMS. CMS' SEDS data were supplemented by annual data from the Medicaid Statistical Information System (MSIS) State Summary Datamart (downloaded August 31, 2011) where Medicaid data were not available in SEDS. Enrollment data for the United States Territories are not included in Figure IV.1; the Territories do not report enrollment data in SEDS, with the exception of 1999, when traditional Medicaid enrollment counts (totaling 612,237) were reported by five Territories: American Samoa (36,549), Guam (8,747), Mariana Islands (6,045), Puerto Rico (559,896), and the Virgin Islands (1,000). In cases where annual ever-enrolled CHIP or Medicaid data were not available for a particular state in SEDS, Mathematica used ever-enrolled data from the quarter with the highest enrollment that year to approximate annual enrollment (Ellwood et al. 2003). See Appendix Tables A.9 and A.10 for cases where annual CHIP enrollment data were approximated using SEDS quarterly data. Quarterly SEDS data were used to approximate annual counts of traditional Medicaid enrollment in the following cases: Colorado 2002-2003, District of Columbia 2000, Georgia 2001 and 2003, Illinois 2001-2002, Louisiana 2001, Missouri 1998, New Hampshire 1999, New York 2003-2005, Tennessee 2003, Utah 2002, Washington 2000, and Wyoming 2001; Medicaid-expansion CHIP enrollment data were not available for New York in 2002, 2003, and 2005. In cases where data on enrollment in traditional Medicaid were not available in SEDS, Mathematica used annual data from the Medicaid Statistical Information System (MSIS) State Summary Datamart. These cases include: Alabama 2000-2005, Georgia 2004-2005, Hawaii 1999, Idaho 1990-2003, New York 2002, Texas 2004-2005, Vermont 2000-2004, Washington 1999, and Wyoming 1999. Medicaid enrollment data were not available in SEDS or the MSIS Datamart for several states in 1998: Alabama, Alaska, Arizona, Arkansas, California, Delaware, District of Columbia, Kansas, Louisiana, Minnesota, Montana, Nevada, New Hampshire, New Mexico, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

Between FFY 2006 and 2010, CHIP enrollment increased from 6.76 million to 7.71 million, or by 14 percent (Figure IV.2). Enrollment growth during this period was fairly widespread, with 36 States experiencing enrollment increases; among these States, the median rate of increase was 19.4

percent over this period (Appendix Tables A.9 and A.10). The largest absolute gains in enrollment were experienced by California, Florida, Texas, and Wisconsin; the number of enrollees increased by roughly 100,000 in Florida, by 104,000 in Wisconsin, and by more than 340,000 in California and Texas. However, the largest relative (percentage) gains occurred in Wisconsin (183 percent) and Tennessee (97 percent), followed by Idaho (71 percent) and Alabama (63 percent). Fourteen States experienced declines in CHIP enrollment of between –3.4 percent and –61.6 percent during the 2006 to 2010 period. The largest absolute declines in enrollment occurred in Georgia and New York, where enrollment declined by roughly 95,000 and 148,000, respectively; relative (percentage) declines were the greatest in Arizona (–59 percent) and New Mexico (–62 percent). Decreases in enrollment in some States have been attributed to children switching from CHIP to Medicaid mostly because of drops in family income and some to reductions in outreach activities (Kaiser Family Foundation 2010a).

Figure IV.2. Trends in CHIP Enrollment, by Program Type, 1998-2010



Source: Mathematica analysis of CMS' CHIP Statistical Enrollment Data System (SEDS).

Notes: The enrollment data shown for FFYs 1998 – 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 – 2010 are annual data from CMS' SEDS as of February 18, 2011, In cases where States did not report annual ever-enrolled data, Mathematica used ever-enrolled data from the quarter with the highest enrollment that year to approximate annual enrollment (Ellwood et al. 2003). See Appendix Tables A.9 and A.10 for cases where annual enrollment data were approximated using SEDS quarterly data. Medicaid-expansion CHIP enrollment data were not available for New York in 2002, 2003, and 2005.

Although total enrollment in CHIP has continued to increase over the past five years despite decreases in several States, there was a notable decline in the growth rate between FFY 2009 and 2010, following the onset of another recession in 2008. As shown in Table IV.1, the rate of increase in CHIP enrollment fluctuated between 3.5 and 5.2 percent between 2007 and 2009, but dropped to 0.1 percent between 2009 and 2010. Fiscal pressures combined with uncertainty related to the congressional reauthorization of CHIP prevented further program expansions in many States between FFY 2008 and 2010, and led some States to cut outreach budgets, raise premiums, or cap enrollment.

Although there was little change in total CHIP enrollment between FFY 2009 and 2010, Medicaid enrollment grew sharply. Following a three-year period of modest growth, traditional

Medicaid enrollment increased by 8 percent in FFY 2009 and by 7 percent from FFYs 2009 to 2010. The recession led many families previously eligible for CHIP to fall below CHIP eligibility thresholds, resulting in a more dramatic increase in enrollment in traditional Medicaid programs (Figure IV.1). The performance bonuses created under CHIPRA could also be a factor driving enrollment gains in traditional Medicaid programs, as those bonuses had incentives tied to raising Medicaid enrollment. In addition, new rules introduced by ARRA provided protection for children enrolled in traditional Medicaid programs (but not CHIP) by requiring States to maintain eligibility levels and enrollment procedures in order to receive a temporary increase in the Federal Medicaid matching rate.[39]

Enrollment in CHIP and Medicaid continues to be relatively concentrated in four States, each with CHIP enrollment counts exceeding 400,000 children: California, Florida, New York, and Texas. Together, these States accounted for almost half (47 percent) of CHIP enrollment in FFY 2010; California and Texas alone accounted for 35 percent of total CHIP enrollment in that year (Appendix Tables A.9 and A.10). These same four States have among the highest levels of child enrollment in Medicaid and represented more than one-third of child enrollment in Medicaid in FFY 2010.

C. Retention of Eligible Children

As States have enrolled more children in their CHIP programs, their focus has expanded from increasing enrollment to ensuring that eligible children remain enrolled. States have instituted a variety of strategies that may directly or indirectly affect whether children stay enrolled in CHIP. These strategies can be categorized into five broad areas: (1) extending eligibility and renewal periods; (2) streamlining renewal procedures (such as reducing and simplifying documentation requirements, eliminating face-to-face interviews, or implementing passive renewals); (3) improving communication with families about upcoming renewal periods; (4) altering premium payment policies (such as reducing premiums and offering grace periods for payment); and (5) improving coordination between CHIP and other public programs (including using data from other public programs to verify eligibility and promoting seamless transfers between CHIP and Medicaid). All States employ some combination of these strategies. Table IV.2 provides a summary of the retention strategies adopted by States as of FFY 2010.[40]

[39] This protection was not extended to CHIP until the adoption of the Affordable Care Act in FFY 2010, whose MOE provision requires States to maintain eligibility and enrollment policies through 2019 for children in both Medicaid and CHIP. One exception to the MOE requirement is that separate CHIP programs can institute an enrollment cap if they are at risk of exhausting all Federal program funding.

[40] A more detailed summary of retention policies adopted by each state can be found in Appendix Tables A.11-A.13.

Table IV.2. Renewal Simplification Policies and State Adoption Status in FFY 2010

Policy (N = 51 Unless Otherwise Noted)	Description	Medicaid-Expansion CHIP (N = 8)	Separate CHIP (N = 17)	Combination (N = 26)	Number of States (N = 51)
Eligibility Renewal Procedures					
12-month frequency of renewal[a]	Renewal occurs on a 12-month period (rather than more frequently)	8	17	26 (4 in Medicaid-expansion CHIP only)	51
No face-to-face interview for renewal (N = 50)	Adoption of a renewal process that does not require a face-to-face interview	8	16	25	49
Continuous coverage	States have the option to provide children with up to 12 months of continuous coverage through Medicaid and CHIP, even if the family experiences a change in income during the year	5	13	18 (4 in separate CHIP only, 1 in Medicaid-expansion CHIP only)	36[b]
Prepopulated form sent to family (N = 50)	States send prepopulated renewal forms to enrollees' families at renewal; confirmation responses required if State has not adopted passive/administrative renewal	6	11	15 (4 in separate CHIP only, 1 in Medicaid expansion only)	32
Income documentation not required[a]	No paper documentation of income is required at renewal	4	9	7 (1 in separate CHIP only, 1 in Medicaid-expansion CHIP only)	20
Online renewal[a]	Clients have the ability to renew online	2	8	9 (3 in separate CHIP only, 1 in Medicaid-expansion CHIP only)	19
Telephone renewal[a]	Clients have the ability to renew over the phone	2	7	6 (1 in Medicaid-expansion CHIP only)	15
Passive/administrative renewal	Families receive prepopulated renewal forms and are required to contact the eligibility office only if their information (income, household size, and so on) has changed	1	2	3 (1 in separate CHIP only)	6
Communication Strategies					
Renewal reminder notices sent (N = 50)	States send notices to all families before renewal date	6	15	25	46
Follow-up with families by caseworkers or outreach workers (N = 50)	Caseworkers or outreach workers follow up with families if coverage is not renewed	5	5	16	26

Table IV.2 (*Continued*)

Policy (N = 51 Unless Otherwise Noted)	Description	Medicaid-Expansion CHIP (N = 8)	Separate CHIP (N = 17)	Combination (N = 26)	Number of States (N = 51)
Premium Payment Policies					
No premium or enrollment fee requirement	Premium and enrollment fees are eliminated	7	3	25 (17 in Medicaid-expansion CHIP only, 1 in separate CHIP only)	35
Grace period for premium nonpayment[a] (N = 29)	States requiring premiums give families grace periods before they lose coverage for nonpayment of premiums	1	11	16	28
No lockout periods[a] (N=28)	Following disenrollment for nonpayment of premiums, children are not barred from reenrolling in the program for a period	0	5	9	14
Coordination Strategies					
Same renewal form (N = 43)	State uses the same renewal form for Medicaid and separate CHIP	NA	13	21	34
Same eligibility system for CHIP and Medicaid (N = 43)	Separate CHIP and Medicaid have the same eligibility systems	NA	8	18	26
Ex parte renewal (N = 49)	States use information collected from other programs, such as the Supplemental Nutrition Assistance Program, to assess ongoing eligibility to limit the amount of information a family has to submit	2	2	9 (2 in Medicaid-expansion CHIP only)	13
Use of ELE for renewal	State uses data and findings from other programs and databases to facilitate renewal	0	1	2	3

Sources: Mathematica analysis of FFY 2010 CARTS data (extracted June 2, 2011, and August 25, 2011). This table summarizes States' responses to the following questions: Section I, "Does your program provide a period of continuous coverage regardless of income changes? Specify number of months"; "Is a preprinted renewal form sent prior to eligibility expiring?" "If yes, check either (1) We send out form to family with their information pre-completed and ask for confirmation, or (2) we send out form but do not require a response unless income or other circumstances have changed"; Section III, "What additional measures does your State employ to simplify an eligibility renewal and retain eligible children in chip? Specify: (1) Conducts follow up through caseworkers/outreach workers, (2) Send renewal reminder notices to all families – (a) How many notices are sent to the family prior to disenrolling the child from the program? (b) At what intervals are reminder notices sent to families? (3) Other"; and Section IIIC Subpart b: "Are you utilizing the express lane option in making eligibility determinations and/or renewals for both Medicaid and CHIP?" [Three States were explicitly using the ELE option for renewals.] "Has the State eliminated an in-person requirement for renewal of CHIP eligibility?" "Does the State do ex parte renewal?";Heberlein et al. 2011.

Notes: CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; ELE = express lane eligibility; N = sample size; NA = not applicable; Delaware did not submit a 2010 CARTS report as of June 30, 2011. Where possible, data have been completed using Heberlein et al. 2011.

[a] Information for these policies is drawn primarily from Heberlein et al. 2011.

[b] Nebraska offers only six months of continuous coverage. Minnesota offers 11.

Several studies have attempted to measure the effectiveness of retention strategies in each of these five broad policy areas. Most of the evidence to date is based on descriptive or qualitative studies, rather than quantitative studies that aim to address questions of causality more rigorously. Caution therefore should be used when drawing conclusions from the current literature, although the available evidence provides at least preliminary support for several retention approaches adopted by States. For example, an impact study found that enrollment would rise by an estimated 16 percentage points were a typical state to adopt a set of strategies, including elimination of asset testing, adoption of presumptive eligibility, and self-declaration of income (Kronebusch and Elble 2004). A study on Louisiana found that the adoption of ex parte renewal, as well as a complement of other strategies aimed at reducing renewal denials for reasons other than eligibility (such as not returning paperwork) cut these procedural denials to less than one percent (U.S. Department of Health and Human Services 2010).

In this section, we describe and report on State implementation of retention policies between FFY 2006 and 2010, highlighting evidence about these policies in the current literature, where available.

1. Extending Coverage and/or Renewal Periods

Continuous coverage is a policy option that allows children to maintain CHIP or Medicaid coverage for up to one year, regardless of changes in income or other family circumstances. By extending the eligibility period, States can reduce churning of children on and off of public coverage due to eligibility redetermination procedures or short-term income variations (Edwards et al. 2010; Bindman et al. 2008). Although continuous coverage policies do not directly address disenrollment at renewal, there is some evidence to suggest that longer periods of continuous enrollment might decrease longer-term disenrollment among eligible children (Dick et al. 2002).

In the early years of CHIP, States chose to redetermine eligibility frequently as a way to identify individuals who were no longer eligible and to maintain program integrity. Federal rules require States to redetermine eligibility at least once every 12 months, and States have trended toward adopting this maximum eligibility period. By FFY 2010, 36 States offered continuous coverage (Table IV.2 and Appendix Table A.11).[41, 42] The prevalence of this policy remained relatively constant between FFY 2006 and 2010—there was a net increase of 3 States using this policy during this period. Five States adopted continuous coverage during the FFY 2006 to 2010 time frame (Indiana, New Mexico, Tennessee, Virginia, and Washington) and 2 States eliminated it (Arizona and Maryland). However, several States with an existing continuous coverage policy extended the length of continuous coverage between FFY 2006 and 2010. Although not all States offering continuous coverage reported on the number of months available, among those providing complete data in FFY 2006, 84 percent (27 of 32 States) offered 12 months of continuous coverage; in FFY 2010, this percentage increased to 94 percent (34 of 36 States). Continuous coverage tends to be more

[41] In 4 of the States (with combination CHIP programs) that used continuous coverage policies in 2010, continuous coverage was provided only to children covered under the separate CHIP program. In 1 of the States (with combination CHIP programs) that used continuous coverage policies in 2010, continuous coverage was provided only to children covered under the Medicaid-expansion CHIP program. In 2006, of the 33 States offering continuous coverage, 5 (combination) States applied the policy to either Medicaid-expansion CHIP or Separate CHIP children only.

[42] Minnesota's separate CHIP program reports 11 months of continuous coverage for pregnant women. According to the State's web site, continuous coverage is offered only until the child is born.

prevalent in separate CHIP States than in Medicaid-expansion CHIP States, and in separate CHIP programs in combination States.

Because most disenrollment occurs at renewal, requiring enrollees to renew less frequently—for example, every 12 months instead of every 6 months—can increase retention rates, even in the absence of a continuous coverage policy (Edwards et al. 2010; Bindman et al. 2008). By January 2011, all States had instituted a 12-month renewal period for children covered under CHIP.[43] In States without continuous coverage, enrollees are still obligated to report income changes in the intervening period.

2. Streamlining Renewal Procedures

Continuous eligibility policies and longer renewal periods can prolong enrollment, but they do not prevent disenrollment spikes during the period of renewal (Merrill and Rosenbach 2006; Shulman et al. 2006). Recognizing that many eligible children lose coverage due to administrative hurdles when it is time for renewal, States have adopted various measures to simplify the renewal process. Strategies that streamline renewal requirements enable families to overcome administrative obstacles that might prevent them from reenrolling while their children are still eligible (Wachino and Weiss 2009; Rosenbach et al. 2007). These strategies include the following (Appendix Table A.11 provides State-level detail):

- **Prepopulated renewal forms.** Using administrative data, many States send prepopulated renewal forms to families to reduce or eliminate the burden of completing the form. The number of States adopting this practice increased from 29 in FFY 2006 to 32 in FFY 2010.
- **Passive renewals.** In some States that send prepopulated renewals, coverage continues automatically unless a family notifies the State of a change in circumstances (such as income) that would render an enrollee ineligible. This procedure—called passive (or administrative) renewal—allows children to remain enrolled in the program without taking any action, provided their families continue to pay their premiums in States requiring premiums. Fairly robust evidence suggests that the adoption of passive renewal policies can improve retention rates (Dick et al. 2002; Shenkman 2002). Conversely, in Florida, changing from passive to active renewal in 2004 was associated with an increase in disenrollment (Herndon et al. 2008; Herndon and Shenkman 2005). Of the 32 States that sent prepopulated forms in 2010, only 6 States had adopted passive renewal policies. In 2006, only 5 States had passive renewal policies in place. Hawaii, Illinois, Tennessee, and Utah had passive renewal throughout the period from FFYs 2006 to 2010. Georgia reporting using passive renewal in FFY 2006 but not in FFY 2010, and New Jersey and Kansas reported adopting the policy by FFY 2010.
- **Self-declaration of income.** Federal law does not require documentation of income for children applying for or renewing coverage under CHIP and Medicaid, though many States have chosen to require paper documentation. Documentation of income can be burdensome for families, particularly low-income families whose work can be informal

[43] Five States with separate CHIP programs that cover only pregnant women (Arkansas, Minnesota, Oklahoma, Rhode Island, and Wisconsin) offered continuous coverage only for their Medicaid-expansion CHIP enrollees.

or unstable, thereby generating disenrollments (Dick et al 2002). Self-declaration of income shifts the burden of verifying income eligibility from families to the CHIP or Medicaid agency, thereby reducing a known barrier to enrollment or reenrollment (Edwards et al. 2010). Recognizing this, several States have eliminated documentation requirements by allowing enrollees to self-declare income at renewal. In 2010, 20 States allowed self-declaration of income at renewal for CHIP enrollees. Nine of these were separate CHIP States, 4 were Medicaid-expansion CHIP States, and 7 were combination States (one did so for separate CHIP enrollees only and one for Medicaid-expansion CHIP enrollees only).[44]

- **Elimination of in-person interviews.** Eliminating the need for in-person renewals or a face-to-face interview can make renewal more convenient (Wooldridge et al. 2009). Almost all States that reported on this practice (49 of 50 States) had eliminated the in-person requirement for renewal by 2010. Mississippi was the only State with an in-person requirement at renewal in 2010.

- **Offering more renewal modes to families.** Allowing enrollees to renew their coverage by telephone or online gives families more options to ensure their children stay covered. One study based on conversations with State officials suggests that streamlined renewal processes such as telephone renewals can reduce administrative disenrollments without risking program integrity (Cohen et al. 2008). In 2010, 15 States allowed families to renew by telephone and 19 States offered online renewals. Seven States offered beneficiaries both options.[45]

3. Policies to Improve Communication with Families about Renewal

Disenrollment of eligible children at the time of renewal can occur due to families' confusion about the renewal process and the eligibility period. In some cases, parents are unaware of their child's disenrollment (Perry 2009). Many States have used outreach and other communication strategies to educate and remind families about renewal requirements. From FFYs 2006 to 2010, States reported very little change in the use of communication strategies, such as sending renewal notices and conducting follow-up with families at redetermination, perhaps because many States had already implemented the policies by 2006 (see Appendix Table A.12 for information on State-level adoption).

Most States provide basic information on the renewal process to families when they enroll in CHIP programs, and those States send notices to remind families to renew their eligibility by a particular date. In FFY 2010, only 4 States (Arizona, Hawaii, South Carolina, and Utah) reported that they did not send reminder notices to families before their children's eligibility expired. Of the 46 States reporting that they sent notices in FFY 2010, 20 States (43 percent) indicated that they usually sent three or more notices. Of the 33 States indicating when they sent the first renewal notice, most (19) sent an initial notice 60 or more days before the end of the eligibility period.

[44] Data on States' income documentation requirements were obtained from Heberlein et al. 2011, which reported on these requirements as of January 2011.

[45] Data on State policies regarding renewal by telephone and online renewal were obtained from Heberlein et al. 2011, which reported on these policies as of January 2011.

Some States use caseworkers or outreach workers to contact families that are at risk of disenrollment due to nonrenewal or that have already been disenrolled because they did not renew. Twenty-six States employed this practice in FFY 2010, compared with 24 in FFY 2006. However, 7 States using the policy in FFY 2006 discontinued it in FFY 2010, suggesting that States could be experimenting with some retention strategies. In FFY 2010, the policy was used by a greater proportion of Medicaid-expansion CHIP States (5 of 8) than separate CHIP States (5 of 17).

In FFY 2010, States were asked to report other strategies they used to help streamline the renewal process. Because this was an open-ended question, States were able to highlight as many or as few aspects of their additional strategies as they desired. Other outreach strategies mentioned by at least a few States include conducting informational campaigns to increase awareness of the need to renew, asking providers to check eligibility and remind beneficiaries to complete their eligibility forms, and sending monthly lists of renewals to health plans to encourage additional follow-up. However, no information is available on the effectiveness of these strategies in raising retention rates in CHIP.

4. Premium Payment Policies

Children whose families are subject to a requirement to pay a premium or an enrollment fee (as discussed in Chapter II) have a higher tendency to disenroll than those not required to pay a premium or enrollment fee (Dick et al. 2002; Shenkman 2002). However, research conducted on the effects of premiums on retention has been unable to disentangle the effects of premium payment policies from other family characteristics. Premiums and enrollment fees are much more prevalent in separate CHIP programs than in Medicaid-expansion CHIP programs as cost-sharing was not permitted in Medicaid-expansion CHIP before the 2006 Deficit Reduction Act. In FFY 2010, 34 States charged premiums or enrollment fees. Under CHIPRA, all States with premiums are required to have at least a 30-day grace period (the same does not hold true for States that require enrollment fees in place of premiums). Of the 28 States that reported some type of grace period in 2010, more than half (16) allow families to pay premiums up to or more than 60 days after the due date.[46]

In addition to extending the length of grace periods, States can also reduce the potentially adverse effects of premiums on retention by eliminating or reducing lock-out periods. Lock-out periods, which prevent children from reenrolling in CHIP after they have been disenrolled for premium nonpayment, were created as a penalty for nonpayment of premiums and to discourage people from dropping coverage during periods when they do not have a need for health care. Although lockout period policies do not directly cause churning, they do have the potential to increase uninsurance (Wachino and Weiss 2009). In 2010, 14 States had lock-out period policies, a net gain of 3 from the 11 States that imposed lock-out periods in 2006.[47] Among these States using lock-out periods in 2010, the median length of the lock-out period was 3.5 months. (Appendix Table A.12 provides State-level detail on premium payment policies.)

[46] Data on States' use of grace periods were obtained from Heberlein et al. 2011, which reported on grace period policies as of January 2011.

[47] Data on State adoption of lock-out periods were obtained from Heberlein et al. 2011, which reported on policies adopted as of January 2011.

5. Improving Coordination Between CHIP and Other Public Programs

Streamlined and coordinated renewal across agencies and programs has the potential to improve retention. Under Title XXI, States are encouraged to find ways to limit disruptions in coverage when eligibility for Medicaid and CHIP must be redetermined. As a result, many States have strengthened coordination mechanisms to ensure seamless transfers of children in separate CHIP programs to Medicaid (both traditional Medicaid and Medicaid-expansion CHIP programs). Mechanisms such as common eligibility systems and paperwork requirements have been associated with higher rates of continuous coverage (Merrill and Rosenbach 2006). In FFY 2010, 34 (of 43) States with separate CHIP programs (79 percent) used the same renewal form for CHIP and Medicaid and 26 States (or 60 percent) reported using a joint eligibility system for all children applying for and renewing public coverage. (Appendix Table A.13 provides State-level detail on the adoption of coordination mechanisms.)

Several newer retention strategies, such as ex parte and ELE renewals, rely on data sharing across public programs to reduce the role of families in the renewal process. Ex parte renewal policies allow States to use information from external administrative databases to verify eligibility and complete the renewal process without contacting households. In Louisiana, the adoption of ex parte renewal was associated with a drop in administrative disenrollment from roughly 20 percent to slightly more than 1 percent, according to interviews with State officials (Cohen et al. 2008). In FFY 2010, 13 States used ex parte renewal procedures for all their CHIP enrollees, 2 of which were States with combination programs that used ex parte renewal procedures only for Medicaid-expansion CHIP enrollees. This represents an increase from FFY 2009, when 11 States used ex parte renewal for all CHIP beneficiaries (and 2 combination States used it for their Medicaid-expansion CHIP enrollees only).[48]

ELE allows States to designate agencies other than CHIP agencies to conduct eligibility determinations and, in some States, eligibility redeterminations. ELE was not available to States before the CHIPRA legislation in 2009, and thus there is not yet any rigorous evidence regarding it. Three States had approved State plan amendments to utilize ELE in 2009, all of which were using ELE at both enrollment and renewal. By July 2011, the total number of States with ELE State plan amendments had grown to eight; however, only four States (the three original States, Alabama, Louisiana, and Maryland, and a new State, South Carolina, approved June 29, 2011) were utilizing ELE at the renewal stage.

D. Discussion

Despite continued program growth (in absolute numbers), the rate of CHIP enrollment growth has fluctuated over time, due in large part to changes in economic conditions and State policies, including eligibility expansions and enrollment simplifications. Enrollment in CHIP generally has followed the pattern of enrollment in Medicaid—both programs increased rapidly after CHIP was implemented in October 1997 (from FFYs 1998 to 2002), after which point the rate of increase slowed, with enrollment plateauing between FFY 2003 and 2005 before resuming a more pronounced upward trend. Enrollment growth continued between FFY 2009 and 2010, albeit at a

[48] Illinois, Maryland, and Texas added it to their Medicaid-expansion CHIP; Florida and Washington eliminated it. Illinois and Texas added it to their Separate CHIP; Washington eliminated it.

slower pace for CHIP than Medicaid, reflecting the greater need for public programs during economic downturns, as well as increased Federal support for children's coverage under CHIP and Medicaid through CHIPRA, the American Recovery and Reinvestment Act of 2009 (ARRA), and the Affordable Care Act.

Although outreach and enrollment activities have been effective in supporting the upward trend in CHIP enrollment (and in total enrollment in public coverage), efforts to improve retention in CHIP and Medicaid also contribute to reducing uninsurance among children. Sommers (2007) estimated that if public programs retained all children who were ever enrolled in a given year, the number of uninsured children in the United States would fall by one-third. Retaining eligible children in Medicaid and CHIP has, therefore, become a central strategy in reducing the number of uninsured children in the United States. Reflecting this, many States have adopted policies and practices to improve retention in public coverage, most notably extending the time between renewals, simplifying renewal procedures for families, and increasing coordination between Medicaid and CHIP. Some States have adopted measures that virtually eliminate the family's role in renewing coverage—such as administrative, ex parte, and ELE renewals—by relying on external information systems to redetermine eligibility. Such measures to automate the renewal process hold promise for increasing the retention of eligible children in public coverage, though whether and to what extent they lead to enrollment and retention of ineligible children requires further study. However, in some States, renewal barriers still exist.

V. CHIP'S ROLE IN COVERAGE FOR LOW-INCOME CHILDREN

Trends showing increased public program enrollment and improved retention are important indicators of the Children's Health Insurance Program's (CHIP) role in providing coverage for low-income children. However, they are not direct measures of progress in reducing uninsurance because changes in the economy and in the private health insurance market also influence these trends. Examining coverage trends pre- and post-CHIP implementation provides a larger context for understanding how CHIP has influenced uninsurance rates. Measuring the effects of CHIP on coverage dynamics and uninsurance trends is difficult because many forces besides CHIP influence these outcomes.

This chapter presents coverage trends since CHIP was enacted, including trends in the changing proportion of children without health insurance over time. The analysis uses a consistent time series of data from the Current Population Survey (CPS) covering the 13-year time period since CHIP was enacted, from 1997 through 2010. This time series captures a short period prior to CHIP implementation, as most States (33 in all) began enrolling children in 1998 and all States had programs in place by the middle of 2000. Trends for low-income children are contrasted with trends for children at higher income levels, as well as with trends for adults, to suggest CHIP's contribution. The findings suggest that, together with Medicaid, CHIP has contributed to reducing uninsurance rates for low-income children.

Previous research has documented substantial declines in uninsurance among low-income children after CHIP was implemented that contrast, sometimes sharply, with uninsurance trends for low-income parents and other groups not eligible for the program (Rosenbach et al. 2007; Choi, Sommers, and McWilliams 2011). Studies also show that CHIP expansions have contributed to reducing racial and ethnic disparities in coverage among low-income children (Shone et al. 2005; Currie et al. 2008; Choi et al. 2011).

A. Coverage Trends During the CHIP Era: 1997 to 2010

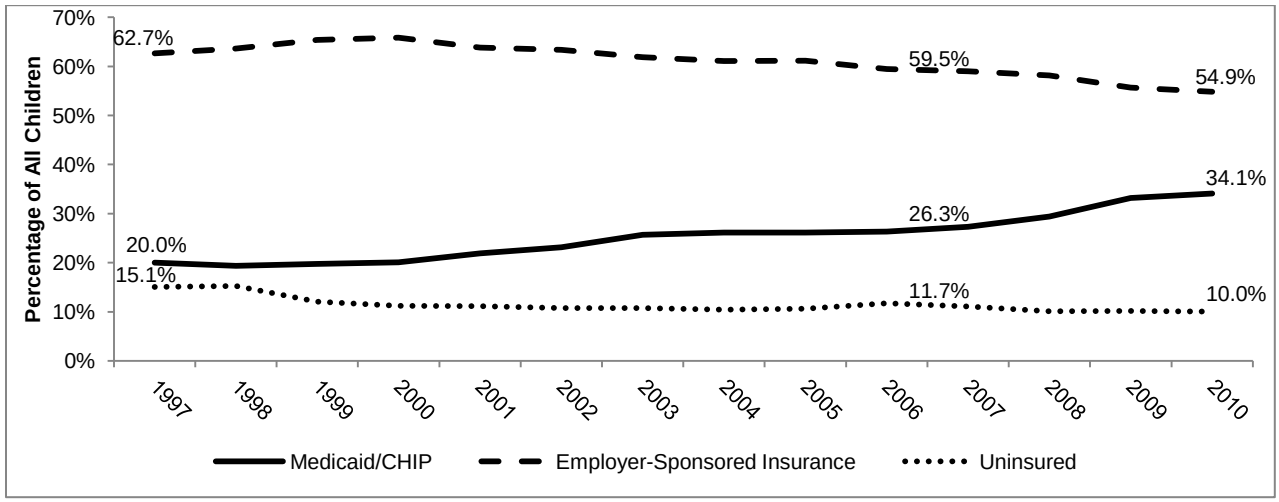
Data from the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), the most widely cited source of information about health insurance coverage, demonstrate the extent to which the availability of CHIP and the expansion of Medicaid have reduced the number of uninsured children despite the simultaneous decline in the availability of employer-sponsored coverage. Gains have been concentrated among low-income children—as we would expect, given the income limits for CHIP and Medicaid eligibility. The gains in coverage have been experienced among all racial and ethnic groups, but have been particularly striking among Hispanic children. During the same period, uninsurance has risen among adults, who are less likely to qualify for public coverage.

1. Trends for Children, Overall and by Income Group

Figure V.1 shows coverage trends for all children. Between 1997 and 2010, the most recent year for which CPS-ASEC data are available, most children had coverage from a parent's employer, but

the proportion with this type of coverage dropped from 62.7 percent to 54.9 percent.[49] Medicaid and CHIP coverage, meanwhile, increased from 20.0 percent to 34.1 percent.[50] Increased public coverage more than offset the loss of employer-sponsored coverage, so that the percentage of children who were uninsured fell from 15.1 percent to 10.0 percent. It is particularly notable that the percentage of uninsured children has continued to fall despite the recession conditions of the last few years that have separated many families from their connection to employer coverage and given families fewer resources to purchase coverage on their own.

Figure V.1. Percentage Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured: All Children, 1997-2010



Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

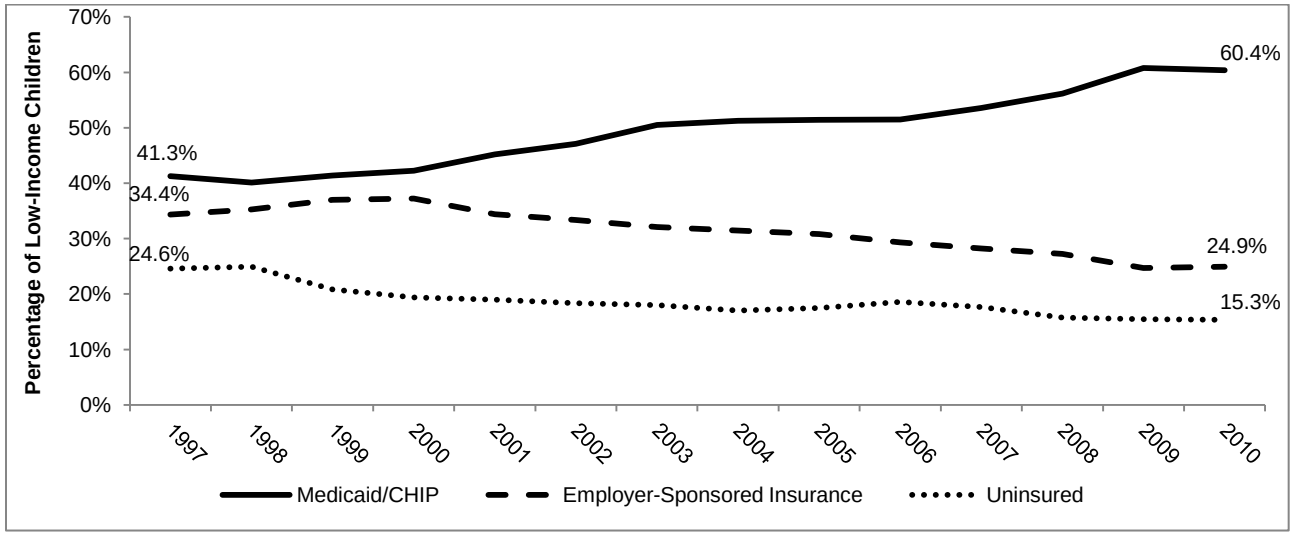
Notes: Children are ages 0-18.

Because both CHIP and Medicaid are means-tested programs, their impact is more visible when low-income children (in families with incomes below 200 percent of the FPL) are the focus, as in Figure V.2. Among these children, coverage from Medicaid and CHIP exceeded employer-sponsored coverage throughout the period, and rose from 41.3 percent in 1997 to 60.4 percent in 2010. The proportion of low-income children who were uninsured fell from 24.6 percent in 1997 to 15.3 percent in 2010.

[49] Interpretation of CPS-ASEC health insurance data is subject to several caveats. Research matching CPS-ASEC responses with Medicaid administrative data shows that significant percentages of respondents in all age groups who are enrolled in Medicaid do not report this coverage on the survey. Consequently, reported coverage is lower than totals from administrative data, and uninsurance estimates are inflated. Introduction of verification questions, in which respondents who said no when asked about all coverage types were asked to confirm that they were uninsured, increased coverage rates beginning with the data for 1999, as did retroactive improvements in procedures for imputing responses among those who did not provide answers to the health insurance questions. A portion of the increase in coverage since 1997 is thus attributable to changes in CPS-ASEC methods. See U.S. Census Bureau, 2008 and U.S. Census Bureau, 2011.

[50] The CPS-ASEC includes separate questions about Medicaid and CHIP coverage. Many analysts, however, believe that respondents do not always distinguish accurately between the two programs. It is particularly difficult to do so in states where the programs have the same name.

Figure V.2. Percentage Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured: Low-Income Children, 1997-2010

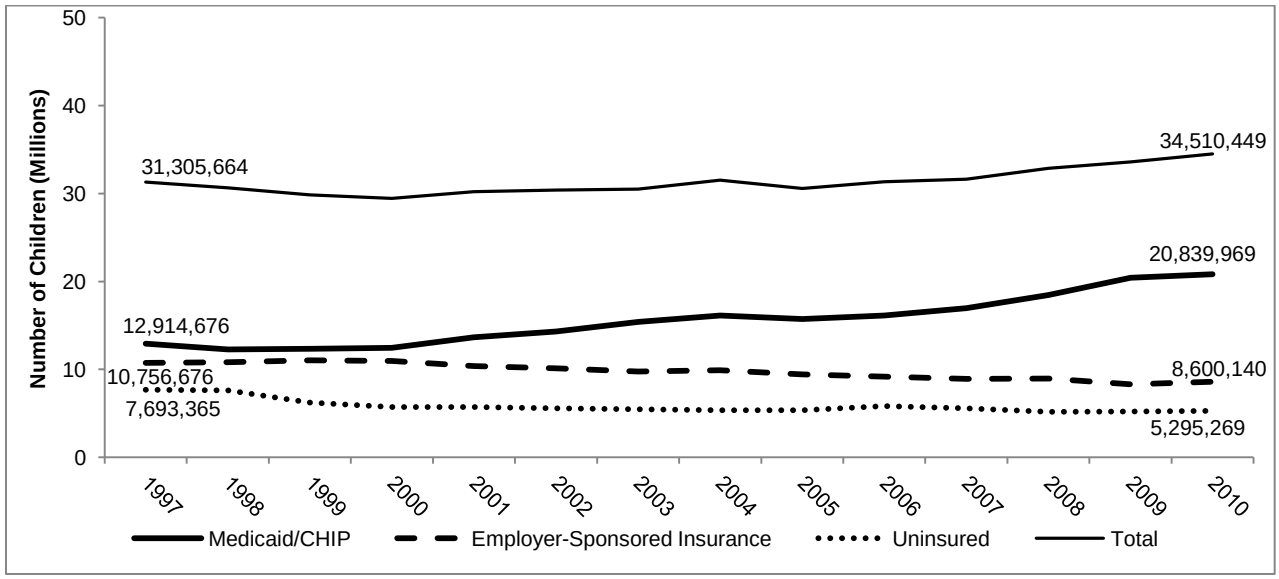


Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds.

Total numbers, rather than percentages, are shown in Figure V.3 and tell a similar story. The total number of children at all income levels remained about the same throughout this period (data not shown), but the number of low-income children fluctuated with economic conditions and increased with the recession that began at the end of 2007. The combination of an increased number of low-income children and increased Medicaid/CHIP coverage among these children produced a sharp rise in reported Medicaid/CHIP enrollment over the last few years. Despite the recent increase in the number of low-income children, however, access to CHIP and Medicaid has kept the number of uninsured low-income children relatively flat during the post-recession time period.

Figure V.3. Total Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured: Low-Income Children, 1997-2010

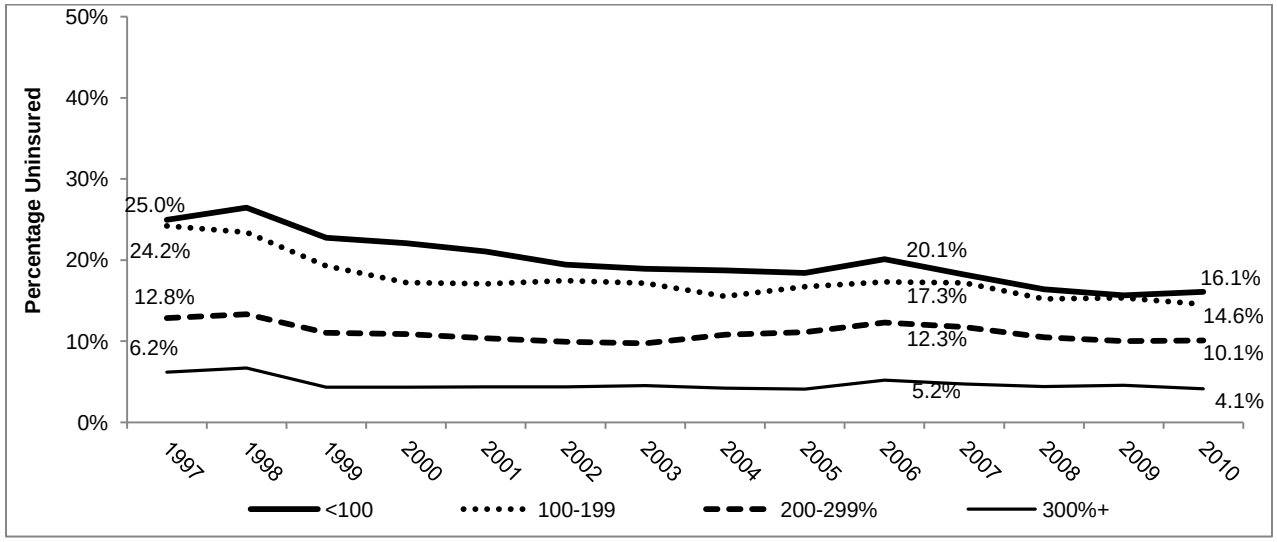


Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds.

Figure V.4 compares uninsurance rates for low- (under 100 and 100-200 percent of the FPL), middle- (200-300 percent of the FPL) and high-income (300 percent of the FPL and above) children. It suggests that the availability of public coverage in the CHIP era has reduced the gap in insurance coverage between low- and high-income children, with a smaller and more recent impact on the gap between middle- and high-income children. Between 1997 and 2006, the difference between uninsurance rates for the lowest- and highest-income children fell nearly 4 percentage points, from 18.8 (25.0 percent minus 6.2 percent) to 14.9 (20.1 percent minus 5.2 percent); the gap between rates for middle- and high-income children increased slightly, from 6.7 to 7.1 percentage points. From 2006 to 2010, coverage rates increased among all three income groups, with uninsurance rates dropping to 16.1 and 14.6 percent for the lowest-income children, 10.1 percent for middle-income children, and 4.1 percent for high-income children. The gap between low-income and high-income insurance rates thus shrunk to 11.2 percentage points, and the gap between middle-income and high-income insurance rates fell to 6.0 percentage points.

Figure V.4. Percentage Uninsured by Poverty Level: Children, 1997-2010

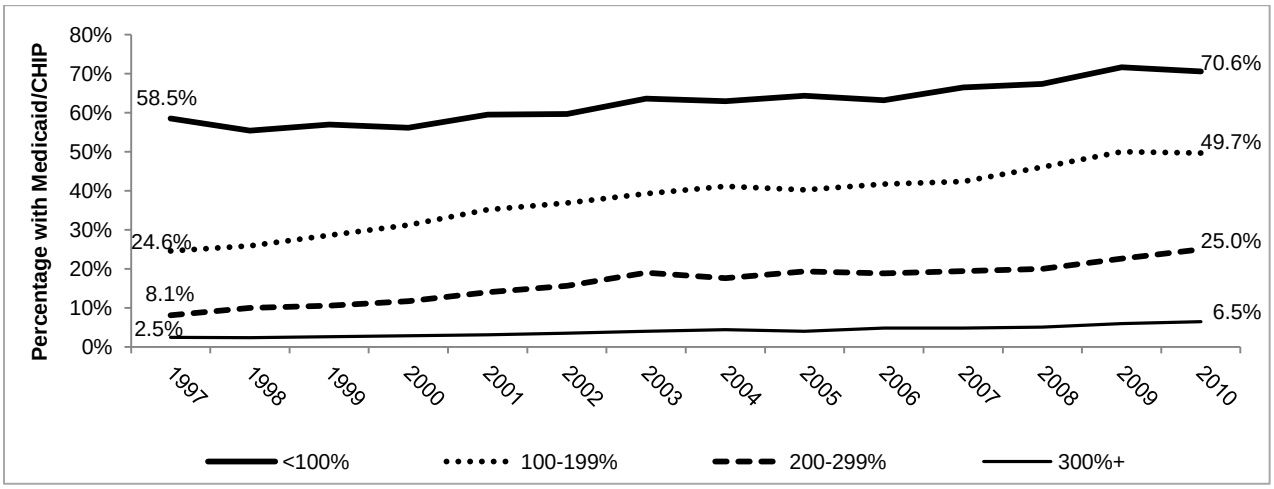


Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Note: Children are ages 0-18.

Between 1997 and 2010, the proportion of children in higher income families (at or above 300 percent of the FPL) with employer-sponsored coverage remained around 80 percent (data not shown). As shown in Figure V.5, Medicaid/CHIP coverage among children in the high-income group increased 4 percentage points, from 2.5 percent to 6.5 percent, as CHIP was implemented throughout the nation, with effective income eligibility limits reaching as high as 350 percent of the FPL in New Jersey and 400 percent of the FPL in New York. There were much larger gains in public coverage among children in families with incomes below 200 percent of the FPL (12.1 percentage points for children below 100 percent of the FPL, and 25.1 percentage points for children in the 100-200 percent of the FPL group).

Figure V.5, Percentage Medicaid/CHIP by Poverty Level: Children, 1997-2010



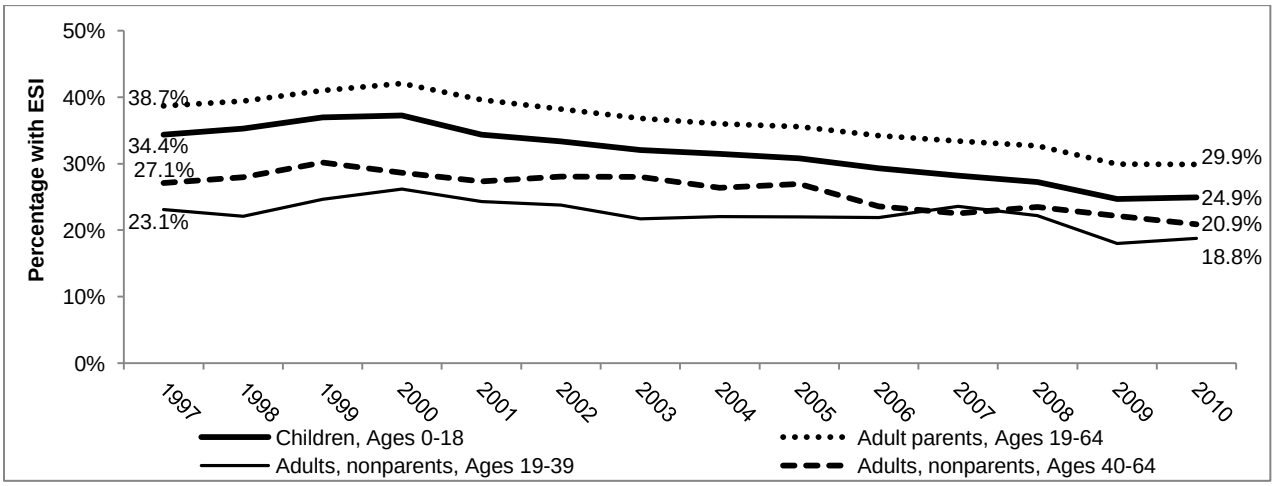
Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Note: Children are ages 0-18.

2. Comparisons with Trends for Low-Income Parents and Other Adults

Coverage patterns among low-income children can also be compared with patterns among low-income parents and among low-income adults without dependent children under age 19 at home ("nonparents").[51] Coverage under employer-sponsored insurance declined for all four groups from 1997 to 2010 (Figure V.6). The decline for children mirrored that of parents, where the coverage rate fell from 38.7 percent in 1997 to 29.9 percent in 2010.

Figure V.6. Percentage Employer-Sponsored Insurance: Low-Income Children and Adults, 1997-2010



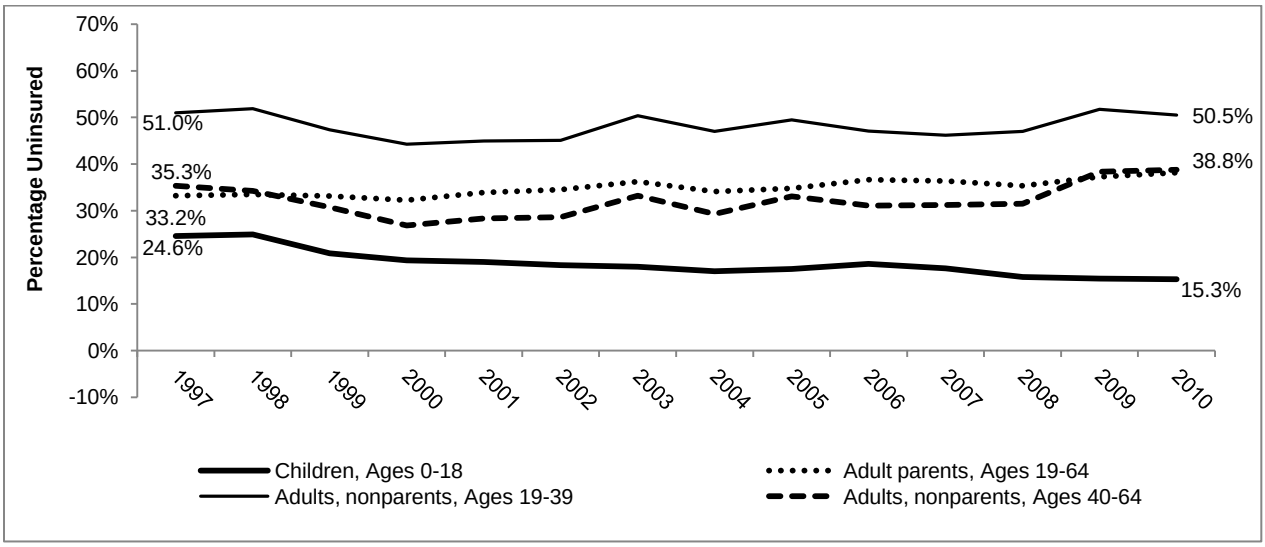
Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Note: Low income is below 200% of federal poverty thresholds.

[51] The "nonparents" label is a convenient simplification, since some of the adults in this category have children older than 18, or children ages 0–18 who do not live with them.

Medicaid and CHIP have expanded somewhat among low-income parents (data not shown), but not enough to offset the decline in employer-sponsored coverage. The net result was that uninsurance among low-income parents increased at the same time that it was declining among their children (Figure V.7). The ineligibility of low-income nonparents (ages 19-64) for public coverage in most States has left them even more likely to become uninsured as employer-sponsored coverage has declined. Coverage patterns among nonparents differ by age, with young, low-income nonparents (ages 19–39) more likely to be uninsured, with rates exceeding 50 percentage points at both the start and the end of the time period. The high rates of uninsurance among low-income nonparents suggest the need for the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), which makes most adults with incomes below 138 percent of the FPL eligible for Medicaid, and provides tax credits to adults with incomes between 138 percent and 400 percent of the FPL to subsidize their purchase of private coverage on the new Affordable Insurance Exchanges.

Figure V.7. Percentage Uninsured: Low-Income Children and Adults, 1997-2010



Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

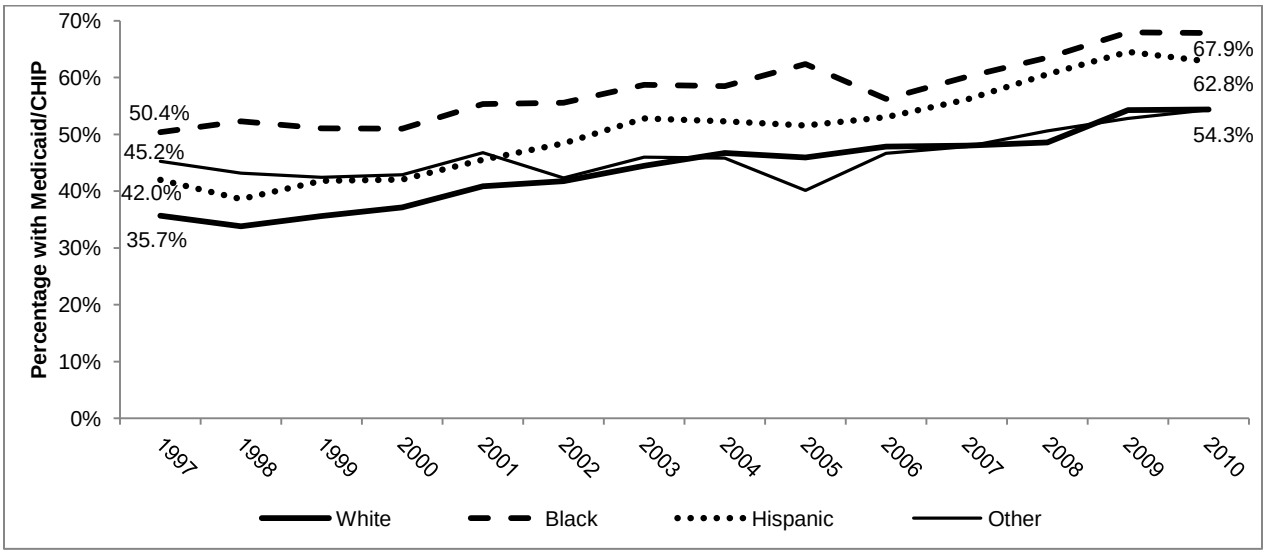
Notes: Low income is below 200% of federal poverty thresholds.

3. Trends for Children by Race and Ethnicity and by Age

The health coverage trends for low-income children show similar patterns across racial and ethnic groups. Medicaid and CHIP coverage increased (Figure V.8), and uninsurance fell (Figure V.9) for Hispanics, non-Hispanic Whites, non-Hispanic Blacks, and non-Hispanic Other (which includes Asian-Americans, Native Hawaiians and Other Pacific Islanders, and American Indians and Alaska Natives). The trends among low-income Hispanic children are particularly striking: uninsurance among these children declined from more than one-third (34.4 percent) in 1997 to less than one-fifth (19.7 percent) in 2010. This improvement was driven by the increase in Medicaid and CHIP coverage, from 42.0 percent in 1997 to 62.8 percent in 2010, despite the fact that some low-income Hispanic children are ineligible for coverage due to their undocumented status or residence in the United States for less than five years. Uninsurance also declined among higher-income Hispanic children (data not shown), but the change was less dramatic, from 16.7 percent in 1997 to 11.6 percent in 2010.

Insurance coverage for low-income children also differs by age group (Figure V.10). Depending on the year, low-income children ages 6 through 12 have been 1.0 to 3.9 percentage points more likely to be uninsured than children ages 0 through 5; there is a bigger gap of 4.6 to 8.6 percentage points between children ages 13 to 18 and those ages 6 to 12, with the older children being more likely to be uninsured. Uninsurance rates for 13- to 18-year-olds dropped in the early part of the period shown, as mandatory Medicaid coverage for children under 100 percent of the FPL born after September 30, 1983, reached higher into this age group each year, and as CHIP programs—which generally cover all children up to age 18—were implemented. Yet an age gap persists, with estimated 2010 uninsurance rates of 12.7 percent for low-income children ages 0 to 5, 14.2 percent for ages 6 to 12, and 20.3 percent for ages 13 to 18.

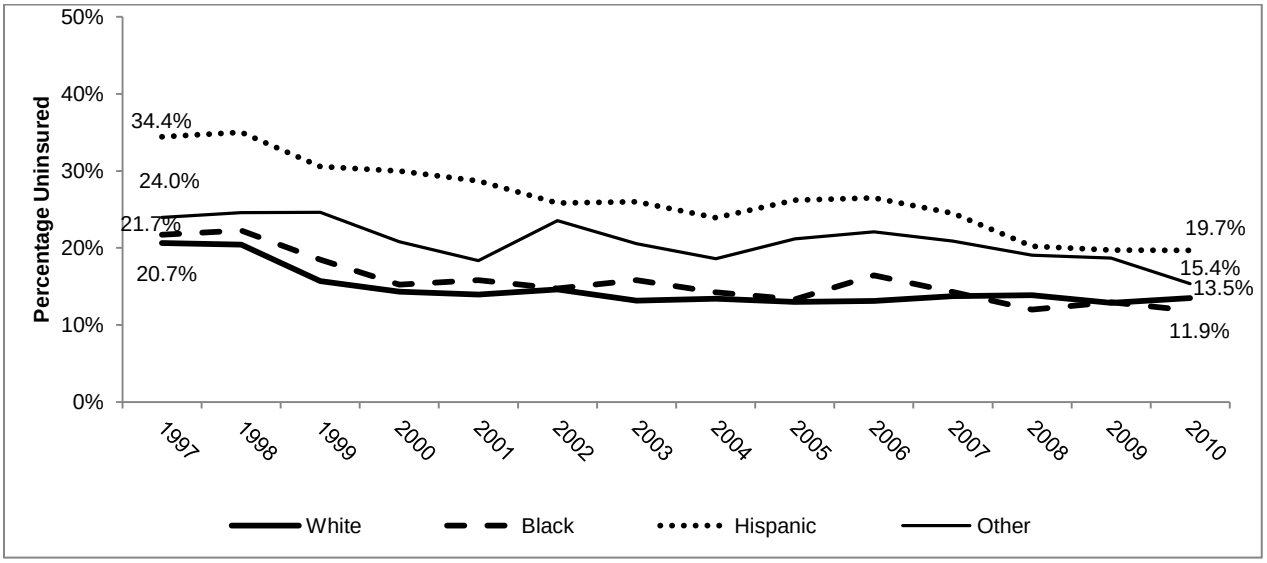
Figure V.8. Percentage Medicaid/CHIP Coverage by Race and Ethnicity: Low-Income Children, 1997-2010



Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds. Hispanic includes all races. Other includes Asian-American, Native-Hawaiian and Other Pacific Islander, and American Indian and Alaska Native. Non-Hispanic respondents indicating more than one race are assigned to a primary race.

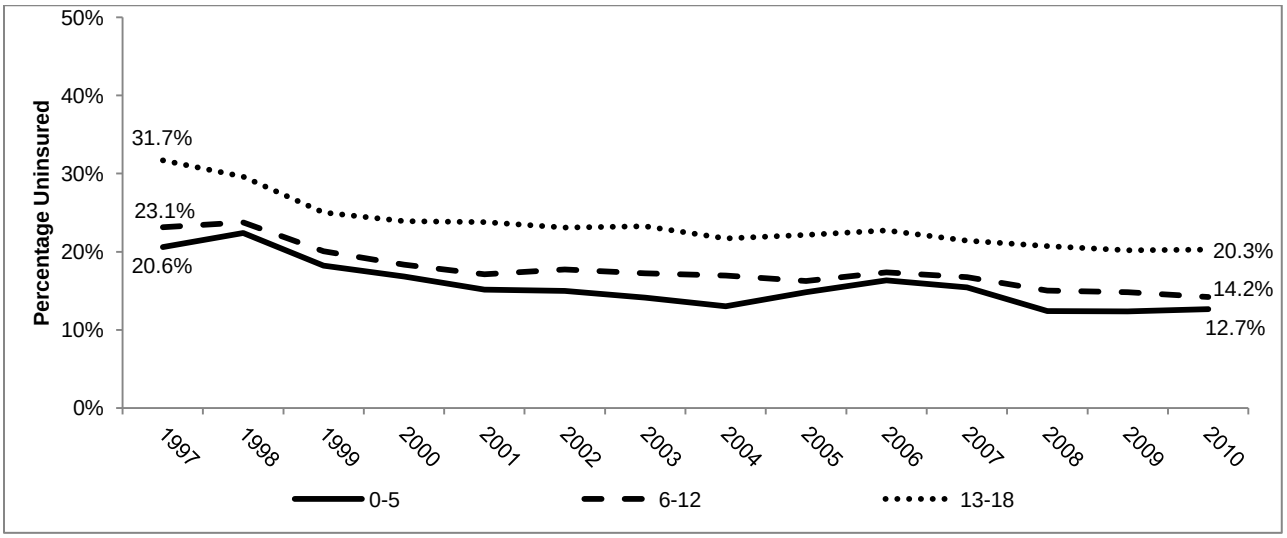
Figure V.9. Percentage Uninsured by Race and Ethnicity: Low-Income Children, 1997-2010



Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds. Hispanic includes all races. Other includes Asian-American, Native-Hawaiian and Other Pacific Islander, and American Indian and Alaska Native. Non-Hispanic respondents indicating more than one race are assigned to a primary race.

Figure V.10. Percentage Uninsured by Age: Low-Income Children, 1997-2010

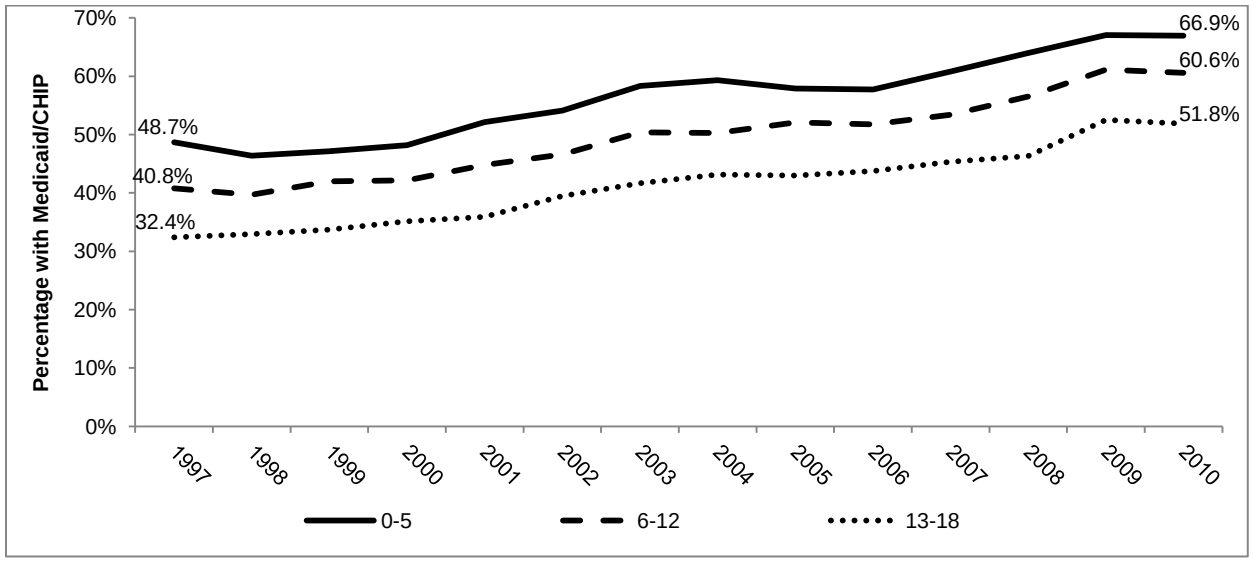


Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds.

Figure V.11 suggests that continuing differences in Medicaid/CHIP coverage are responsible for the differences in coverage among the three age groups. Medicaid/CHIP coverage among all three groups of low-income children has risen since 1997, from less than half to about two-thirds among the youngest children, from about 40 percent to about 60 percent among the 6- to 12-year-olds, and from less than one-third to more than half of the 13- to 18-year-olds. Estimated coverage rates for the oldest children did jump an estimated 6.2 percentage points, from 46.2 percent to 52.5 percent, between 2008 and 2009, before dropping slightly to 51.8 percent in 2010. Estimates for the two groups of younger children dropped slightly between 2009 and 2010 as well.

Figure V.11. Percentage Medicaid/CHIP Coverage by Age: Low-Income Children, 1997-2010



Source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC).

Notes: Children are ages 0-18. Low-income is below 200% of federal poverty thresholds.

B. Discussion

CHIP and Medicaid have contributed to reducing the number of uninsured children. Declines in private coverage levels for populations not eligible for CHIP, including children at higher income levels and low-income parents and other adults, reinforce the importance of CHIP's role in covering low-income children. While coverage gains are evident for children in all racial and ethnic groups, gains for Hispanic children have been particularly large and have contributed to reducing coverage disparities for low-income children. Coverage expansions and other changes introduced in the Affordable Care Act will further alter the landscape and CHIP's role in covering low-income children and their families.

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VI. ASSESSING CHILD HEALTH QUALITY THROUGH PERFORMANCE MEASURES

Quality health care is defined as care that is effective, safe, timely, patient-centered, efficient, and equitable (Institute of Medicine 2001). One way to measure the current status of the quality of care States provide in their Children's Health Insurance Program (CHIP) and Medicaid programs is to examine State reports on a core set of performance measures. States began to voluntarily report the 24 initial core set of quality measures for children in Federal fiscal year (FFY) 2010; States have been reporting on three of these measures since FFY 2003. This chapter focuses on the State-reported performance measures and what they tell us about the quality of care provided to children in CHIP and Medicaid. This analysis draws on CHIP Annual Reporting Template System (CARTS) data but also includes findings from the Department of Health and Human Services Annual Reports on the Quality of Care for Children in Medicaid and CHIP.

A. Background and Motivation

The Federal government has long been concerned about quality in public insurance programs, particularly for children covered by CHIP and Medicaid because these programs cover more children than any other payer--55 percent of all U.S. children--including a large share of children with special health care needs (2011 Current Population Survey Annual Social and Economic Supplement). The U.S. Department of Health and Human Services (HHS) has been proactive in trying to improve quality. For example, the external quality review protocols, originally published by HHS in 2001, include detailed instructions for the calculation and validation of performance measures in Medicaid managed care; the voluntary reporting of four child health measures in the CHIP Annual Reporting Template System (CARTS) began in 2003; and HHS established the Division of Quality, Evaluation and Health Outcomes in April 2005. Since its establishment, this division has launched a Medicaid/CHIP quality web site, produced technical assistance documents, offered direct assistance to States, provided feedback to States on their reporting, and convened a Medicaid/CHIP quality conference.

Earlier studies of CHIP found that enrollment appears to be associated with increases in parent satisfaction ratings with the quality of their child's health care. In a 2002 survey of CHIP enrollees in 10 States, more than 80 percent of CHIP enrollees' parents said they believe that children with CHIP coverage received better care than children who were uninsured (Wooldridge et al. 2005). In a telephone survey of recently enrolled CHIP families, the percentage of parents who rated their child's health care as "best" rose from 34.9 percent before enrollment to 41.6 percent after enrollment (Kempe 2005). However, although access improved for racial and ethnic minority children and children with special health care needs, disparities in access to care remained (Wooldridge et al. 2005). More recent research reported that access to specialists is more difficult for publicly insured than privately insured children (Bethell et al. 2011).

The CHIP Reauthorization Act (CHIPRA) has spurred a new focus on measuring and improving quality. Section 401(a) of CHIPRA required the Secretary of HHS to identify and publish an initial recommended core set of child health quality measures for voluntary reporting by Medicaid and CHIP programs. These performance measures are used to assess the quality of health care on a variety of dimensions, such as health care structures, processes, and outcomes; State reporting on them is voluntary (Sebelius 2010). CHIPRA required that the initial set of quality measures be drawn from measures already in use to assess children's health care quality. They were also required to cover a broad array of health care quality domains and services; to include children of all ages; to be

evidence-based and understandable to families; and to be able to identify disparities by race, ethnicity, socioeconomic status, and special health care needs status (Agency for Healthcare Research and Quality 2011). The legislation called for the measures, when taken together, to be appropriate for estimating the overall national quality of health care for children. The final technical specifications on the selected 24 measures were released in February 2011.52 CHIPRA also provided funding for technical assistance to States on reporting and using the performance measures; this assistance was put into place by CMS in FFY 2011. Beyond the performance measures, CHIPRA also appropriated $100 million to test and evaluate State approaches to assess quality of care for program participants in both CHIP and Medicaid; a total of 18 States (some working in groups) were awarded CHIPRA quality demonstration grants. CHIPRA also required HHS to report on the quality of care for children in Medicaid and CHIP, and two reports have been published to date (see Sebelius 2010 and Sebelius 2011).[53]

This chapter reviews selected child health quality measures. First is a discussion of the 24 performance measures that were reported in CARTS in FFY 2010, describing the methods, data sources, measure stewards, and most frequently reported measures is provided. Next is a review of the five measures of preventive and primary care services for children enrolled in CHIP and Medicaid reported by States in 2010, three of which are the child health quality measures that States have reported since FFY 2003. A historical comparison of performance in FFY 2006 and 2010 for States reporting in both time periods is discussed, followed by a discussion on two measures of dental access reported in the Secretary's 2011 annual report on quality (Sebelius 2011).

B. Methods Used to Report Child Health Quality Measures

The core set of child health quality measures first reported in 2010 includes 24 measures organized into five domains, per the technical specifications: prevention and health promotion (13 measures); availability (one measure); management of acute conditions (5 measures); management of chronic conditions (4 measures); and family experiences of care (one measure) (Centers for Medicare & Medicaid Services 2011a). Table VI.1 provides a brief description of each measure within these domains. Standardized technical specifications were provided for these measures to facilitate the calculation of the measures in comparable ways across States.[54] Fifteen of the measures were drawn from Health Plan Employer Data and Information Set® (HEDIS) specifications, making this the most frequent source of measures (Table VI.2).[55] Three of the measures had been included for voluntary State reporting by CHIP programs through CARTS since 2003 (as discussed in Section C); they are well-child visits in the first 15 months of life (measure #10); well-child visits in the third, fourth, fifth, and sixth years of life (measure #11); and children's and adolescents' access to primary care practitioners (measure #14).[56]

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[52] See Mangione-Smith 2011 for details about the history of the measures development.

[53] Sebelius (2011) also summarizes all of the Federal efforts to measure and improve quality of care, as well as efforts to coordinate across Federal and State agencies.

[54] The measure steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure's performance changes.

[55] HEDIS is a tool developed by the National Committee for Quality Assurance (NCQA) to measure performance; because the methods used are standardized, it permits comparison of the measures by State and over time.

[56] A fourth measure on asthma was reported from FFY 2003 to 2009 but was discontinued in 2010.

Beginning in 2010, States could choose to report only on children in CHIP, only children in Medicaid, or both (before FFY 2010, States could report only on CHIP or on both CHIP and Medicaid enrollees, but could not report on Medicaid only). However, among states that reported in 2010, all states reported on both CHIP and Medicaid enrollees combined; thus, we are not able to break out any of the reported measures for just CHIP or just Medicaid enrollees.

Table VI.1. 24 Child Health Quality Performance Measures Reported in CARTS FFY 2010

Domain	Measure Number	Measure Description
Prevention and Health Promotion		
Prenatal and Postpartum Care	1	Prenatal and Postpartum Care: Timeliness of Prenatal Care
	2	Frequency of Ongoing Prenatal Care
	3	Percent of Live Births Weighing Less Than 2,500 grams
	4	Cesarean Rate for Nulliparous Singleton Vertex
Immunizations	5	Childhood Immunization Status
	6	Immunizations for Adolescents
Screenings	7	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents
	8	Developmental Screening in the First Three Years of Life
	9	Chlamydia Screening
Well-Child Visits	10	Well-Child Visits in the First 15 Months of Life
	11	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
	12	Adolescent Well-Care Visits
Dental Care	13	Total Eligibles Who Received Preventive Dental Services
Availability		
	14	Child and Adolescent Access to Primary Care Practitioners
Management of Acute Conditions		
Appropriate Use of Antibiotics	15	Appropriate Testing for Children with Pharyngitis
	16	Otitis Media with Effusion–Avoidance of Inappropriate Use of Systemic Antimicrobials in Children–Ages 2–12
Dental Care	17	Total Eligibles who Received Dental Treatment Services
Emergency Care	18	Ambulatory Care: Emergency Department Visits
Inpatient Safety	19	Pediatric Central-Line Associated Blood Stream Infections–NICU and PICU
Management of Chronic Conditions		
Asthma	20	Annual Number of Asthma Patients with >1 Asthma-Related Emergency Room Visits
Attention Deficit Hyperactivity Disorder	21	Follow-Up Care for Children Prescribed ADHD Medication
Diabetes	22	Annual Pediatric Hemoglobin A1C Testing
Mental Health	23	Follow-Up After Hospitalization for Mental Illness
Family Experiences of Care		
	24	CAHPS 4.0 (Child Version including Medicaid and Children with Chronic Conditions Supplemental Items)

Source: Mathematica analysis of FFY 2010 CARTS reports, as of June 30, 2011.

Notes: ADHD = attention deficit hyperactivity disorder; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FFY = Federal fiscal year; NICU = neonatal intensive care unit; PICU = pediatric intensive care unit.

Table VI.2. Child Health Quality Measure Stewards, FFY 2010

Measure Steward	Number of Measures	Measure Numbers
NCQA/HEDIS	15	1, 2, 5, 6, 7, 9, 10, 11, 12, 14, 15, 18, 21, 23, 24[a]
CMS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Form 416 System	2	13, 17
Centers for Disease Control and Prevention	2	3, 19
California Maternal Quality Care Collaborative	1	4
Child and Adolescent Health Measurement Initiative and NCQA	1	8
American Medical Association/Physician Consortium for Performance Improvement	1	16
Alabama Medicaid	1	20
NCQA/non-HEDIS	1	22

Source: Mathematica analysis of FFY 2010 CARTS reports, as of June 30, 2011, and as reported in Sebelius 2011.

Note: See Table VI.1 for a crosswalk of measure numbers and measure descriptions; AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; HEDIS = Health Plan Employer Data and Information Set; NCQA = National Committee for Quality Assurance. The measure steward is responsible for updating or retiring measures as the technical specifications are changed, new clinical evidence emerges, or the measure's performance changes.

[a] To report measure 24, States have the option of attaching their CAHPS results to the CARTS report or submitting the raw data directly to AHRQ.

Although the measure specifications are standardized, not all States reported using those methods in FFY 2010. For example, 93 percent of States reporting well-child visits in the first 15 months of life (measure # 10) reported using HEDIS methods, while 7 percent of States used other methods (Table VI.3). For the three historical measures (measures # 10, # 11, and # 14), the number of States using HEDIS methods has increased over time (data shown in Appendix Table A.14). States also can select the source of data they use to compute the measures. Table VI.3 describes the data sources States reported for each measure. Administrative data were the most frequently used data source; for the 17 measures with more than one State reporting the measure, more than half of the States used administrative data. The next most frequent data source was a hybrid approach that combined administrative data with medical records data. Although hybrid methods are more resource-intensive than measures using administrative data alone, rates produced using hybrid methods tend to be substantially higher than administrative data-only rates (Pawlson 2007). Few States used other data sources to report their measures in FFY 2010.

C. Measures Reported by States, FFY 2010

Forty-two States and the District of Columbia voluntarily reported at least one of the 24 quality measures in FFY 2010 (Figure VI.1) (see Appendix Table A.15 for State-level reporting patterns).[57] The number of measures reported by States in 2010 ranged from zero measures in eight States (Arkansas, Delaware, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas) to 18 measures in one State (Georgia). The median number of measures reported was 7; 14 States reported at least half of the CHIPRA quality measures.

[57] Delaware did not submit a CARTS report in 2010 and therefore did not report on any measures.

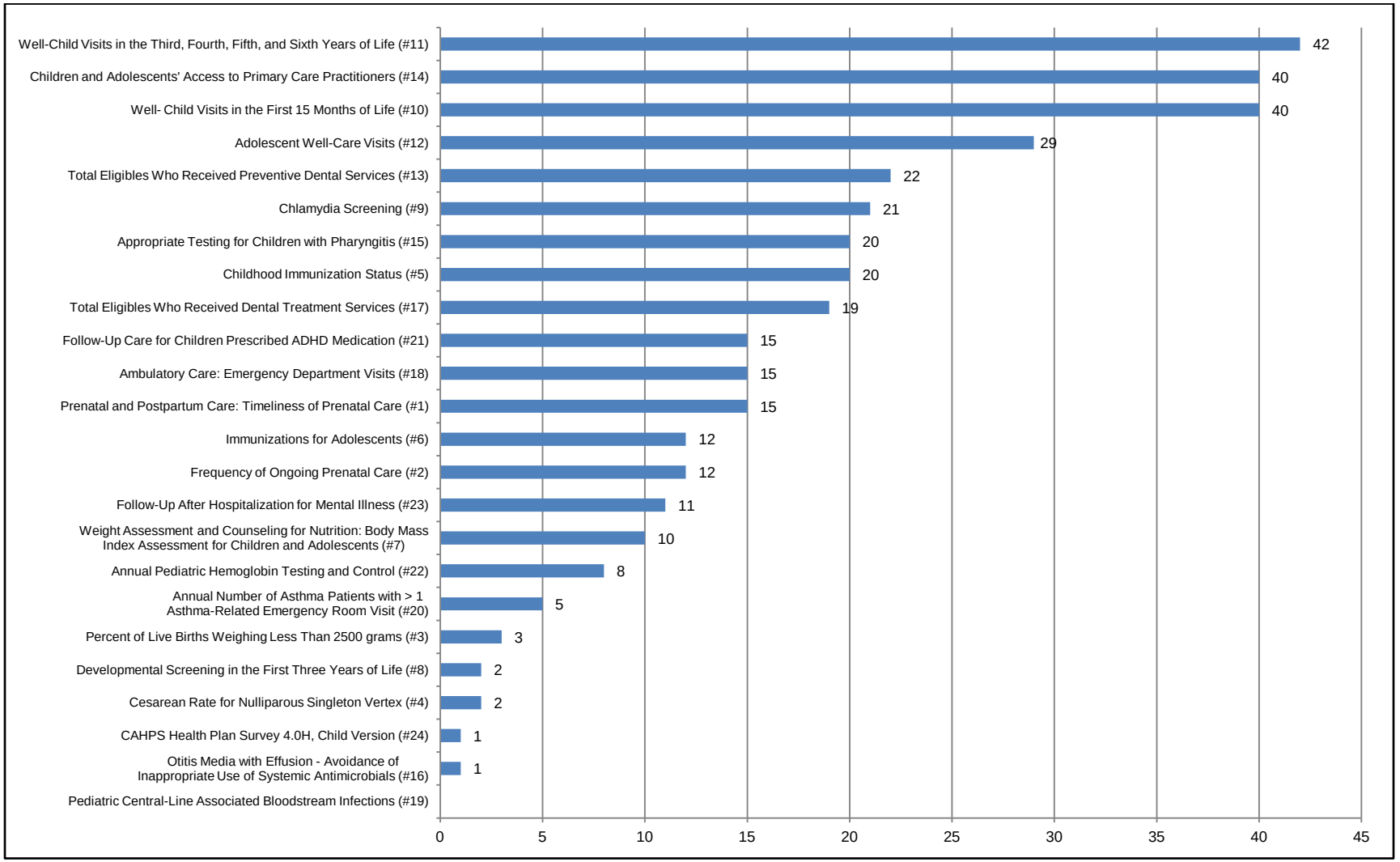
Table VI.3. Specifications and Data Sources Used to Report Child Health Quality Measures in FFY 2010

Measure	Number of States Reporting	Percentage of States Using HEDIS Specifications to Report (if applicable)	Percentage of States Using Each Data Source		
			Administrative Data	Hybrid Data (administrative and medical record data)	Other Data/ Not Specified
HEDIS Measures (Measure Number and Description)					
1 Prenatal and Postpartum Care: Timeliness of Prenatal Care	15	100	47	47	7
2 Frequency of Ongoing Prenatal Care	12	100	58	42	0
5 Childhood Immunization Status	20	95	45	45	10
6 Immunizations for Adolescents	12	100	42	50	8
7 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	10	70	40	40	20
9 Chlamydia Screening	21	100	90	5	5
10 Well-Child Visits in the First 15 Months of Life	40	93	70	23	5
11 Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	42	93	71	24	5
12 Adolescent Well-Care Visits	29	97	66	28	7
14 Child and Adolescent Access to Primary Care Practitioners	40	95	90	3	8
15 Appropriate Testing for Children with Pharyngitis	20	100	90	5	5
18 Ambulatory Care: Emergency Department Visits	15	73	87	0	14
21 Follow-Up Care for Children Prescribed ADHD Medication	15	100	100	0	0
23 Follow-Up After Hospitalization for Mental Illness	11	100	91	0	9
24 CAHPS 4.0 (Child Version including Medicaid and Children with Chronic Conditions Supplemental Items)	1	100	0	0	0
Non-HEDIS Measures					
3 Percent of Live Births Weighing Less Than 2,500 grams	3	NA	33	33	33
4 Cesarean Rate for Nulliparous Singleton Vertex	2	NA	50	50	0
8 Developmental Screening in the First Three Years of Life	2	NA	100	0	0
13 Total Eligibles Who Received Preventive Dental Services	22	NA	95	0	5
16 Otitis Media with Effusion—Avoidance of Inappropriate Use of Systemic Antimicrobials in Children—Ages 2—12	1	NA	100	0	0
17 Total Eligibles Who Received Dental Treatment Services	19	NA	95	5	0
19 Pediatric Central-Line Associated Blood Stream Infections—NICU and PICU	0	NA	--	--	--
20 Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visits	5	NA	100	0	0
22 Annual Pediatric Hemoglobin A1C Testing	8	NA	88	13	0

Source: Mathematica analysis of FFY 2010 CARTS reports, as of June 30, 2011.

Notes: To report HEDIS measure 24, States have the option of attaching their CAHPS results to the CARTS report or submitting the raw data directly to AHRQ. One State reported the measure in CARTS; 15 other States reported directly to AHRQ. ADHD = attention deficit hyperactivity disorder; AHRQ = Agency for Healthcare Research and Quality; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and System; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FFY = Federal fiscal year; HEDIS = Healthcare Effectiveness Data and Information Set; NA = not applicable; NICU = neonatal intensive care unit; PICU = pediatric intensive care unit.

Figure VI.1. Number of States Reporting the CHIPRA Quality Measures in FFY 2010 CARTS Reports



Source: Mathematica analysis of CARTS FFY 2010 reports, as of June 30, 2011, and as reported in Sebelius 2011.

Notes: Measure numbers appear in parentheses. To report measure 24, States have the option of attaching their CAHPS results to the CARTS report or submitting the raw data directly to AHRQ. One State reported the measure in CARTS; 15 other States reported directly to AHRQ; ADHD = attention deficit hyperactivity disorder; AHRQ = Agency for Healthcare Research and Quality; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and System; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FFY = Federal fiscal year; NA = not applicable; NICU = neonatal intensive care unit; PICU = pediatric intensive care unit.

The most frequently reported measures in FFY 2010 were the three that States have reported through CARTS since 2003, well-child visits in the first 15 months of life, well-child visits in the third, fourth, fifth, and sixth years of life, and child and adolescent access to primary care practitioners (Figure VI.1). This finding is not surprising, as States had experience reporting on these measures for the past eight years. Other frequently reported measures include adolescent well-care visits (29 States), total eligibles who received preventive dental services (22 States), and Chlamydia screening (21 States).

Seven measures were reported by five or fewer States. These measures included otitis media with effusion (one State) and pediatric central-line associated bloodstream infections (zero States). When States did not report a measure, they were asked to specify the reason for not reporting. The most commonly cited reason for not reporting was that the data were not available, although many States did not specify reasons for not reporting each measure (see Appendix Table A.16 for measure-level detail). Other reasons for not reporting were because reporting was voluntary or because of budget and data system limitations.

This analysis focuses on five measures of primary and preventive care services for children enrolled in CHIP and Medicaid that were frequently reported by States. They are (1) well-child visits in the first 15 months of life (measure # 10); (2) well-child visits in the third, fourth, fifth, and sixth years of life (measure # 11); (3) child and adolescent access to primary care practitioners (PCPs) (measure # 14); (4) childhood immunization status (measure # 5); and (5) adolescent well-care visits (measure #12). The latter two measures were new in FFY 2010, but the first three measures have been reported voluntarily since 2003. For these three measures, we provide comparative information for FFY 2006 and FFY 2010, including only those States that reported in both periods and that used HEDIS or HEDIS-like specifications.[58,59] Although the populations in Medicaid and CHIP and commercial (private insurance) plans are different demographically, we also compare the 2010 results for these four measures to commercial health plan data to put findings in context.

We also report on two dental services measures, percentage of children receiving any dental service, and percentage of children receiving preventive dental services, for FFYs 2000 and 2009. The data for these measures are from the early and periodic screening, diagnosis, and treatment (EPSDT) CMS-416 form, as reported in the secretary's 2011 Report on Quality of Care for Children in Medicaid and CHIP (Sebelius 2011).[60, 61]

[58] Before FFY 2010, States were permitted to report "HEDIS-like" methods. This was discontinued in FFY 2010, when States reported using either HEDIS or other methods.

[59] We compare reporting in FFYs 2006 and 2010 because these are the comparison years used throughout this report.

[60] The CARTS dental measures also use data from the Form 416 EPSDT report. However, fewer States reported the dental measures through CARTS than through the EPSDT system in FFY 2010. Many States were unable to adhere to the CHIPRA measure specifications (which are slightly different from the Form 416 reporting requirements) within the time allotted for reporting in FFY 2010.

[61] Comparable data for children enrolled in commercial (private insurance) health plans was not available for the dental measures.

1. Well-Child Visits in the First 15 Months of Life

The American Academy of Pediatrics (AAP) and Bright Futures recommend that children receive nine well-child visits in the first 15 months of life (AAP 2010).[62] States were to report the percentage of CHIP and Medicaid program participants that received from zero to six or more well-child visits during the first 15 months of life. From FFYs 2006 to 2010, States made progress in the percentage of CHIP and Medicaid participants who received at least one well-child visit in the first 15 months of life, as well as the percentage that received six or more well-child visits.

Twenty-seven States reported in both FFYs 2006 and 2010 on this measure using HEDIS or HEDIS-like specifications (four States in FFY 2006 reported using HEDIS-like specifications). The mean percentage of children receiving at least one well-child visit rose from 88.5 percent in FFY 2006 to 94.1 percent in 2010 (Table VI.4). By FFY 2010, the reported State percentages were clustered closely, with half of all States reporting between 95.7 and 99.1 percent of children receiving at least one well-child visit (the 25th and 75th percentiles, respectively). The percentage of participants who received six or more well-child visits in their first 15 months of life grew from an average of 43.8 percent in FFY 2006 to 52.9 percent in FFY 2010. The median also increased (from 46.7 percent in FFY 2006 to 55.8 percent in FFY 2010). The range between the 25th and 75th percentiles decreased, showing a reduction in the variation across States. Although rates for one visit and six or more visits progressed in this period, on average, States do not meet the AAP recommendations: the recommendation from AAP is nine visits in the first 15 months of life, but on average, half of children received less than six visits in FFY 2010. The median percentage of children receiving 6 or more well-child visits was lower among CHIP and Medicaid participants (55.8 percent) compared to children enrolled in commercial health plans (76 percent) in FFY 2010.

Table VI.4. Percentage of CHIP and Medicaid Children and Commercially Insured Children with at Least One Well-Child Visit and Six or More Well-Child Visits in the First 15 Months of Life, FFYs 2006 and 2010

	Percentage of Participants with at Least One Well-Child Visit in First 15 Months of Life		Percentage of Participants with Six or More Well-Child Visits in First 15 Months of Life	
	2006	2010	2006	2010
Total Number of States Reporting Using HEDIS/HEDIS-Like Specifications	27	27	24	24
Mean	88.5	94.1	43.8	52.9
Median	95.9	97.4	46.7	55.8
25th Percentile	89.1	95.7	33.7	52.4
75th Percentile	97.5	99.1	53.1	61.7
Health Plan Commercial (Private Insurance) Median	NA	NA	NA	76

Sources: FFYs 2006 and 2010 CARTS reports, as of June 30, 2011, and as reported in Sebelius 2011.

Notes: These calculations are based on a subset of all States reporting using HEDIS or HEDIS-like specifications (4 States reported in FFY 2006 used HEDIS-like specifications). For comparison purposes, only States that reported this measure in both FFYs 2006 and 2010 are shown. States reported a combined rate for both CHIP and Medicaid enrolled children; separate rates for CHIP and Medicaid could not be extracted from the reported data. Commercial data from unpublished National Committee for Quality Assurance data reported in Sebelius 2011; 2006 commercial data not available. NA=Not available.

[62] The AAP and Bright Futures recommend well-child visits at birth, then at three to five days, one month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months.

2. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

The AAP and Bright Futures recommend annual well-child visits for children ages 3 and older (AAP 2010). According to data reported in CARTS by 31 States in FFY 2010, nearly two-thirds of children ages 3 through 6 enrolled in CHIP or Medicaid had a well-child visit. From FFY 2006 to FFY 2010, the 31 States that reported in both periods made progress on this measure, increasing from an average of 56.4 percent of CHIP and Medicaid enrollees having one or more well-child visits in 2006 to 63.1 percent in 2010 (Table VI.5).[63] In addition to an overall average increase, States became more clustered, with half of States reporting between 56.1 and 74.8 percent of children having one or more well-child visits (the 25th and 75th percentiles, respectively). The median rate of well-child visits between ages 3 and 6 for CHIP/Medicaid participants (64.9 percent) was slightly lower than the median rate for children enrolled in commercial health plans (71 percent) in FFY 2010.

Table VI.5. Percentage of CHIP and Medicaid Children and Commercially Insured Children with One or More Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, FFYs 2006 and 2010

	Percentage of Participants with One or More Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	
	2006	2010
Total Number of States Reporting Using HEDIS/HEDIS-Like Specifications	31	31
Mean	56.4	63.1
Median	58.2	64.9
25th Percentile	44.6	56.1
75th Percentile	66.6	74.8
Health Plan Commercial Median	NA	71

Sources: FFYs 2006 and 2010 CARTS reports, as of June 30, 2011, and as reported Sebelius 2011.

Notes: These calculations are based on a subset of all States reporting using HEDIS or HEDIS-like specifications (4 States reported in FFY 2006 used HEDIS-like specifications). For comparison purposes, only States that reported this measure in both FFYs 2006 and 2010 are shown. States reported a combined rate for both CHIP and Medicaid enrolled children; separate rates for CHIP and Medicaid could not be extracted from the reported data. Commercial data from unpublished National Committee for Quality Assurance data reported in Sebelius 2011; 2006 commercial data not available. NA=Not available.

3. Percentage of Children with a Primary Care Practitioner Visit

The AAP/Bright Futures guidelines recommend an annual primary care visit beginning at 3 years of age through age 21; between 12 and 24 months, children should have four such visits, at 12, 15, 18, and 24 months. States reported higher rates of performance on the percentage of children enrolled in CHIP and Medicaid with a primary care visit than on the well-child visit measures in FFYs 2006 and 2010. Average rates in FFY 2006 were relatively high to start, ranging from 79.9 to 92.5 percent in FFY 2006, depending on the age group (Table VI.6). By 2010, the vast majority of children enrolled in CHIP and/or Medicaid had at least one primary care visit per year (87.1 to 95.6 percent). Improvement was documented across every age group from FFY 2006 to 2010, although the percentages are consistently higher for younger children. The 12- to 24-months age group was

[63] Four States in FFY 2006 used HEDIS-like specifications.

most likely to receive at least one primary care visit per year, and the 12- to 19–year-old age group was the least likely. The median rates for primary care visits among CHIP/Medicaid enrollees of all ages are comparable to commercial health plan median rates for primary care visits (Sebelius 2011).

Table VI.6. Percentage CHIP and Medicaid Children and Commercially Insured Children with a Primary Care Visit, FFYs 2006 and 2010

	2006				2010			
	12 to 24 Months	25 Months to 6 Years	7 to 11 Years	12 to 19 Years	12 to 24 Months	25 Months to 6 Years	7 to 11 Years	12 to 19 Years
Total Number of States Reporting Using HEDIS/HEDIS-Like Specifications	28	28	27	27	28	28	27	27
Mean	92.5	85.7	85.9	79.9	95.6	88.3	88.8	87.1
Median	95.0	87.1	85.6	84.0	96.2	88.9	90.9	88.4
25th Percentile	91.7	83.4	83.6	79.1	95.6	85.9	87.4	85.5
75th Percentile	95.8	88.9	89.9	86.1	97.6	91.0	93.2	90.6
Health Plan Commercial Median	NA	NA	NA	NA	98	92	92	89

Sources: FFYs 2006 and 2010 CARTS FFY 2010 reports, as of June 30, 2011, and as reported in Sebelius 2011.

Notes These calculations are based on a subset of all States reporting using HEDIS or HEDIS-like specifications (6 States used HEDIS-like specifications in 2006). For comparison purposes, only States that reported this measure in both FFY 2006 and 2010 are shown. States reported a combined rate for both CHIP and Medicaid enrolled children; separate rates for CHIP and Medicaid could not be extracted from the reported data. Commercial data from unpublished National Committee for Quality Assurance data reported in Sebelius 2011; 2006 commercial data not available. NA=Not available.

4. Adolescent Well-Care Visits and Childhood Immunization Status at Age 2

In addition to the three preventive health measures already discussed, two additional preventive measures were reported frequently by States in FFY 2010. The percentage of eligible CHIP and Medicaid participants receiving adolescent well-care visits was reported by 29 States. Rates for adolescent well-care visits reported for children enrolled in CHIP and Medicaid were lower than those for younger children and lower than the recommendations laid out by the AAP. The mean and median percentage for adolescent well-child visits was 47.0 percent; and this median rate was higher than the reported median rate for commercially insured children (41 percent).

The percentage of Medicaid and/or CHIP participants with up-to-date immunizations at age 2 was reported by 20 States, 19 of which used HEDIS specifications and are reported here (Table VI.7). The mean percentage for having up-to-date childhood immunizations at age 2 was 63.5 percent. The range in reporting for this measure was large, ranging from 11.8 to 88.2 percent (data not shown). The main factors driving the wide range across States appear to be the variation in data sources (hybrid versus administrative data) and differences across States in which immunizations were included in the measure. The commercial health plan median rate was slightly higher than the CHIP/Medicaid median rate (79 percent compared to 70.6 percent), but as reported in Sebelius (2011), this could be an artifact of data anomalies in State reporting in CARTS (not all States used the comparable set of immunizations that commercial health plans report on).

Table VI.7. Percentage of CHIP and Medicaid Children and Commercially Insured Children with Adolescent Well-Care Visits and Immunization Status at Age 2, FFY 2010

	Adolescent Well-Care Visits	Childhood Immunization Status: Percent Up to Date on Immunizations at 2 years
Total Number of States Reporting Using HEDIS Specifications	29	19
Mean	47.0	63.5
Median	47.0	70.6
25th Percentile	37.4	58.6
75th Percentile	56.7	78.2
Health Plan Commercial Median	41	79

Source: FFY 2010 CARTS reports, as of June 30, 2011, and as reported in Sebelius 2011.

Notes These calculations are based on a subset of all States reporting using HEDIS specifications. States reported a combined rate for both CHIP and Medicaid enrolled children; separate rates for CHIP and Medicaid could not be extracted from the reported data. Commercial data from unpublished National Committee for Quality Assurance data reported in Sebelius 2011.

5. Dental Measures for Children Enrolled in Medicaid

Dental disease is the most common chronic disease of childhood, with nearly 60 percent of children ages 5 to 17 having decayed, filled, or missing permanent teeth (U.S. Department of Health and Human Services 2000; Trenholm et al. 2005). As reported in Sebelius (2011), data collected by the Centers for Medicare & Medicaid Services (CMS) show a clear record of improved access to dental care in Medicaid between FFYs 2000 and 2009 (similar data for CHIP are not yet available). Approximately 40 percent of children in Medicaid received a dental service in 2009, reflecting a nearly 50 percent increase since FFY 2000; and use of preventive dental services increased by 61 percent in the same period (Table VI.8). States have made progress, but they remain below the Healthy People 2010 goal of 56 percent of children (and adults) having a dental visit within a year (Sebelius 2011).[64] Recognizing this, CMS set goals for FFY 2015 to increase by 10 percentage points the FFY 2011 proportion of all Medicaid and CHIP children getting preventive dental services and children ages 6 to 9 getting dental sealants.

Table VI.8. Receipt of Dental Services in Medicaid, FFYs 2000 and 2009

	Percentage of Children Receiving Any Dental Service	Percentage of Children Receiving Any Dental Service	Percentage of Children Receiving Preventive Dental Service	Percentage of Children Receiving Preventive Dental Service
	FFY 2000	FFY 2009	FFY 2000	FFY 2009
Total Number of States Reporting	51	51	50	50
Mean	27	40	21	35
Median	26	40	26	36
25th Percentile	21	37	16	33
75th Percentile	32	46	27	40

Source: EPSDT CMS Form 416, as reported in Sebelius 2011.

[64] Sebelius (2011) used the Healthy People 2010 goal as the benchmark because these data were collected in FFY 2009. However, the Healthy People 2020 goal is lower: 49 percent (U.S. Department of Health and Human Services n.d.).

Availability of dental providers accepting Medicaid has been an ongoing problem in Medicaid; the fact that the percentage of children with any dental service and any preventive dental service increased in this period—while the program grew by more than 10 million children—indicates that dental provider capacity in Medicaid also increased in this period (Sebelius 2011).

D. Discussion

This assessment has shown that more publicly insured children received preventive, primary care, and dental services in FFY 2010 than had in the past. Nearly all children in the various age groups examined had a primary care visit in FFY 2010 among the States that reported using HEDIS or HEDIS-like specifications. Well-child visits were less frequently reported: about 63 percent of all enrolled children ages 3 through 6 had one in FFY 2010, although this is an improvement over FFY 2006, when on average 56 percent of enrolled children had a well-child visit in the 31 States reporting in both years. Notably, median PCP visit rates for Medicaid and CHIP are comparable to rates for commercial plans, and adolescent well-child visit rates are higher in Medicaid and CHIP than in commercial plans.

Still, children in CHIP and Medicaid are not receiving as many primary care/preventive services as recommended by the AAP/Bright Futures: for example, among States reporting using HEDIS or HEDIS-like measures in FFYs 2006 and 2010, only half of the children had six or more well-child visits in the first 15 months of life in FFY 2010, compared with the nine visits recommended by the AAP. Children ages 3 to 6 were less likely than infants to have had a single well-child visit in FFY 2010 (63 percent of children ages 3 to 6 had one visit, compared with 94 percent of infants). Among the 29 States reporting well-child visits for adolescents in FFY 2010 using HEDIS specifications, fewer than half of the children received the recommended annual well-child visit. About two-thirds of children in FFY 2010 among the 19 States reporting using HEDIS specifications were up to date on immunizations at age 2, although this could be a function of the variation in data sources States used for this measures and differences among States in which immunizations were included in the measure. Finally, dental services use improved from FFY 2000 to FFY 2009, although it remains below the Healthy People 2010 goal. Recognizing this important health problem, HHS has instituted new goals for States as part of its oral health strategy to try to increase the percentage of children who receive preventive dental services and dental sealants on a permanent molar tooth.

States are a large health care purchaser for children in the United States, and their role is about to expand as a result of health care reform. The use of a core set of children's health care quality measures enables ongoing monitoring of the quality of care provided to children enrolled in Medicaid and CHIP, and targeted efforts to improve quality within and across States. This review indicates that the use of recommended primary care, preventive, and dental services increased over time, but that room for more improvement exists. New investments from CHIPRA will support State efforts to improve the collection, reporting, and use of child health quality measures, and enable States to begin using what they learn from the measures to improve the care provided to children in Medicaid and CHIP.

VII. PROGRAM CHALLENGES AND ACCOMPLISHMENTS

The annual Children's Health Insurance Program (CHIP) Annual Reporting Template System (CARTS) reports conclude with a narrative section asking States to describe the political and fiscal environment in their State and how it has influenced their programs, the greatest challenge for the program, and notable accomplishments achieved during the past year. This chapter synthesizes information reported by States in their 2010 CARTS reports, highlighting common themes and providing examples from State reports to illustrate these themes. It concludes with a discussion of implications of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) for State CHIP programs.

Several common themes emerge when comparing States' responses in the 2010 report with what they reported in previous years going back to 2006. In describing the political and fiscal environment and key challenges, States have reported tight budgets for many years, but especially since the economic downturn that began in 2007. Uncertainty surrounding CHIP reauthorization also contributed to budget concerns in 2007 and 2008. Because of strong support for the program, most States have been able to maintain their programs without significant cuts in enrollment or benefits, but many have had to cope with reduced staff and administrative resources. Accomplishments often focus on streamlining and simplifying enrollment and renewal processes. Over time, more States adopted policies and practices designed to keep eligible children enrolled, and these strategies were likely to involve automation and electronic data exchange. Another common accomplishment reported by States is improved coordination between Medicaid and CHIP to ensure that children do not lose coverage and instead transfer seamlessly from one program to the other. These experiences have given States a solid foundation for meeting the requirements set forth in the Affordable Care Act to coordinate Medicaid, CHIP, and Affordable Insurance Exchange processes, ensuring application and enrollment processes are as smooth as possible for individuals and families.

A. Political and Fiscal Environment, FFY 2010

With most States still struggling to rebound from the recession that extended for most of Federal fiscal years (FFYs) 2008 and 2009, the economy was by far the most common and significant factor influencing Medicaid and CHIP programs in FFY 2010. Of the 45 States reporting on their political and fiscal environments in FFY 2010, 41 cited budget problems as a continuing concern. Many States described similar patterns related to the economic downturn: sustained unemployment and falling wages resulting in greater demand for public coverage at the same time that economic forces reduced State revenues and created serious budget deficits. Notably, however, support for CHIP remained strong despite these budget challenges and several States reported eligibility expansions. Only 12 States reported that cost cutting had occurred or was planned. Several States mentioned the maintenance of effort (MOE) provisions in the Affordable Care Act as a factor contributing to sustained eligibility for Medicaid and CHIP. Although States are maintaining Medicaid and CHIP eligibility levels, some have taken other steps to reduce program costs.

- Early in FFY 2010, **Arizona** notified the Centers for Medicare & Medicaid Services (CMS) of its intent to terminate its separate CHIP program. With the passage of the Affordable Care Act several months later, the State withdrew its request so that it would comply with the act's MOE requirements and continue to receive Federal funding for its Medicaid program.

- **Arizona** and **Tennessee** both froze enrollment in CHIP during FFY 2010. Several other States noted that their ability to prevent enrollment freezes and waiting lists despite fiscal challenges was an important accomplishment that year. **Pennsylvania** said that it preserved open enrollment in its CHIP program; however, open enrollment is still threatened by the Commonwealth's dire fiscal circumstances.

- **Illinois** said it expected legislation would be passed to increase income and residency verification requirements and to eliminate the use of passive renewal. These changes will make it harder for some families to enroll and remain enrolled.

- The **District of Columbia, Florida, Idaho, Nevada, Oklahoma,** and **South Dakota** mentioned making cuts to provider reimbursement rates to cope with budget deficits. **California** and **New Hampshire** reported increasing CHIP premium amounts and **New Mexico** mentioned implementing cost-cutting measures but did not further specify the actions it will take.

B. Greatest Challenge Reported by States, FFY 2010

Consistent with State reports about the demanding fiscal climate, 28 States specifically pointed to the economic downturn and related financial problems as the greatest challenge they faced in FFY 2010. Six of these 28 States and three others described additional challenges related to staffing cuts and hiring freezes at the State and local levels that, along with increased enrollment and increased caseloads, generally made it more difficult to manage the program. With limited staff resources, States looked for ways to do business more efficiently and prioritized how staff spent their time.

- **Louisiana** said its greatest challenge was staff shortages and related high caseloads. Despite having electronic eligibility case records that allow work to be processed in a virtual environment throughout the State, a paperless renewal process, a centralized call center, and streamlined processes such as express lane eligibility (ELE) and administrative renewals, the State said it is challenging for eligibility staff to maintain good application processing times, conduct proactive outreach, and provide a high level of customer service in the face of limited resources.

- **Washington** reported its biggest challenge was rapid growth in CHIP enrollment combined with a hiring freeze that led to higher caseloads. The State uses every administrative efficiency available (such as electronic verification of income) to meet application processing time lines and manage the annual review process.

Many States talked about the challenge of implementing CHIP Reauthorization Act (CHIPRA) requirements, specifically those related to prospective payment of Federally qualified health centers and rural health clinics and expanded dental and mental health benefits; a few States also mentioned the challenge of keeping up with the Affordable Care Act legislation and its potential impact on CHIP.

- **Virginia** reported that its greatest challenge was implementing the numerous changes required by CHIPRA and the Affordable Care Act, as well as other program enhancements, in an environment of budget cuts, lost staff positions, and changes in agency administration at the State and federal levels. Coverage for mental health and substance abuse treatment was expanded to comply with mental health parity requirements, cost-sharing for pregnancy-related services was eliminated, and payment methods for Federally qualified health centers and rural health clinics were revised.
- **New Hampshire** reported having difficulty complying with CHIPRA mandates that have tied up scarce resources and have the potential to utilize the dollars that should have gone to enrolling children into health and dental insurance.

Several States reported challenges associated with declining enrollment levels as CHIP enrollees become Medicaid eligible with the loss of income. Some States raised concerns about children transitioning smoothly from separate CHIP programs to Medicaid or Medicaid-expansion CHIP programs.

- **California** has studied its retention rates for many years, distinguishing between disenrollments that cannot be avoided (such as the child ages out of the program or becomes eligible for another form of coverage) and those that are possibly avoidable (missing information or documentation or nonpayment of premium). The State reported a decline in one-year CHIP retention rates from 2007 to 2008 that it attributed partly to the economy (children becoming eligible for Medicaid because family incomes declined) and partly to an increase in program premium levels.
- **Montana** reported that its CHIP program has experienced a notable decline in enrollment because many former enrollees have been referred to the CHIP-funded Medicaid expansion group. The State added that CHIP and Medicaid-eligible families are confused as they transfer between the two programs because of differences in eligibility criteria, documentation needs, and benefit packages.
- **Nevada** reported having seen a slow but steady decline in enrollment in the CHIP program that appeared to be directly related to the current economic conditions. The State said that most of those who left are Medicaid eligible or potentially eligible for Medicaid at redetermination.

Other challenges mentioned by more than one State include having limited political support for the program (**Alaska**, **Illinois**, **Utah**, and **Wyoming**), and new (**Maine**) or outdated (**South Carolina**) data systems that made it difficult for the State to retrieve some of the information it needed for management purposes.

C. Accomplishments Reported by States, FFY 2010

Two major themes capture many of the accomplishments reported by States in their 2010 reports: (1) using technology to streamline and simplify enrollment and retention and (2) improving quality measurement and quality of care. Although States have focused on simplification strategies for many years, current efforts are advancing the use of online applications, prepopulated renewal forms, and electronic exchange of information between different programs or agencies to reduce the burden on families. Many States implemented simplification measures to qualify for a CHIPRA performance bonus. Several States were implementing or exploring the use of ELE, and many States

reported use of interagency agreements to verify income electronically and/or to verify citizenship and identity using the SSA State Verification Exchange System (SVES).

- **Colorado** continued making progress on qualifying for a CHIPRA performance bonus, implementing premium assistance subsidies in its Medicaid program and working toward implementing administrative renewals and ELE. **Louisiana** implemented its ELE component in April 2010, using data from the Supplemental Nutrition Assistance Program to automatically enroll approximately 19,000 children.
- **New York** eliminated the requirement for a personal interview in its Medicaid program, opening the door for further streamlining and simplification between Medicaid and CHIP.
- **Ohio** implemented continuous and presumptive eligibility, qualifying it for a performance bonus for the first time. **Alaska** earned a 2010 performance bonus that was five times larger than the bonus it received in 2009.
- **Tennessee** enhanced its eligibility redetermination process by giving families more time to complete the renewal application, making reminder calls and sending postcards to families around the renewal time, and making calls to families with children denied coverage under CHIP because they appear to be eligible for Medicaid.
- **Iowa** took advantage of two CHIPRA options: verifying citizenship and identity electronically with the Social Security Administration (SSA) and establishing a dental-only program for children with other health insurance that does not include dental coverage. **Pennsylvania** implemented electronic verification of citizenship through SSA and is implementing an expanded dental benefit.
- **Wyoming** rolled out a new online application, online renewal forms, prepopulated renewal forms, and a renewal reminder system.

Several States reported that it was an accomplishment simply to maintain the program given the fiscal problems they faced. These included **Alaska**, **Connecticut**, the **District of Columbia**, **Idaho**, **Missouri**, and **Wisconsin**.

CHIPRA included provisions to advance quality measurement and quality improvement, and many States noted accomplishments in these areas. Several States, for example, highlighted their work on the CHIPRA quality demonstration projects. A few States mentioned that health plans participating in their programs had received high rankings in quality. Others noted they had added new quality measures to their standard reports.

- **Alaska** is participating in a three-State quality demonstration program with **Oregon** and **West Virginia**.[65] The States are testing the 24 new child health quality measures and evaluating the pediatric medical home concept across different payment and delivery systems.

[65] CHIPRA quality demonstration grants were awarded to 10 States for projects involving a total of 18 States.

- **California** received grants from private foundations to undertake two child health quality improvement projects, one on oral health and another on developing a quality assessment and improvement strategy.
- **Rhode Island** reported that all three participating health plans had achieved national distinction with rankings by the National Center for Quality Assurance and *U.S. News and World Report* among the highest for all Medicaid plans in the nation. **Nevada** highlighted improvements by its largest managed care plan in 7 of 13 Health Plan Employer Data and Information Set (HEDIS) measures since 2009 and in 10 of 13 measures since 2008. **Arizona** exceeded the program's goals for all of its reported quality measures and in most cases exceeded the HEDIS national Medicaid mean.
- **Colorado** added new quality measures for weight assessment and counseling for nutrition and physical activity for children and adolescents. **Colorado** also received a CHIPRA grant to innovate with new and improve upon existing models of care models of care delivery for school-based health centers.
- **Virginia** reported that its CHIP program implemented several initiatives to improve health outcomes, including early intervention services for young children with developmental delays and participation in text4baby, an initiative to improve birth outcomes among low-income pregnant women.

Ten States cited increased enrollment and fewer uninsured children as accomplishments. Six States mentioned participating in outreach efforts supported by grants and other outside resources. Several States mentioned coordinating with recipients of CHIPRA outreach grants.

- **Louisiana** reported data from its annual Household Insurance Survey showing uninsured rates for low-income children declining from 5.4 percent in 2007 to 5.0 percent in 2009. **West Virginia** reported its uninsured rate for children from families whose incomes were less than 200 percent of the Federal poverty level (FPL) was below 3 percent and that the rate had declined from the previous year.
- **Florida** noted that although the legislature had not funded outreach since 2008, program staff continued to work with their KidCare partner agencies to develop outreach strategies with no additional funding. The University of South Florida's Covering Kids and Families project received a $1 million CHIPRA outreach grant that enabled it to continue working with its community partners to support back-to-school campaigns and other community outreach efforts.
- **New Jersey** reported continued efforts to identify uninsured children in the schools, with pilot schools using a tracking database and submitting the names of uninsured children to the Division of Medical Assistance and Health Services, which then sends out an application.

D. Implications of the Affordable Care Act for State CHIP Programs

The Affordable Care Act extended the funding for CHIP through FFY 2015 and required States to maintain the minimum income eligibility thresholds for children in Medicaid and CHIP at March 2010 levels through September 30, 2019. Although funding for CHIP after FFY 2015 is not assured, the Affordable Care Act specified a 23 percentage point increase in Federal financial

participation for CHIP from FFY 2016 through FFY 2019. Few States discussed the implications of the Affordable Care Act in their FFY 2010 CARTS reports.

States are likely to discuss the implications of the Affordable Care Act in future CARTS reports. Among the many changes introduced by the act, the following have the greatest potential to affect CHIP programs:

- A new minimum Medicaid eligibility threshold for all children younger than 19 of 133 percent of the FPL, including children currently eligible under a separate CHIP program, effective January 1, 2014;
- New Medicaid eligibility for parents and other adults younger than 65 at income levels not exceeding 133 percent of the FPL, allowing parents and children to be covered under the same plan, effective January 1, 2014;
- Elimination of most income disregards in Medicaid and CHIP so that income eligibility is established using a common modified adjusted gross income (MAGI) method; a standard 5 percent disregard will be applied to everyone, raising the effective income thresholds for Medicaid and CHIP by 5 percentage points;
- New options for States to cover children of public employees in CHIP if minimum agency contributions and other requirements are met.[66]

The Affordable Care Act also mandates development of Affordable Insurance Exchanges (operated by States or the Federal government) through which certified health plans and tax credits would be made available to eligible individuals. The exchanges must be coordinated with Medicaid and CHIP so that eligibility for the appropriate program is established based on a single application that a person can submit online, over the telephone, by mail, or in person. In addition to distinguishing between CHIP and Medicaid populations, States will have to keep track of those who are newly eligible for Medicaid because the amount of Federal financial participation will be higher for these people. The Affordable Care Act also stipulates that CHIP enrollees be assured coverage through a qualified health insurance exchange plan that is certified as comparable to CHIP in the event that State programs exhaust their Federal allotments and are unable to continue enrolling children in CHIP.

In many ways the changes set in motion by the Affordable Care Act mark the beginning of a new era in coverage for low-income children and families. The reforms have the potential to streamline and simplify the process of getting coverage for millions of low-income families and to reduce some of the complexity involved in operating public coverage programs. It is still too early in the implementation process for States to know how these changes will affect their programs. Future evaluation activities will focus on documenting State experiences and gathering insights about the role of CHIP in the evolving health care landscape.

[66] At the time of this report, five states (Alabama, Montana, Texas, Kentucky, and Pennsylvania) have been approved to expand coverage to children of State employees.

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APPENDIX A

ADDITIONAL TABLES

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Table A.1 Research Questions to be Answered in Congressionally Mandated Evaluation of CHIP

Program Context and Design Features	2011 Interim Congressional Report	2013 Final Congressional Report
How do key design features (program type, income eligibility levels, premiums and cost-sharing, and so on) vary across States? What design changes have States made? Why?	CARTS, SEDS, other program data	Site visits; Survey of program administrators
How do CHIP benefit packages and delivery system features compare with Medicaid and private coverage?	CARTS, SEDS, other program data National data sources on Medicaid and private insurance	Site visits; Survey of program administrators
How has the economic downturn affected States? In what ways are States preparing for implementation of national health care reform? How has the enactment of the Affordable Care Act affected State CHIP programs?	CARTS and secondary data	Site visits; Survey of program administrators; National data sources on State economic indicators
What is the current State budget picture? How has the passage of CHIPRA changed the funding debates in each State?		Site visits; Survey of program administrators; National data sources on State economic indicators
What effect do program design features have on key program outcomes (enrollment, retention, access, use, and satisfaction)? Do States with specific program features experience increased enrollment and/or lower rates of uninsurance?		Site visits; Survey of program administrators; CHIP survey; SLAITS; CPS/ACS; CARTS, SEDS, other program data
Outreach and Enrollment		
What are effective and ineffective outreach strategies for Medicaid and CHIP?	CARTS and secondary data	Site visits; Focus groups; Survey of program administrators; CHIP survey; Medicaid survey
How do different outreach strategies affect families' knowledge of public programs and motivation to enroll?		Site visits; Focus groups Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data; SLAITS
What policies and practices are States employing to improve enrollment outcomes? What strategies are used for specific populations, such as children with special needs, racial/ethnic minorities, and children in immigrant families?	CARTS, SEDS, other program data	Site visits; Survey of program administrators
What are the trends in CHIP enrollment, Medicaid enrollment, and enrollment in public coverage overall for the study States? How do trends differ across States?	CARTS, SEDS, other program data	Enrollment/administrative data
To what extent are trends driven by changes in new enrollment versus changes in disenrollment/retention?		Enrollment/administrative data
How do families learn about CHIP and Medicaid? What information is most helpful in their decisions about applying/enrolling? What aspects of the program are most appealing, and what factors influence enrollment decisions?		Site visits; Focus groups; CHIP survey; Medicaid survey; SLAITS
What are the principal barriers to enrollment in Medicaid and CHIP? What roles do waiting lists and waiting periods play?		Site visits; Focus groups; Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data; SLAITS
What are the trends in program churning and transitions between Medicaid and CHIP? How do these vary across States? What effect do these have on enrollment in public coverage?		Enrollment/administrative data

Table A.1 (*Continued*)

Program Context and Design Features	2011 Interim Congressional Report	2013 Final Congressional Report
In States that are more successful in enrolling eligible children in Medicaid and CHIP, what practices make them more successful? If other States adopt these practices, are they likely to get the same results?		Site visits; Focus groups; Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data
How do premiums, cost-sharing, and other program design features influence enrollment outcomes?		Site visits; Focus groups; Enrollment/administrative data
How does coordination (or lack of coordination) between Medicaid and CHIP affect the enrollment of children in both programs?		Site visits; Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data; SLAITS
What are the impacts of State budget constraints and maintenance-of-effort requirements on the level of State outreach and enrollment efforts?		Site visits; Survey of program administrators Enrollment/administrative data
How do outreach and enrollment findings compare with findings from the previous evaluation?		All of the above
Retention and Disenrollment		
What are more- and less-effective retention practices for Medicaid and CHIP?	CARTS, SEDS, other program data	Site visits; Focus groups; Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data
How do families learn about program renewal requirements and procedures? What are their experiences with the renewal process?		Site visits; Focus groups; CHIP survey; Medicaid survey; SLAITS
How long do children remain enrolled? How does this vary across States? What policies and practices seem to influence enrollment duration?		Site visits; Focus groups; CHIP survey; Medicaid survey; Enrollment/administrative data
Why do children exit the program? To what extent are exits intended/voluntary versus unintended?		Focus groups; CHIP survey; Enrollment/administrative data; SLAITS
What portion of children exiting to uninsured status are still eligible for CHIP or Medicaid? What portion returns to the program after a spell of disenrollment?		CHIP survey; Medicaid survey; Enrollment/administrative data
How do premiums, cost-sharing, and other program design features influence retention outcomes?		Site visits; Focus groups; Enrollment/administrative data
Access, Utilization, Content of Care, and Satisfaction		
What evidence is available about the quality of care provided to children enrolled in CHIP?	CARTS and published literature	
What experiences do enrollees have in seeking and obtaining health care? Have they had difficulties in finding a doctor or dentist? Have they been able to get timely appointments? How do these experiences compare with their experiences before enrollment?		Focus groups
Where do enrollees usually access care? Do they have a usual source of care?		Focus groups
How adequate are provider networks in meeting the needs of enrollees?		Site visits; Survey of program administrators; CHIP survey; Medicaid survey
What types of services do enrollees receive? To what extent does the care received include recommended preventive care screenings, guidance, immunizations, and other services?		CHIP survey; Medicaid survey
How well does the process of care align with the core principles of a patient-centered medical home?		Focus groups; CHIP survey; Medicaid survey

Table A.1 (*Continued*)

Program Context and Design Features	2011 Interim Congressional Report	2013 Final Congressional Report
How well are providers communicating with families?		Focus groups; CHIP survey; Medicaid survey
How do cost-sharing and other benefit design features affect access and use?		Site visits; Focus groups; CHIP survey; Medicaid survey
How do the costs incurred by families compare with other coverage the child may have had before, or to which the families currently have access?		Focus groups
What unmet health care needs do children have while enrolled? Are costs a factor?		Focus groups; CHIP survey; Medicaid survey
How has the program affected family well-being (financial burden and confidence that their child's health care needs will be met)?		Focus groups; CHIP survey; Medicaid survey
How satisfied are families with the health services received and with the program overall?		Focus groups; CHIP survey; Medicaid survey
What impact does CHIP have on access, use, content of care, and satisfaction?		CHIP survey
How do findings in this area compare with findings from the previous evaluation?		All of the above
Relationship Between CHIP and Other Coverage		
To what extent is CHIP substituting for (crowding out) private coverage? What share of new enrollees was uninsured before enrolling?	CARTS and published literature	Site visits; Focus groups; CHIP survey; Medicaid survey
What type of coverage do children have before enrollment and after disenrolling? How long do they have that coverage and why do they lose it?		Focus groups; CHIP survey; Medicaid survey; Enrollment/administrative data
What share of CHIP enrollees has private coverage before enrolling? What share has access to private coverage while enrolled? How does that vary with program design/crowd-out policies?		Focus groups; CHIP survey; Medicaid survey; Enrollment/administrative data
For those uninsured before enrolling, how long were they uninsured? Was this influenced by CHIP waiting period policies?		Focus groups; CHIP survey; Medicaid survey; Enrollment/administrative data
How does the coverage children have before enrolling and after they exit compare with coverage under CHIP? What are the major differences in covered services and costs?		Site visits; Focus groups; CHIP survey; Medicaid survey
How has CHIP affected the Medicaid program (for example, structure, scope, enrollee perceptions, relationship with other coverage)?		Site visits; Focus groups; Survey of program administrators; CHIP survey; Medicaid survey
How has CHIP altered or factored into the movement of low-income children between public coverage, private coverage, and uninsurance?		Site visits; Survey of program administrators; CHIP survey; Medicaid survey; Enrollment/administrative data
Does CHIP serve as a short- or long-term coverage approach for low-income children?		Site visits; CHIP survey; Enrollment/administrative data
Are children making seamless transitions from CHIP to Medicaid and vice versa? What policies are in place to promote these transitions? What improvements could be made?		Site visits; CHIP survey; Medicaid survey; Enrollment/administrative data
How does the role of public coverage for low-income children vary from \State to State? How has CHIP affected this dynamic?		Site visits; CHIP survey; Medicaid survey; Enrollment/administrative data
How do findings in this area compare with findings from the previous evaluation?		All of the above

Table A.1 (*Continued*)

Program Context and Design Features	2011 Interim Congressional Report	2013 Final Congressional Report
Effects on the Uninsured		
What effect has CHIP had on the rate of health insurance among low-income children?	Published literature	Published literature; Enrollment/administrative data; CPS, ACS
Implications for Health Reform		
What lessons from CHIP are most applicable to health reform?		Site visits; Survey of program administrators
How has the Affordable Care Act affected State programs, and what future changes are expected?		Site visits; Survey of program administrators
How are families of CHIP enrollees likely to respond to coverage options introduced through health reform? How important are different plan/coverage features in their health insurance decisions?		Focus groups; CHIP survey; Medicaid survey

Notes: ACS = American Communities Survey; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; CPS = Current Population Survey; SEDS = Statistical Enrollment Data System; SLAITS = State and Local Integrated Telephone Survey. The Affordable Care Act refers to the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 collectively.

Table A.2. Mandatory and Optional Medicaid Benefits

List of Benefits
Mandatory
• Inpatient hospital service
• Outpatient hospital service
• Physician service
• Early and periodic screening, diagnostic, and treatment (EPSDT) service for individuals younger than 21 (screening, vision, dental, and hearing services listed in the Medicaid statute, including optional services that are not otherwise covered by a State)
• Family planning service and supplies
• Federally qualified health center service
• Freestanding birth center service
• Home health service
• Laboratory and X-ray service
• Nursing facility service (for ages 21 and older)
• Nurse midwife service (to the extent authorized to practice under State law or regulation)
• Nurse practitioners service (to the extent authorized to practice under State law or regulation)
• Rural health clinic services
• Tobacco cessation counseling and pharmacotherapy for pregnant women
• Nonemergency transportation[a]
Optional (number of States covering benefit)
• Medical or remedial care provided by licensed practitioner under State law
• Intermediate care facility service for individuals with mental retardation (51)
• Clinic services (50)
• Skilled nursing facility service for individuals older than 21 (50)
• Occupational therapy service (50)
• Optometry service (50)
• Physical therapy service (50)
• Prescribed drugs (50)
• Hospice service (48)
• Inpatient psychiatric service for individuals younger than 21 (48)
• Dental service (46)
• Eyeglasses (45)
• Services for individuals with speech, hearing, and language disorders (45)
• Audiology service (43)
• Inpatient hospital service, nursing facility service, and intermediate care service for individual ages 65 or older in institutions for mental disease (42)
• Emergency hospital service[b] (40)
• Dentures (37)
• Preventative service (37)
• Personal care service (35)
• Private duty nursing service (33)
• Rehabilitative service (33)
• Diagnostic service (32)
• Program for All-Inclusive Care for the Elderly (PACE) services (31)
• Screening service (30)
• Chiropractic service (29)
• Critical hospital service (22)
• Respiratory care for ventilator-dependent individuals (22)
• Primary care case management service (14)
• Service furnished in religious nonmedical health care institution (13)
• Home and community-based service (HCBS)[c] (4)
• Sickle cell disease-related service (2)
• Health home for enrolled individuals with chronic conditions (new benefit as of January 1, 2011)

Source: Medicaid and CHIP Payment and Access Commission (MACPAC) 2011.

Notes: This table provides a list of mandatory and optional State benefits for the 50 States and the District of Columbia. It does not include services provided under a Medicaid waiver.

[a] Federal regulations require States to provide transportation services; they may do so as an administrative function or as part of the Medicaid benefit package.

[b] Federal regulations define these services as being necessary to prevent the death or serious impairment of the health of the recipient and, because of the threat to life, necessitates the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet Medicare's participation requirements or the definition of inpatient or outpatient hospital services under Medicaid rules.

[c] Although only four States provide HCBS under the State plan option, all States offer HCBS through waivers.

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Table A.3. CHIP Benefit Packages for Separate CHIP Programs and Separate CHIP Components of Combination Programs as of FFY 2010

State	Benchmark Coverage Equivalent to: The Federal Employee Health Benefits Program	Benchmark Coverage Equivalent to: State Employee Coverage	Benchmark Coverage Equivalent to: Coverage Offered by the HMO with Largest Commercial Enrollment in the State	Benchmark-Equivalent Coverage	Secretary-Approved Coverage	Existing Comprehensive State-Based Coverage	Changes Reported in CARTS from FFY 2006 to FFY 2010
Separate CHIP Programs							
Total	0	1	2	1	12	0	
Alabama			X				Annual maximum dental benefits charge increased
Arizona					X		
Colorado			X				Dental benefits cap increased Cap on hearing aids lifted
Connecticut[a]							
Georgia					X		Reestablished the full dental benefit in concert with the rollout of a managed care delivery system
Kansas					X		
Mississippi					X		Mental health limits were removed due to mental health parity
Nevada					X		Added back coverage of nonmedical vision services, orthodontia, and EPSDT Annual dental cap removed
New York					X		Vaccines will be provided Coverage limits for inpatient and outpatient mental health and substance abuse services were removed
Oregon					X		
Pennsylvania					X		Modified outpatient physical health benefits to achieve mental health parity Removed the annual and lifetime maximums on inpatient substance abuse treatments
Texas					X		Dental benefits were restored
Utah				X			New benefit tiers based on FPL Benchmark for CHIP benefits was changed from the State employees benefits to the benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the State
Vermont					X		
Washington					X		Mental health benefits were expanded
West Virginia		X					Changed vision benefits Removed dental limit for members between with incomes from 201 to 250 % of the FPL Removed limits from certain services in order to ensure compliance with mental health parity and CHIPRA
Wyoming					X		Implemented mental health parity and medically necessary dental and orthodontic services

Table A.3 (*Continued*)

State	Benchmark Coverage Equivalent to: The Federal Employee Health Benefits Program	Benchmark Coverage Equivalent to: State Employee Coverage	Benchmark Coverage Equivalent to: Coverage Offered by the HMO with Largest Commercial Enrollment in the State	Benchmark-Equivalent Coverage	Secretary-Approved Coverage	Existing Comprehensive State-Based Coverage	Changes Reported in CARTS from FFY 2006 to FFY 2010
Separate CHIP Components of Combination Programs							
Total	0	9	0	1	12	0	
Arkansas[a]							
California		X					
Delaware					X		Dental benefits became available
Florida					X		Expanded mental health benefits Increased dental benefits
Idaho					X		SCHIP program adopted the Medicaid benefit structure (Secretary–approved coverage for both programs)
Illinois		X					
Indiana				X			Telemedicine added Expanded mental health benefits
Iowa		X					Changes due to mental health parity Began offering dental-only program and medically necessary orthodontia
Kentucky					X		
Louisiana		X					
Maine					X		
Massachusetts					X		
Michigan		X					
Minnesota[a]							American Sign Language interpreter services were added to interpreter coverage Removed circumcision coverage for nonmedically necessary procedures
Missouri					X		
Montana					X		Expanded mental health services Expanded dental benefits Hearing aids are covered now
New Hampshire					X		
New Jersey		X					
North Carolina		X					
North Dakota		X					

Table A.3 (*Continued*)

State	Benchmark Coverage Equivalent to: The Federal Employee Health Benefits Program	Benchmark Coverage Equivalent to: State Employee Coverage	Benchmark Coverage Equivalent to: Coverage Offered by the HMO with Largest Commercial Enrollment in the State	Benchmark-Equivalent Coverage	Secretary-Approved Coverage	Existing Comprehensive State-Based Coverage	Changes Reported in CARTS from FFY 2006 to FFY 2010
Oklahoma[a]							Dental services added
Rhode Island[b]							
South Dakota					X		
Tennessee		X					Outpatient and inpatient mental health/substance abuse limits were removed Orthodontic services offered
Virginia					X		
Wisconsin					X		

Sources: FFYs 2006-2010 CARTS reports, Section 1, Question 9, "Have you made changes to any of the following policy or program areas during the reporting period: Benefit structure?" and "For each topic you responded yes to above, please explain the change and why the change was made." National Academy for State Health Policy 2011.

Notes: *All Medicaid-expansion CHIP programs, even those offered in Combination program States, are required to offer the Federally specified Medicaid benefits package, including EPSDT services. Separate CHIP programs have greater benefit design flexibility than Medicaid-expansion CHIP programs. Federal regulations require all separate CHIP programs to provide a comprehensive benefit package, within the choices listed in the table. Thus Medicaid-expansion CHIP programs are not displayed on this table. CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; CHIPRA = CHIP Reauthorization Act; EPSDT = early and periodic screening, diagnostic, and treatment; FPL = Federal poverty limit; FFY – Federal fiscal year; HMO = health maintenance organization.

[a] State CHIP fact sheets were not available for Arkansas, Connecticut, Minnesota, and Oklahoma.

[b] Rhode Island's separate CHIP program covers unborn child only.

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Table A4. Dominant Delivery System: As of Q1, FFYs 2006-2010

State	Prog. Type	Dominant Delivery System																			
		Fee-For-Service					Primary Care Case Management					Managed Care					Mixed				
		2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010
States that Changed Their Delivery Systems																					
Georgia	S						X						X	X	X	X					
Illinois	C	X	X						X	X	X										
Missouri	C												X	X		X	X			X	
Montana	C		X	X	X	X						X									
Ohio	M													X	X	X	X	X			
South Carolina	M	X	X	X											X	X					
Tennessee[a]	C											X	X						X	X	X
Virginia	C												X	X	X	X	X				
Washington	S											X	X	X						X	X
Wisconsin	C												X		X	X	X		X		
Wyoming	S	X	X	X											X	X					
States that Did Not Change Their Delivery Systems																					
Alabama	S	X	X	X	X	X															
Alaska	M	X	X	X	X	X															
Arizona	S											X	X	X	X	X					
Arkansas	C	X	X	X	X	X															
California	C											X	X	X	X	X					
Colorado	S											X	X	X	X	X					
Connecticut	S											X	X	X	X	X					
Delaware	C											X	X	X	X	X					
Dist. of Columbia	M											X	X	X	X	X					
Florida	C											X	X	X	X	X					
Hawaii	M											X	X	X	X	X					
Idaho	C						X	X	X	X	X										
Indiana	C											X	X	X	X	X					
Iowa	C																X	X	X	X	X
Kansas	S											X	X	X	X	X					
Kentucky	C						X	X	X	X	X										
Louisiana	C						X	X	X	X	X										
Maine	C						X	X	X	X	X										
Maryland	M											X	X	X	X	X					
Massachusetts	C																X	X	X	X	X
Michigan	C											X	X	X	X	X					
Minnesota	C											X	X	X	X	X					
Mississippi	S	X	X	X	X	X															

Table A.4 (*Continued*)

State	Prog. Type	Dominant Delivery System																			
		Fee-For-Service					Primary Care Case Management					Managed Care					Mixed				
		2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010
Nebraska	M																X	X	X	X	X
Nevada	S											X	X	X	X	X					
New Hampshire	C											X	X	X	X	X					
New Jersey	C											X	X	X	X	X					
New Mexico	M											X	X	X	X	X					
New York	S											X	X	X	X	X					
North Carolina	C	X	X	X	X	X															
North Dakota	C						X	X	X	X	X										
Oklahoma	C											X	X	X	X	X					
Oregon	S											X	X	X	X	X					
Pennsylvania	S											X	X	X	X	X					
Rhode Island	C											X	X	X	X	X					
South Dakota	C						X	X	X	X	X										
Texas	S											X	X	X	X	X					
Utah	S											X	X	X	X		X				
Vermont	S						X	X	X	X	X										
West Virginia	S	X	X	X	X	X															

Sources: Q1 FFY 2006, Q1 FFY 2007, Q1 FFY 2008, Q1 FFY 2009, and Q1 FFY 2010 SEDS data, accessed June 15, 2011.

Notes: A dominant delivery system was defined as one that enrolled at least two-thirds of CHIP enrollees; otherwise, the delivery system was considered a mixed system. CHIP = Children's Health Insurance Program; FFY = Federal fiscal year; SEDS = Statistical Enrollment Data System. For Program Type, M = Medicaid-expansion CHIP program; S = separate CHIP program; C = combination program.

[a] Tennessee did not report delivery system information in Q1 FFY 2006, but the State's web site indicates Tennessee has operated a managed care delivery system since 1994 (State of Tennessee 2006).

Table A.5. CHIP Buy-In Programs in FFYs 2005 and 2010

State	Buy-In Program for Children		Income Eligibility Level for Buy-In Program (as a percentage of FPL)		Monthly Premium for Each Child ($)		Benefit Package		Waiting Period (Months)
	2005	2010	2005	2010	2005	2010	2005	2010	2010
Number of States	7	15							
Connecticut	X	X	> 300	> 300	168-220	195	CHIP	CHIP	2
Florida	X	X	> 200	> 200	98-110	133-159	CHIP, or CHIP without dental	CHIP or Medicaid	0
Illinois		X		> 300		70-300		CHIP	12
Maine	X	X	> 200	> 200	102	250	CHIP	CHIP	0
Massachusetts		X		Any		0-64		More limited than CHIP	0
Minnesota		X		> 275		480		Medicaid	0
New Hampshire	X	X	300-400	300-400	130	205	More limited than CHIP	CHIP	3
New Jersey		X		> 350		144		CHIP	6
New York	X	X	208-250	> 400	97-152	115-238	CHIP	CHIP	0
North Carolina	X	X	200-235	200-225	197	177	CHIP	CHIP	0
Ohio		X		> 300		291-581		Medicaid	3
Oregon		X		> 300		230-371		More limited than CHIP	2
Pennsylvania	X	X	200-235	> 300	~132	~190	CHIP	CHIP	6
Tennessee		X		> 250		239		CHIP	3
Wisconsin		X		> 300		90		More limited than CHIP	3

Sources: Heberlein et al. 2011; Pernice and Bergman 2006.

Notes: CHIP=Children's Health Insurance Program; X=State offered program that year.

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Table A.6a. Premium Assistance Programs for Children, 2006 and 2010

	For Children	
	2006	2010
State	Number Enrolled	Number Enrolled
Arizona	NA	6
Arkansas	NA	NA
Colorado	NA	143
Idaho	332	114
Illinois	1,019	NA
Massachusetts	Not Reported	27,325
Michigan	NA	NA
Nevada	NA	NA
New Jersey	73	216
New Mexico	NA	NA
Oklahoma	NA	Not Reported
Oregon	NA	1,010
Utah	NA	Not Reported
Wisconsin	831	220
Totals	2,255	≥ 29,034

.

Sources: 2006 and 2010 CARTS data analyzed by Mathematica Policy Research.

Note: Questions analyzed: "Does your State offer an employer-sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds? For children? For adults? Under what authority? Briefly describe how your program operates. Number of children/adults ever enrolled during the reporting period."; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; N = number; NA = not applicable.

[a] According to CARTS data.

[b] New Mexico has a premium assistance program for children. However, it is not paid for using CHIP funds (New Mexico Human Services Department 2006, 2007).

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Table A.6b. Premium Assistance Programs for Adults, 2006 and 2010

	For Adults			
	2006		2010	
State	Covered Population	Number Enrolled	Covered Population	Number Enrolled
Arizona		NA	No	NA
Arkansas		NA	Parents and caretaker relatives	7,135
Colorado		NA	Parents and caretaker relatives	84
Idaho	Parents and caretaker relatives, childless adults	382	Parents and caretaker Relatives	343
Illinois	Parents and caretaker relatives	475		
Massachusetts	Childless adults	Not reported	Parents and Caretaker relatives	8,337
Michigan	Childless adults	82,000		
Nevada		NA	Parents and caretaker relatives	10
New Jersey	Parents and caretaker relatives	145	Parents and caretaker relatives	83
New Mexico		NA	Parents and caretaker relatives, pregnant women, childless adults	55,748
Oklahoma		NA	No	NA
Oregon		NA	No	NA
Utah		NA	Parents and caretaker relatives, childless adults, pregnant women	Not reported
Wisconsin	Parents and caretaker relatives	610	Parents and caretaker relatives	256
Totals	6	83,612	9	≥ 71,996

Sources: 2006 and 2010 CARTS data analyzed by Mathematica Policy Research.

Note: Questions analyzed: "Does your State offer an employer-sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds? For children? For adults? Under what authority? Briefly describe how your program operates. Number of children/adults ever enrolled during the reporting period."; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; N = number; NA = not applicable.

[a] According to CARTS data.

[b] New Mexico has a premium assistance program for children. However, it is not paid for using CHIP funds (New Mexico Human Services Department 2006, 2007).

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Table A.7. CHIP Modes of Application and Eligibility Determination Policies, FFYs 2006 and 2010

	Application Processes and Modes of Application										Eligibility Determination Policies			
	Eliminated Face-to-Face Interview Requirement		Joint Medicaid/ Separate CHIP Application		Phoned-In Application		Web-Based Application (application can be downloaded and mailed in)		Online Application (application can be submitted online)		Presumptive Eligibility		Express Lane Eligibilitya	
State	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2009	2010
Total	47	49	36	37	19	14	47	51	19	34	11	16	8	11
Medicaid-Expansion CHIP States														
Alaska	X	X	NA	NA			X	X						
District of Columbia		X	NA	NA			X	X						
Hawaii	X	X	NA	NA			X	X					[b]	[b]
Maryland*	X	X	NA	NA			X	X		X				X
Nebraska	X	X	NA	NA			X	X		X				
New Mexico	X	X	NA	NA			X	X			X	X		
Ohio	X	X	NA	NA		B	X	X		X		X		
South Carolina	X	X	NA	NA			X	X						
Separate CHIP States														
Alabama	X	X	X	X			X	X	X	X			[c]	[c]
Arizona	X	X	X	X	X		X	X		X			[b]	[b]
Colorado	X	X	X	X			X	X	X			X		
Connecticut	X	X	X	X	X	X	X	X						
Georgia	X	X		[d]	X	X	X	X	X	X				[e]
Kansas	X	X	X	X			X	X	X	[f]	X	X		
Mississippi			X	X			X	X						
Nevada	X	X					X	X	X	X				
New York	X	X	X	X			X	X			X	X		
Oregon	X	X	X	X			X	X		X				X
Pennsylvania	X	X	X	X	X	X	X	X	X	X				
Texas	X	X	X	X	X	X	X	X	X	X				
Utah	X	X	X	X	X	X	X	X	X	X				
Vermont	X	X	X	X			X	[g]		X				
Washington	X	X	X	X	X		X	X	X	X				
West Virginia	X	X	X	X	X	X	X	X	X	X				
Wyoming	X	X	X	X			X	X		X				

Table A.7 *(Continued)*

State	Application Processes and Modes of Application										Eligibility Determination Policies			
	Eliminated Face-to-Face Interview Requirement		Joint Medicaid/ Separate CHIP Application		Phoned-In Application		Web-Based Application (application can be downloaded and mailed in)		Online Application (application can be submitted online)		Presumptive Eligibility		Express Lane Eligibility[a]	
	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2006	2010	2009	2010
Combination States (S = in separate CHIP program only; M = in Medicaid-expansion CHIP program only; B = in both Medicaid-expansion CHIP and separate CHIP programs.)														
Arkansas	X	X	S				X	X		X				
California	X	X	S	[d]	X	X	X	X	X	X	X	X	[b]	[b]
Delaware[h]	X	X	S	S	X			X		X			[b]	
Florida	X	X	S	S			X	X	X	X		M[i]		
Idaho	X	X	S	S			X	X						
Illinois	X	X	S	S	X	X	X	X	X	X	X	X	[b]	[b]
Indiana	X	X	S	S	X	X	X	X		X				
Iowa	X	X	S	[d]			X	X	S	X		X		X
Kentucky		X	S	S	X			X						
Louisiana*	X	X		S	M	X	M	X		X			M[j]	M[j]
Maine	X	X	S	S	X		X	X			M			
Massachusetts	X	X	S	S	X		X	X	X	X[k]	X	X		
Michigan	X	X	S	S			X	X	X	X	X	X		
Minnesota	X	X	S	S		X		X						
Missouri*	X	X		S			M	X		X	M	M		
Montana*	X	X		S			S	X	NA	X				
New Hampshire	X	X	S	S			X	X		X[l]	M	M		
New Jersey	X	X	S	S			X	X	X	X	X	X	X	X
North Carolina	X	X	S	S			X	X						
North Dakota	X	X	S	S			X	X		X				
Oklahoma*	X	X		S	M		M	X		X				
Rhode Island	X	X	S	S			X	X						
South Dakota	X	X	S	S			X	X						
Tennessee[m]		[n]	-		-		-	X	-	X	-	S[o]		
Virginia	X	X	S	S	X	X	X	X	X	X				
Wisconsin	X	X	S	S	X	X	X	X	X	X		M		

Table A.7 *(Continued)*

Sources: FFY 2006, 2009, and 2010 CARTS reports, accessed June 2, 2011, Section 1, “Does your program require a face-to-face interview during initial application?”, “Is a joint application (i.e., the same, single application) used for your Medicaid and separate health program?”, and “Please check all the methods of application utilized by your State.” In Section IIIC, Subpart B, States are asked "Does the State provide presumptive eligibility to children who appear to be eligible for Medicaid and CHIP to enroll pending a full determination of eligibility?" and "11. Are you utilizing the Express Lane option in making eligibility determinations and/or renewals for both Medicaid and CHIP?"; State websites; Heberlein et al. 2011; Cohen Ross, Cox and Marks 2007.

Notes: CHIP=Children’s Health Insurance Program; CARTS=CHIP Annual Reporting Template System. *State changed program type between 2006 and 2010. Louisiana, Missouri, and Oklahoma had Medicaid-expansion CHIP programs, Maryland had a combination program, and Montana had a separate CHIP program in 2006; "-" denotes nonresponse by State; M=Policy used in State’s Medicaid-expansion CHIP program only; NA = not applicable; S=Policy used in the separate CHIP program only; X=State had policy in place.

[a] CARTS does not separate Express Lane Eligibility by program type. Express Lane Eligibility was not an option for States until 2009.

[b] State reported having an Express Lane Eligibility option in FFY 2009 and 2010 CARTS reports. However, it does not have an approved State Plan Amendment initiating the program. These States may have an ELE look-alike program in place.

[c] Alabama did not report having an Express Lane Eligibility option in FFY 2010 CARTS report. However, its State Plan Amendments initiating Express Lane Eligibility were approved on October 1, 2009, and April 1, 2010.

[d] California, Georgia, and Iowa utilize separate applications for CHIP and Medicaid, but both programs will accept the other's application. In California, the family must consent to the application transfer.

[e] Georgia's Express Lane Eligibility SPA was approved in early 2011.

[f] Kansas responded that its separate CHIP program allowed for online submission in 2010, but the form must be downloaded and printed, according to the State plan web site, accessed September 6, 2011.

[g] Vermont did not report having a separate CHIP web-based application available in 2010, but it is available according to Green Mountain Care 2011.

[h] Delaware did not submit a CARTS report in 2010. Where applicable, Delaware 2010 data were confirmed through its State website: Delaware DHSS 2009.

[i] Florida's Medicaid-expansion CHIP program offers presumptive eligibility to newborns through the birth month of the following year when born to a mother eligible for Medicaid on the date of the child’s birth, according to FFY 2010 CARTS report.

[j] Louisiana did not report having an Express Lane Eligibility option in FFY 2009 and 2010 CARTS reports. However, the State Plan Amendment was approved on October 10, 2009.

[k] In Massachusetts, online applications may only be submitted by authorized users, who are usually providers, according to FFY 2010 CARTS report.

[l] In New Hampshire, online submission of Medicaid-expansion CHIP applications is done only through providers with access to NH Easy, according to KFF 2011.

[m] Tennessee did not submit a CARTS report in 2006. Where applicable, Tennessee 2006 data were confirmed through Ross, Cox and Marks 2007.

[n] Tennessee did not report a face-to-face interview requirement in FFY 2010 CARTS report, but it is generally required in its Medicaid-expansion CHIP program according to the Tennessee DHS 2011.

[o] In Tennessee’s separate CHIP program, only newborns up to four months old and pregnant women are eligible for presumptive eligibility, according to FFY 2010 CARTS report.

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Table A.8. Documentation Required at Initial CHIP Application, FFYs 2006, 2007, and 2010

	Eliminated Assets Test		Income Documentation[a]		Citizenship Documentation[a]		Documentation of Insured Status[a]		Residency Documentation[a,b]	Documented Use of Income Disregards[a,b]
State	2006	2010	2007	2010	2007	2010	2007	2010	2010	2010
TOTAL (SD or SDIV, where applicable)	46	47	14	15	14	22	36	42	44	22
Medicaid-Expansion CHIP States										
Alaska	X	X	DR	DR	DR	SDIV	SD	SD	SD	DR
District of Columbia	X	X	DR	DR	DR	DR	-	SD	DR	DR
Hawaii	X	X	SD	SDIV	DR	DR	SD	SD	SD	SD
Maryland*	X	X	SD	SD	DR	DR	DR	DR	DR	DR
Nebraska	X	X	DR	DR	DR	DR	SD	DR[c]	SD[i]	DR
New Mexico	X	X	DR	DR	DR	DR	DR	SD	SD	DR
Ohio	X	X	DR	DR	DR	DR	DR	DR	SD	DR
South Carolina		[d]	DR	DR	DR	DR	SD	SD	SD	-
Separate CHIP States										
Alabama	X	X	SD	SD	SD	SDIV	SD	SDIV	SD	SD
Arizona	X	X	SD	SDIV	DR	DR	SD	SDIV	SD	-
Colorado	X	X	SD	DR	DR	DR	SD	SD	SD	SD
Connecticut	X	X	SD	SDIV	SD	SDIV	SD	SD	SD	SDIV
Georgia	X	X	DR	DR	DR	DR	SD	SDIV	SD	DR
Kansas	X	X	DR	DR	SD	SD	SD	DR[i]	SD[i]	-
Mississippi	X	X	DR	DR	DR	SDIV	DR	SD	SD	SD
Nevada	X	X	DR	DR	SD	SD	SD	SD	SD	-
New York	X	X	DR	DR	SD	SD	DR	DR	DR	-
Oregon		X	DR	DR	SD	DR	SD	SDIV	SD	SDIV
Pennsylvania	X	X	DR	DR	SD	SDIV	SD	SDIV	SD	SD
Texas		[e]	DR	DR	SD	DR	SD	DR	SD	DR
Utah	X	X	DR	DR	SD	DR	DR	DR	SD	DR
Vermont	X	X	SD	SD	SD	DR	SD	SD	SD	SD
Washington	X	X	DR	SDIV	DR	SDIV	SD	SD	SD	SDIV
West Virginia	X	X	DR	DR	SD	DR	DR	SDIV	SD	-
Wyoming	X	X	SD	SD	DR	DR	SD	SD	SD	SD
Combination States										
Arkansas		[f]	SD	SD	DR	SDIV	SD	SD	SD	SD
California	X	X	DR	DR	DR	DR	SD	SD	SD	DR
Delaware[g]	X	X	DR	DR	DR	DR	DR	SD	DR	-
Florida	X	X	DR	SDIV	SD	SDIV	SD	SD	SD	SD
Idaho	X	X	SD	SDIV	SD	SDIV	SD	SD	SD	-

Table A.8 (*Continued*)

State	Eliminated Assets Test		Income Documentation[a]		Citizenship Documentation[a]		Documentation of Insured Status[a]		Residency Documentation[a,b]	Documented Use of Income Disregards[a,b]
	2006	2010	2007	2010	2007	2010	2007	2010	2010	2010
Illinois	X	X	DR	DR	DR	SDIV	SD	SD	SD	DR
Indiana	X	X	DR	DR	DR	DR	SD	SDIV	SD	SD
Iowa	X	X	DR	DR	DR	DR	SD	SDIV	SDIV	DR
Kentucky	X	X	DR	DR	DR	DR	SD	SD	SD	DR
Louisiana*	X	X	DR	SDIV	DR	SDIV	SD	SDIV	SDIV	DR
Maine	X	X	DR	DR	DR	SDIV	DR	SDIV	SD	SDIV
Massachusetts	X	X	DR	DR	DR	DR	SD	SDIV	SDIV	-
Michigan	X	X	SD	SD	DR	SD	SD	SD	SD	SD
Minnesota	X	X	DR	DR	DR	SDIV	DR	DR	SD	SD
Missouri*	X	[h]	DR	DR	DR	DR	SD	SD	SD	-
Montana*	X	X	SD	DR	SD	SDIV	SD	SDIV	SD	SD
New Hampshire	X	X	DR	DR[i]	DR	DR[i]	DR	DR[i]	DR[i]	-
New Jersey	X	X	DR	SDIV	DR	SDIV	DR	SDIV	SD	SDIV
North Carolina	X	X	DR	DR	DR	DR	SD	SD	DR	SDIV
North Dakota	X	X	DR	DR	DR	DR	SD	SD	SD	DR
Oklahoma*	X	X	-	DR	-	DR	-	SDIV	SD	SDIV
Rhode Island	X	X	DR	DR	DR	DR	SD	SD	DR	DR
South Dakota	X	X	DR	DR	DR	SDIV	SD	SDIV	SD	DR
Tennessee[c]	-	X	SD	SD	DR	DR	SD	SD	SD	SD
Virginia	X	X	DR	DR	DR	SDIV	SD	SD	SD	SD
Wisconsin	X	X	SD	DR	DR	SDIV	DR	SDIV	SDIV	DR

Sources: FFY 2006, 2007, and 2010 CARTS reports, accessed June 2, 2011, Section 1, States are asked "Does your program require an assets test?" and “Indicate what documentation is required at initial application.”; State web sites 2011; Heberlein et al. 2011.

Notes: CHIP=Children’s Health Insurance Program; CARTS=CHIP Annual Reporting Template System.*State changed program type between 2006 and 2010. Louisiana, Missouri, and Oklahoma had Medicaid-expansion CHIP programs, Maryland had a combination program, and Montana had a separate CHIP program in 2006; "-" denotes nonresponse by State; DR = documentation required; SD = self-declaration; SDIV = self-declaration with internal verification; X=State had policy in place.

[a] States are asked whether applicants can self-declare, self declare with internal verification, or are required to provide documentation. These variables are not split by program type in CARTS reports

[b] Documentation required for Residency and Use of Income Disregards was asked only on the FFY 2010 CARTS questionnaire.

[c] Tennessee did not submit a FFY 2006 CARTS report.

[d] In South Carolina's 2010 Medicaid-expansion CHIP program, countable resources may not total more than $30,000.

[e] In Texas' 2010 Medicaid-expansion CHIP and separate CHIP programs, those with incomes above 150% of the FPL may not have assets that exceed specified limits (after certain allowances are made).

[f] In Arkansas' 2010 separate CHIP program, assets must be less than $3,000 for a household size of 2, with $100 per additional individual.

[g] Delaware did not submit a FFY 2010 CARTS report. Where applicable, Delaware FFY 2010 data were confirmed through Delaware DHSS 2009.

[h] In Missouri's 2010 separate CHIP program, net worth must be below $250,000 to be eligible.

[i] New Hampshire did not submit a FFY 2010 CARTS report. Information gathered from NH Healthy Kids 2011.

Table A.9 Number of Children Enrolled in CHIP from FFY 1998 Through FFY 2010, by State (alphabetically listed)

State	Type of CHIP Program (2010)	Number of Children Ever Enrolled in CHIP Programs													Change from 2006 to 2010	
		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Number of Children	Percentage
Total		660,351	1,966,716	3,358,417	4,597,614	5,336,508	5,883,155	6,111,038	6,159,844	6,755,199	7,105,986	7,355,746	7,695,264	7,705,723	950,524	14.1
Number of States Reporting		28	46	51	51	51	49	50	50	50	51	51	51	51	51	51
Alabama	Separate	8,492[a]	39,455[b]	37,587	49,008	66,027[c]	78,554	79,407	81,856	84,257	106,691	110,821	110,158	137,545	53,288	63.2
Alaska	Medicaid exp.	--	8,033[a]	13,413	21,831	22,306	22,934	21,966	22,322	20,432	17,558	18,707	11,655	12,473	-7,959	-39.0
Arizona	Separate	--	26,870[b]	59,601	86,863	92,673	90,468	87,681	88,005	96,669	104,209	112,072	66,275	39,589	-57,080	-59.0
Arkansas	Combo	--	913[a]	1,892	2,884	1,912	--	799[b]	1,214	89,238	89,642	93,446	101,312	100,770	11,532	12.9
California	Combo	18,713[a,b]	229,461	484,359	697,306	861,445	955,152	1,035,752	1,223,475	1,391,405	1,538,416	1,692,087	1,748,135	1,731,605	340,200	24.5
Colorado	Separate	14,847[b]	24,116	34,889	45,773	51,826	74,144	57,244	59,530	69,997	84,649	99,555	102,395	106,643	36,646	52.4
Connecticut	Separate	6,649 [a,b]	14,728	19,925	18,632	20,500	20,971[c]	21,438	22,289	23,301	23,632	22,320	21,874	21,033	-2,268	-9.7
Delaware	Combo	--	2,433[b]	4,474	5,567	9,719[a]	9,903	10,250	10,354	10,751	11,143	11,192	12,599	12,852	2,101	19.5
District of Columbia	Medicaid exp.	--	2,180[a, d]	2,264	2,807	5,060	5,875	6,093	6,631	6,332	6,566	8,746	9,260	8,100	1,768	27.9
Florida	Combo	27,435[a,b]	154,594	227,463	298,705	368,180	443,177	419,707	384,801	303,595	323,529	354,385	417,414	403,349	99,754	32.9
Georgia	Separate	--	--	120,626[b]	182,762	221,005	251,711	280,083	306,733	343,690	356,285	311,243	254,365	248,268	-95,422	-27.8
Hawaii	Medicaid exp.	--	--	341[a]	7,137	8,474	16,526	19,237	20,602	22,031	23,958	28,803	24,691	27,256	5,225	23.7
Idaho	Combo	--	8,482[a]	12,449	16,896	16,895	16,877	19,054[b]	21,839	24,727	33,060	43,526	44,319	42,208	17,481	70.7
Illinois	Combo	27,780[a]	42,699[b]	62,507	63,043 [d,e]	68,032	135,609	234,027	281,432	316,781	345,576	356,460	376,618	329,104	12,323	3.9
Indiana	Combo	21,172[a]	31,246	44,373[b]	56,986	66,225	73,762	80,698	129,544	133,696	130,368	124,954	142,665	141,497	7,801	5.8
Iowa	Combo	4,798[a]	13,288[b]	19,958	28,636	34,506	37,060	41,636	46,562	49,575	50,238	50,390	52,608	63,985	14,410	29.1
Kansas	Separate	--	14,443[b]	26,306	34,279	40,838	45,662	44,350	47,323	48,934	49,536	51,173	48,090	56,384	7,450	15.2
Kentucky	Combo	3[a]	415	55,593[b]	68,273	94,608	94,053	94,500	63,728	65,290	70,197	72,360	73,143	79,380	14,090	21.6
Louisiana	Combo	--	21,580[a]	49,995	79,261[d]	74,654	104,908	105,580	146,347	142,389	154,286[b]	164,998	170,082	157,012	14,623	10.3
Maine	Combo	3,204[a,b]	13,657	22,742	27,003	22,586	29,474	29,171	30,654	31,114	31,037	30,947	31,349	32,994	1,880	6.0
Maryland	Medicaid exp.	27,880[a]	69,452	93,081	109,983[b]	125,180	130,161	111,488	120,316	136,034	132,887[f]	132,864	124,622	118,944	-17,090	-12.6
Massachusetts	Combo	17,528[a,b]	67,852	113,034	108,308	119,732	128,790	166,508	162,679	201,037	184,483	200,950	143,044	142,279	-58,758	-29.2
Michigan	Combo	6,226[a,b]	41,145	55,375	76,181	71,882	77,467	87,563	89,257	118,501	64,771	67,763	72,035	69,796	-48,705	-41.1
Minnesota	Combo	--	19[a]	24	49	49	4,366[b]	4,784	5,076	5,343	5,408	5,621	5,470	5,164	-179	-3.4
Mississippi	Separate	5,477[a]	13,218	12,156 [b]	52,436	64,805	75,010[c]	82,900	79,352	83,359	81,565	84,370	86,839	95,556	12,197	14.6
Missouri	Combo	10,809[a]	49,529	73,825	106,954	150,533	150,954	176,014	115,355	106,577	81,764[b]	88,911	103,709	86,261	-20,316	-19.1
Montana	Combo	--	1,019[b]	8,317	13,518	13,875	13,084	15,281	15,841	17,304	20,115	22,679	25,749	25,231[a]	7,927	45.8
Nebraska	Medicaid exp.	2,119[a]	9,713	11,400	13,933	16,227	45,490	44,646	44,706	44,981	46,199	49,185	48,139	47,922	2,941	6.5
Nevada	Separate	--	7,573[b]	15,946	28,026	37,878	47,183	38,519	39,316	39,317	41,862	38,592	33,981	31,554	-7,763	-19.7

Table A.9 (*Continued*)

State	Type of CHIP Program (2010)	Number of Children Ever Enrolled in CHIP Programs													Change from 2006 to 2010	
		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Number of Children	Percentage
New Hampshire	Combo	--	4,554[a,b]	4,272	5,982	8,138	9,893	10,969	11,892	12,393	12,088	12,236	13,197	10,630	-1,763	-14.2
New Jersey	Combo	16,810 [a,b]	50,551	89,034	99,847	117,053	119,272	127,244	129,591	142,805	150,277	151,805	167,009	187,211	44,406	31.1
New Mexico	Medicaid exp.	--	1,942[a]	7,971	10,347	19,940	18,841	20,804	24,310	25,155	16,525	14,944	11,169	9,654	-15,501	-61.6
New York	Separate	279,917[b]	519,401[a]	769,457	872,949	807,145[g]	795,111[g]	765,030	618,973[c,g]	688,362	651,853	517,256	532,635	539,614	-148,748	-21.6
North Carolina	Combo	--	59,542[b]	103,567	99,995	120,378	150,444	174,434	196,181	248,366 [a]	240,152	253,112	259,652	253,892	5,526	2.2
North Dakota	Combo	--	266[e]	2,573 [b]	3,404	4,463	4,953	5,137	5,725	6,318	5,469	7,617	6,983	7,192	874	13.8
Ohio	Medicaid exp.	49,565[a]	83,688	118,290	162,446	183,034	207,854	220,190	216,495	221,643	231,538	251,278	265,680	253,711	32,068	14.5
Oklahoma	Combo	17,538[a]	41,900	57,719	38,858	84,490	91,914	100,761	108,100	116,012	117,084	117,507[b]	123,681	122,874	6,862	5.9
Oregon	Separate	6,488[b]	27,285	37,092	41,468	42,976	44,752	46,720	52,722	59,039	63,090	73,686	51,835	64,727	5,688	9.6
Pennsylvania	Separate	--	81,758[b]	119,710	141,163	148,689	160,015	177,415	179,807	188,765	227,367	256,627	264,847	273,221	84,456	44.7
Rhode Island	Combo	2,030[a]	4,907	11,539	17,398	19,515	24,505 [b]	25,573	27,144	25,492	26,067	26,031	19,596	23,253	-2,239	-8.8
South Carolina	Medicaid exp.	43,074[a]	56,819	60,415	66,183	66,591	90,764	75,597	80,646	68,870	59,920	73,620[b]	85,046	73,438[f]	4,568	6.6
South Dakota	Combo	1,047[a]	3,191	5,888 [b]	9,043	11,233	12,288	13,397	14,038	14,584	14,982	15,277	15,249	15,872	1,288	8.8
Tennessee	Combo	12,662[a]	17,291	14,861	8,615	10,216[c]	--	--	--	--	41,363[a,b]	63,619	83,333	81,341	39,978[h]	96.7
Texas	Separate	25,176[a]	50,878[b]	131,096	501,167	727,459[g]	726,428	650,856	526,406	585,461	710,690	731,916	869,867	928,483	343,022	58.6
Utah	Separate	2,752[b]	14,898	25,294	34,655	33,808	37,766	38,693	43,931	51,967	44,785	51,092	59,806	62,071	10,104	19.4
Vermont	Separate	--	--	4,081[b]	5,352	6,162	6,541	6,693	6,614	6,519	6,132	6,496	7,092	7,026	507	7.8
Virginia	Combo	--	18,826[b]	37,681	73,102	67,974[a]	83,716	99,569	124,055	137,182	144,163	155,289	167,589	173,515	36,333	26.5
Washington	Separate	--	--	2,616[b]	7,621	8,754	9,571	25,256	24,176	25,005	23,136	27,657	27,415	35,894	10,889	43.5
West Virginia	Separate	160[a]	7,957[b]	21,659	33,144[c]	35,949	35,320	36,906	38,614	39,855	38,582	37,645	38,200	37,539	-2,316	-5.8
Wisconsin	Combo	--	12,949[a]	47,140	57,183	59,850	68,641	67,893	57,165	57,034	62,523[b]	52,940	153,917	161,469	104,435	183.1
Wyoming	Separate	--	--	2,547[b]	4,652	5,059	5,241	5,525	6,120	7,715	8,570	8,976	8,871	8,342	627	8.1

Source: CMS' CHIP Statistical Enrollment Data System (SEDS).

Notes: The enrollment data shown for FFYs 1998 to 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 to 2010 are annual data from CMS' SEDS as of February 18, 2011, verified and provided by CMS. In cases where States did not report annual ever-enrolled data, ever-enrolled data from the quarter with the highest enrollment that year were used to approximate annual enrollment (Ellwood et al. 2003). CHIP=Children's Health Insurance Program; Combo = Combination CHIP program; Medicaid exp. = Medicaid-expansion CHIP program; Separate = Separate CHIP program; "--" denotes that the State did not report enrollment in SEDS for that fiscal year.

[a] State implemented a Medicaid-expansion CHIP program.

[b] State implemented a separate CHIP program.

[c] State eliminated its Medicaid-expansion CHIP program.

[d] State did not report annual ever-enrolled Medicaid-expansion CHIP data. The enrollment count shown is based on the highest quarterly ever-enrolled Medicaid-expansion CHIP count reported by the State for that federal fiscal year (FFY).

[e] State did not report annual ever-enrolled separate CHIP data. The enrollment count shown is based on the highest quarterly ever-enrolled separate CHIP count reported by the State for that FFY.

[f] State eliminated its separate CHIP program.

[g] State did not report annual or quarterly Medicaid-expansion CHIP data. Therefore, the ever-enrolled count shown is for the State's separate CHIP program only.

[h] Tennessee has no recorded enrollees for 2006. The absolute and percentage difference in enrollment reported is for 2007 to 2010.

Table A.10. Number of Children Enrolled in CHIP from FFY 1998 Through FFY 2010, by State and Program Type

State	Number of Children Ever Enrolled in CHIP Programs													Change from 2006 to 2010	
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Number of Children	Percentage
Total	660,351	1,966,716	3,358,417	4,597,614	5,336,508	5,883,155	6,111,038	6,159,844	6,755,199	7,105,986	7,355,746	7,695,264	7,705,723	950,524	14.1
Number of States Reporting	28	46	51	51	51	49	50	50	50	51	51	51	51	51	51
Medicaid-Expansion CHIP States															
Alaska	--	8,033[a]	13,413	21,831	22,306	22,934	21,966	22,322	20,432	17,558	18,707	11,655	12,473	-7,959	-39.0
District of Columbia	--	2,180[a, b]	2,264	2,807	5,060	5,875	6,093	6,631	6,332	6,566	8,746	9,260	8,100	1,768	27.9
Hawaii	--	--	341[a]	7,137	8,474	16,526	19,237	20,602	22,031	23,958	28,803	24,691	27,256	5,225	23.7
Maryland	27,880[a]	69,452	93,081	109,983 [c]	125,180	130,161	111,488	120,316	136,034	132,887 [d]	132,864	124,622	118,944	-17,090	-12.6
Nebraska	2,119[a]	9,713	11,400	13,933	16,227	45,490	44,646	44,706	44,981	46,199	49,185	48,139	47,922	2,941	6.5
New Mexico	--	1,942[a]	7,971	10,347	19,940	18,841	20,804	24,310	25,155	16,525	14,944	11,169	9,654	-15,501	-61.6
Ohio	49,565[a]	83,688	118,290	162,446	183,034	207,854	220,190	216,495	221,643	231,538	251,278	265,680	253,711	32,068	14.5
South Carolina	43,074[a]	56,819	60,415	66,183	66,591	90,764	75,597	80,646	68,870	59,920	73,620[c]	85,046	73,438 [d]	4,568	6.6
Separate CHIP States															
Alabama	8,492 [a]	39,455 [c]	37,587	49,008	66,027[e]	78,554	79,407	81,856	84,257	106,691	110,821	110,158	137,545	53,288	63.2
Arizona	--	26,870 [c]	59,601	86,863	92,673	90,468	87,681	88,005	96,669	104,209	112,072	66,275	39,589	-57,080	-59.0
Colorado	14,847 [c]	24,116	34,889	45,773	51,826	74,144	57,244	59,530	69,997	84,649	99,555	102,395	106,643	36,646	52.4
Connecticut	6,649 [a,c]	14,728	19,925	18,632	20,500	20,971[e]	21,438	22,289	23,301	23,632	22,320	21,874	21,033	-2,268	-9.7
Georgia	--	--	120,626[c]	182,762	221,005	251,711	280,083	306,733	343,690	356,285	311,243	254,365	248,268	-95,422	-27.8
Kansas	--	14,443[c]	26,306	34,279	40,838	45,662	44,350	47,323	48,934	49,536	51,173	48,090	56,384	7,450	15.2
Mississippi	5,477[a]	13,218	12,156 [c]	52,436	64,805	75,010[e]	82,900	79,352	83,359	81,565	84,370	86,839	95,556	12,197	14.6
Nevada	--	7,573[c]	15,946	28,026	37,878	47,183	38,519	39,316	39,317	41,862	38,592	33,981	31,554	-7,763	-19.7
New York	279,917[c]	519,401[a]	769,457	872,949	807,145[f]	795,111[f]	765,030	618,973 [e,f]	688,362	651,853	517,256	532,635	539,614	-148,748	-21.6
Oregon	6,488[c]	27,285	37,092	41,468	42,976	44,752	46,720	52,722	59,039	63,090	73,686	51,835	64,727	5,688	9.6
Pennsylvania	--	81,758[c]	119,710	141,163	148,689	160,015	177,415	179,807	188,765	227,367	256,627	264,847	273,221	84,456	44.7
Texas	25,176[a]	50,878[c]	131,096	501,167	727,459[e]	726,428	650,856	526,406	585,461	710,690	731,916	869,867	928,483	343,022	58.6
Utah	2,752[c]	14,898	25,294	34,655	33,808	37,766	38,693	43,931	51,967	44,785	51,092	59,806	62,071	10,104	19.4
Vermont	--	--	4,081[c]	5,352	6,162	6,541	6,693	6,614	6,519	6,132	6,496	7,092	7,026	507	7.8
Washington	--	--	2,616[c]	7,621	8,754	9,571	25,256	24,176	25,005	23,136	27,657	27,415	35,894	10,889	43.5
West Virginia	160[a]	7,957[c]	21,659	33,144 [e]	35,949	35,320	36,906	38,614	39,855	38,582	37,645	38,200	37,539	-2,316	-5.8
Wyoming	--	--	2,547[c]	4,652	5,059	5,241	5,525	6,120	7,715	8,570	8,976	8,871	8,342	627	8.1
Combination States															
Arkansas	--	913[a]	1,892	2,884	1,912	--	799[c]	1,214	89,238	89,642	93,446	101,312	100,770	11,532	12.9
California	18,713[a,c]	229,461	484,359	697,306	861,445	955,152	1,035,752	1,223,475	1,391,405	1,538,416	1,692,087	1,748,135	1,731,605	340,200	24.5

Table A.10 (*Continued*)

State	Number of Children Ever Enrolled in CHIP Programs													Change from 2006 to 2010	
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Number of Children	Percentage
Delaware	--	2,433[c]	4,474	5,567	9,719[a]	9,903	10,250	10,354	10,751	11,143	11,192	12,599	12,852	2,101	19.5
Florida	27,435[a,c]	154,594	227,463	298,705	368,180	443,177	419,707	384,801	303,595	323,529	354,385	417,414	403,349	99,754	32.9
Idaho	--	8,482[a]	12,449	16,896	16,895	16,877	19,054[c]	21,839	24,727	33,060	43,526	44,319	42,208	17,481	70.7
Illinois	27,780[a]	42,699[c]	62,507	63,043[b,g]	68,032	135,609	234,027	281,432	316,781	345,576	356,460	376,618	329,104	12,323	3.9
Indiana	21,172[a]	31,246	44,373[c]	56,986	66,225	73,762	80,698	129,544	133,696	130,368	124,954	142,665	141,497	7,801	5.8
Iowa	4,798[a]	13,288[c]	19,958	28,636	34,506	37,060	41,636	46,562	49,575	50,238	50,390	52,608	63,985	14,410	29.1
Kentucky	3[a]	415	55,593[c]	68,273	94,608	94,053	94,500	63,728	65,290	70,197	72,360	73,143	79,380	14,090	21.6
Louisiana	--	21,580[a]	49,995	79,261[b]	74,654	104,908	105,580	146,347	142,389	154,286[c]	164,998	170,082	157,012	14,623	10.3
Maine	3,204[a,c]	13,657	22,742	27,003	22,586	29,474	29,171	30,654	31,114	31,037	30,947	31,349	32,994	1,880	6.0
Massachusetts	17,528[a,c]	67,852	113,034	108,308	119,732	128,790	166,508	162,679	201,037	184,483	200,950	143,044	142,279	-58,758	-29.2
Michigan	6,226[a,c]	41,145	55,375	76,181	71,882	77,467	87,563	89,257	118,501	64,771	67,763	72,035	69,796	-48,705	-41.1
Minnesota	--	19[a]	24	49	49	4,366[c]	4,784	5,076	5,343	5,408	5,621	5,470	5,164	-179	-3.4
Missouri	10,809[a]	49,529	73,825	106,954	150,533	150,954	176,014	115,355	106,577	81,764[c]	88,911	103,709	86,261	-20,316	-19.1
Montana	--	1,019[c]	8,317	13,518	13,875	13,084	15,281	15,841	17,304	20,115	22,679	25,749	25,231[a]	7,927	45.8
New Hampshire	--	4,554[a,c]	4,272	5,982	8,138	9,893	10,969	11,892	12,393	12,088	12,236	13,197	10,630	-1,763	-14.2
New Jersey	16,810[a,c]	50,551	89,034	99,847	117,053	119,272	127,244	129,591	142,805	150,277	151,805	167,009	187,211	44,406	31.1
North Carolina	--	59,542[c]	103,567	99,995	120,378	150,444	174,434	196,181	248,366[a]	240,152	253,112	259,652	253,892	5,526	2.2
North Dakota	--	266[a]	2,573[c]	3,404	4,463	4,953	5,137	5,725	6,318	5,469	7,617	6,983	7,192	874	13.8
Oklahoma	17,538[a]	41,900	57,719	38,858	84,490	91,914	100,761	108,100	116,012	117,084	117,507[c]	123,681	122,874	6,862	5.9
Rhode Island	2,030[a]	4,907	11,539	17,398	19,515	24,505 [c]	25,573	27,144	25,492	26,067	26,031	19,596	23,253	-2,239	-8.8
South Dakota	1,047[a]	3,191	5,888[c]	9,043	11,233	12,288	13,397	14,038	14,584	14,982	15,277	15,249	15,872	1,288	8.8
Tennessee	12,662[a]	17,291	14,861	8,615	10,216[e]	--	--	--	--	41,363[a,c]	63,619	83,333	81,341	39,978[d]	96.7
Virginia	--	18,826[c]	37,681	73,102	67,974[a]	83,716	99,569	124,055	137,182	144,163	155,289	167,589	173,515	36,333	26.5
Wisconsin	--	12,949[a]	47,140	57,183	59,850	68,641	67,893	57,165	57,034	62,523[c]	52,940	153,917	161,469	104,435	183.1

Source: CMS' CHIP Statistical Enrollment Data System (SEDS).

Notes: The enrollment data shown for FFYs 1998 to 2008 are annual data from CMS' SEDS, accessed August 23, 2011. The enrollment data shown for FFYs 2009 to 2010 are annual data from CMS' SEDS as of February 18, 2011, verified and provided by CMS. In cases where States did not report annual ever-enrolled data, ever-enrolled data from the quarter with the highest enrollment that year were used to approximate annual enrollment (Ellwood et al. 2003). Program Type as of FFY 2010. CHIP=Children's Health Insurance Program. "--" denotes that the State did not report enrollment in SEDS for that fiscal year.

[a] State implemented a Medicaid-expansion CHIP program.

[b] State did not report annual ever-enrolled Medicaid-expansion CHIP data. The enrollment count shown is based on the highest quarterly ever-enrolled Medicaid-expansion CHIP count reported by the State for that federal fiscal year (FFY).

[c] State implemented a separate CHIP program.

[d] State eliminated its separate CHIP program.

[e] State eliminated its Medicaid-expansion CHIP program.

[f] New York had a Medicaid-expansion CHIP program in place between FFY 1999 and 2005. Enrollment data for New York's Medicaid-expansion CHIP program were not available in SEDS for FFYs 2002, 2003, and 2005.

[g] State did not report annual ever-enrolled separate CHIP data. The enrollment count shown is based on the highest quarterly ever-enrolled separate CHIP count reported by the State for that FFY.

[h] Tennessee has no recorded enrollees for FFY 2006. The absolute and percentage difference in enrollment reported is for FFYs 2007 to 2010.

Table A.11. State Renewal Policies and Procedures

State	Eligibility and Renewal Periods			Renewal Procedures								
	Continuous Coverage (If yes, number of months)		Frequency of Renewal (Months)[a]	Prepopulated Renewal Form Sent to Family		Passive Renewal (Response not required)		Income Documentation Not Required[a]	Elimination of Face-to-Face Interviews	Renewal by Telephone[a]	Online Renewal[a]
	2006 (N=50)	2010 (N=51)	Jan 2010 (N=51)	2006 (N=51)	2010 (N=50)	2006 (N=51)	2010 (N=51)	Jan 2011 (N=51)	2010 (N=49)	Jan 2011 (N=51)	Jan 2011 (N=51)
Number of States	33	36	51	29	32	5	6	20	49	15	19
Medicaid Expansion States											
Alaska	6	12	12	X	X				X		
District of Columbia			12	X	X				X		
Hawaii			12	X	X	X	X	X	X		
Maryland*	6		12	X	X			X	X		
Nebraska	6	6	12	X	X				X		X
New Mexico		12	12		X			X	X	X	
Ohio	12	12	12					X	X	X	X
South Carolina	12	12	12						X		
Separate CHIP States											
Alabama	12	12	12	X	X			X	X		X
Arizona	12	[b]	12	X	X				X	X	X
Colorado	12	12	12	X	X			X	X	X	
Connecticut			12	X	X			X	X		
Georgia			12	X		X			X		
Kansas	12	12	12		X[c]		X		X		
Mississippi	X[d]	12	12								
Nevada	12	12	12	X	X				X		
New York	12	12	12					X	X		
Oregon	12	12	12						X	X	
Pennsylvania	12	12[e]	12	X	X				X	X	X
Texas	6	12[f]	12	X	X				X		X
Utah	12	12	12	X	X	X	X	X	X	X	
Vermont			12					X	X		X
Washington		12	12	X				X	X	X	X
West Virginia	12	12	12	X	X			X	X		X
Wyoming	12	12	12		X			X	X	X	X

Table A.11 (*Continued*)

State	Eligibility and Renewal Periods			Renewal Procedures							
	Continuous Coverage (If yes, number of months)		Frequency of Renewal (Months)[a]	Prepopulated Renewal Form Sent to Family		Passive Renewal (Response not required)		Income Documentation Not Required[a]	Elimination of Face-to-Face Interviews	Renewal by Telephone[a]	Online Renewal[a]
	2006 (N=50)	2010 (N=51)	Jan 2010 (N=51)	2006 (N=51)	2010 (N=50)	2006 (N=51)	2010 (N=51)	Jan 2011 (N=51)	2010 (N=49)	Jan 2011 (N=51)	Jan 2011 (N=51)
Combination States (S = in Separate CHIP program only; M = in Medicaid-expansion CHIP program only; B = in both Medicaid expansion and Separate CHIP programs.)											
Arkansas[g]	M(12)	M(12)[h]	M(12)					M	B		
California	B(12)	B(12)	B(12)	S	S[i]				B	[i]	[i]
Delaware	S(12)	S(12)	B(12)		--				B	B	
Florida	B(12)	B(12)	B(12)	B	B			B	B		B
Idaho	B(12)	B(12)	B(12)	B	B			B	B		
Illinois	B(12)	B(12)	B(12)	B	B	B	B		B	B	
Indiana		B(12)[j]	B(12)						B		
Iowa	S(12)	B(12)	B(12)	S	S				B		S
Kentucky			B(12)	B	B				B		
Louisiana*	B(12)	B(12)	B(12)						B	B	B
Maine	B(12)	B(12)	B(12)	B	B				B		
Massachusetts			B(12)						B	B	
Michigan	B(12)	B(12)	B(12)					B	B		B
Minnesota[g]	S(10)	S(11)[k]	B(12)[k]						B		
Missouri*			B(12)						B		
Montana*	B(12)	B(12)	B(12)		B				B	B	
New Hampshire			B(12)						B		
New Jersey	B(12)	B(12)	B(12)	B	B		B		B		
North Carolina	B(12)	B(12)	B(12)						B		
North Dakota	S(12)	B(12)	B(12)	B	B				B		S
Oklahoma*[g]			M(12)	M	B			B	B		B
Rhode Island[g]			M(12)	B	M				B		
South Dakota			B(12)						B		
Tennessee		S(12)	B(12)	S	S	B	S	S	B		B
Virginia		S(12)[l]	B(12)	S	S			B	B		S
Wisconsin[g]			M(12)		B				--	M	M

Table A.11 (*Continued*)

Sources: FFY 2010 CARTS reports, accessed June 2, 2011, and August 25, 2011, Section 1, “Does your program provide a period of continuous coverage regardless of income changes? Specify number of months,” “Is a preprinted renewal form sent prior to eligibility expiring?” “If yes, check either (1) We send out form to family with their information pre-completed and ask for confirmation, or (2) We send out form but do not require a response unless income or other circumstances have changed”; and Section IIIC. Subpart B: “Has the State eliminated an in-person requirement for renewal of CHIP eligibility?”; Heberlein et al. 2011; Cohen Ross, Cox and Marks 2007.

Notes: CHIP=Children’s Health Insurance Program; CARTS=CHIP Annual Reporting Template System; Combo=combination program; "--" denotes nonresponse or insufficient information provided by State; *State changed program type between FFYs 2006 and 2010. Louisiana, Missouri, and Oklahoma had Medicaid-expansion CHIP programs, Maryland had a combination program, and Montana had a separate CHIP program in FFY 2006. North Carolina had a combination program in FFYs 2008 and 2009 only.

[a] Information was not available in CARTS reports. Data were obtained from Heberlein et al. 2011.

[b] Arizona provides continuous coverage for the first year of coverage only. Source: Heberlein et al. 2011.

[c] Response inferred based on implementation of passive renewal policy.

[d] Mississippi confirmed in its CARTS report that it uses a continuous coverage policy, but did not specify a number of months.

[e] Pennsylvania’s Medicaid program has a 12-month renewal period, but income is reviewed every 6 months for some enrollee groups, excluding children in foster care, pregnant women, and families whose only enrollee is younger than one year old.

[f] In Texas, continuous coverage applies only to those families below 185 percent of the FPL. Other families are required to verify income eligibility every six months.

[g] Separate CHIP program covers pregnant women only. Renewal policies, as they pertain to separate CHIP, may therefore not be applicable.

[h] In Arkansas, children from families whose incomes are above 133% of the FPL and who younger than 6 years of age, and those above 100% of the FPL and older than 6 years of age receive 12 months of continuous eligibility.

[l] The use of preprinted renewal forms and telephone and online renewals varies by county in California.

[j] In Indiana, only children younger than 3 years of age are eligible for 12 months of continuous coverage.

[k] In Minnesota, children and parents who qualify under the State's Section 1115 expansion program have eligibility reviewed at 12 month intervals. All other enrollees are subject to income reviews every 6 months and eligibility reviews every 12 months.

[l] In Virginia, children covered under CHIP receive12 months of continuous coverage unless the family's income exceeds the program's income-eligibility guideline or the family leaves the State.

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Table A.12. State Renewal Policies and Procedures

State	Communication Strategies					Premium Payment Policies			
	Renewal Reminder Notices Sent (If yes, number of notices sent)		Number of Days Before First Expiration Notice Is Sent	Follow-Up with Families by Outreach Workers		Premium or Enrollment Fees Required		Grace Period for Nonpayment[a,b]	Lock-Out Period[a,c]
	2006 (N=50)	2010 (N=50)	2010	2006 (N=50)	2010 (N=50)	2006 (N=51)	2010 (N=51)	Jan 2011 (N=29)	Jan 2011 (N=28)
Number of States	47	46		24	26	31	34	28	14
Medicaid-Expansion CHIP States									
Alaska	2	2	45					NA	NA
District of Columbia	2	3	--	X	X			NA	NA
Hawaii			NA		X			NA	NA
Maryland*	2	2	--	X	X	X[e]	X	45 days	6 months
Nebraska	2	2	30		X			NA	NA
New Mexico	2	2	45					NA	NA
Ohio	1	≥ 1	20	X	X			NA	NA
South Carolina	2		NA	X				NA	NA
Separate CHIP States									
Alabama	2	1	30			X	X[f]	NA	NA
Arizona	2		NA	X		X	X	60 days	
Colorado	1	≥ 1	60	X		X	X[f]	NA	NA
Connecticut	1	≥ 1	--		X	X	X	30 days	3 months
Georgia	1	3	--			X	X	30 days	1 month
Kansas	3	≥ 1	--			X	X	12 months	
Mississippi	2-3	3-4	90	X				NA	NA
Nevada	2	2-3	60	X		X	X	60 days	
New York	≥ 2	~4	90	X	X	X	X	30 days	
Oregon	2	2	45					NA	NA
Pennsylvania	3	3	90	X	X		X	30 days	6 months
Texas	3	3[g]	~105	X	X	X	X[f]	NA	NA
Utah	2		NA			X	X	30 days	--
Vermont	1	3	42			X	X	30 days[h]	
Washington	2	3	35		X	X	X	90 days	3 months
West Virginia	2	2	60				X	30 days	6 months
Wyoming	3	3	60					NA	NA
Combination States (S = in separate CHIP program only; M = in Medicaid-expansion CHIP program only; B = in both Medicaid expansion and separate CHIP programs.)									
Arkansas[d]	B(2)	B(≤ 3)	~69					NA	NA
California	B(≥ 3)	B(≥ 3)	60	B	B	S	S	S (60 days)	
Delaware	B(1)	--	90	B	--	S	S	S (60 days)	
Florida	B(2)	B(2)	--	B	B	S	S	S (30 days)	S (1 month)
Idaho	B(2)	B(1)	≥45		B	S	S	S (60 days)	
Illinois		B(2)	70		B	S	S	S (60 days)	S (3 months)
Indiana	B(3)	B(1)[i]	--			S	S	S (60 days)	
Iowa	B(3)	B(4)	67			S	S	S (30 days)	
Kentucky	B(2)	B(2)	~15	B		S		NA	NA
Louisiana*	B(2)	B(2)	~15	B	B		S	S (60 days)	
Maine	B(2)	B(1)	~42			S	S	S (12 months)	S (≤3 months)[j]
Massachusetts	B(2)	B(1)	--		B	B	S	S (60 days)	

Table A. 12 (*Continued*)

State	Communication Strategies					Premium Payment Policies			
	Renewal Reminder Notices Sent (If yes, number of notices sent)		Number of Days Before First Expiration Notice Is Sent	Follow-Up with Families by Outreach Workers		Premium or Enrollment Fees Required		Grace Period for Nonpayment[a,b]	Lock-Out Period[a,c]
	2006 (N=50)	2010 (N=50)	2010	2006 (N=50)	2010 (N=50)	2006 (N=51)	2010 (N=51)	Jan 2011 (N=29)	Jan 2011 (N=28)
Michigan	B(2)	B(2)	--		B	S	S	S (30 days)	
Minnesota[d]	B(≥ 2)	B(2)	45	B	B	B[k]	B[k]		S (4 months)
Missouri*		B(2)	45		B	B	S	S (20 days)	S (6 months)[l]
Montana*	B(3)	B(3)	75					NA	NA
New Hampshire	B(≥ 2)	B(≥ 1)	--	B	B	S	S	S (60 days)	S (3 months)
New Jersey	B(1)	B(3)	75	B	B	S	S	S (60 days)	
North Carolina	B(4)	B(4)	70		B	S	S[f]	NA	NA
North Dakota	B(≥ 2)	B(3)	55	B				NA	NA
Oklahoma*[d]	B(≥ 1)	B(2)	45	B	B		S[m]	--	--
Rhode Island[d]	B(3)	B(3)	60	B	B	B	M	M (60 days)	M (4 months)
South Dakota	B(≥ 2)	B(≥ 1)	--	B	B			NA	NA
Tennessee	--	B(3)	100	--				NA	NA
Virginia	B(3)	B(3)	90	B	B			NA	NA
Wisconsin[d]	B(2)	B(2)	~45			B	S	S (60 days)	S (6 months)

Sources: Mathematica analysis of FFY 2010 CARTS data (extracted June 2, 2011, and August 25, 2011). This table summarizes States' responses to the following questions: Mathematica analysis of FFY 2010 CARTS data (extracted June 2, 2011 and August 25, 2011). This table summarizes States responses to the following questions: Section 1, Question 1 "Does your program require premiums or an enrollment fee?"; Section III, "What additional measures does your State employ to simplify an eligibility renewal and retain eligible children in CHIP? Specify: (1) Conducts follow up through caseworkers/outreach workers, (2) Send renewal reminder notices to all families – (a) how many notices are sent to the family prior to disenrolling the child from the program? (b) At what intervals are reminder notices sent to families? (3) Other"; Heberlein et al. 2011; Cohen Ross, Cox and Marks 2007.

Notes: CHIP=Children's Health Insurance Program; CARTS=CHIP Annual Reporting Template System; Combo=combination program; "--" denotes nonresponse or insufficient information provided by State; NA = Not applicable; X=State has policy in place; *State changed program type between FFYs 2006 and 2010. Louisiana, Missouri, and Oklahoma had Medicaid-expansion CHIP programs, Maryland had a combination program, and Montana had a separate CHIP program in FFY 2006. North Carolina had a combination program in FFYs 2008 and 2009 only.

[a] Information not provided through CARTS. These data are from Heberlein et al. 2011.

[b] CHIPRA required States to provide a 30-day premium payment grace period under CHIP before cancelling a child's coverage. If a State does not charge premiums, grace period is noted as "NA".

[c] A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the program.

[d] These States have separate CHIP programs to cover pregnant women only. Renewal policies, as they pertain to separate CHIP, may therefore not be applicable.

[e] Maryland had a combination program in 2006. It only charged premiums in the separate CHIP part of its program.

[f] In Alabama, Colorado, North Carolina and Texas, families are charged an enrollment fee rather than a premium. Grace periods are not required on enrollment fees.

[g] Texas reported sending 3 notices to its CHIP program participants and 2 to its Medicaid-expansion CHIP participants in 2010.

[h] In Vermont, premiums are paid on a prospective basis; payments must be received by the first business day following the month it was due for coverage to continue. If the premium is paid in the calendar month after the child lost coverage, the family does not have to reapply.

[i] Indiana does not mark that they send renewal notices, but in their notes, they state "A simple renewal form is sent to families to complete and return to the agency."

[j] In Maine, for each month there is an unpaid premium, there is a month of ineligibility up to a maximum of 3 months. The penalty period begins in the first month following the enrollment period in which the premium was overdue.

[k] Minnesota charges premiums in MinnesotaCare, only.

[l] In Missouri, only children in families with incomes above 225 percent of the FPL are subject to the lock-out period and required to pay back missed premiums.

[m] Oklahoma only charges premiums in its Section 1115 Demonstration program, "Insure Oklahoma." No grace period is required.

Table A.13. State Renewal Policies and Procedures

State	Data Coordination for Eligibility Redetermination				Coordination Between CHIP and Medicaid			
	Use of ELE for Renewal		Ex Parte Renewal		Same Renewal Form for Medicaid and Separate CHIP Programs		Same Eligibility System for Medicaid and Separate CHIP Programs	
	2009 (N=50)	2010 (N=51)	2009 (N=50)	2010 (N=49)	2006 (N=16)	2011 (N=43)	2006 (N=10)	2010 (N=43)
Number of States	3	3	11	13	10	34	8	26
Medicaid-Expansion CHIP States								
Alaska					NA	NA	NA	NA
District of Columbia					NA	NA	NA	NA
Hawaii	[b]	[b]	X	X	NA	NA	NA	NA
Maryland*		[b,c]		X	X	NA	NA	NA
Nebraska					NA	NA	NA	NA
New Mexico					NA	NA	NA	NA
Ohio					NA	NA	NA	NA
South Carolina					NA	NA	NA	NA
Separate CHIP States								
Alabama	X[d]	X[d]			X	X		
Arizona	[b]	[b]				X	--	
Colorado					X	X	X	X
Connecticut					--	Y	--	
Georgia					--		--	
Kansas				--	--	X	--	X
Mississippi					--	X	--	X
Nevada							--	
New York					--		--	
Oregon		[b,c]	X	X	--	X	--	X
Pennsylvania					--	X	--	
Texas				X	--	X	--	
Utah					--	X	X	X
Vermont					X	X	X	X
Washington			X		X	X	--	X
West Virginia					--	X	--	X
Wyoming						[e]	--	
Combination States (S = in separate CHIP program only; M = in Medicaid-expansion CHIP program only; B = in both Medicaid-expansion CHIP and separate CHIP programs.)								
Arkansas[a]					--	X	--	X
California	[b]	[b]				[e]	--	
Delaware	[b]			--	--	X	--	X
Florida			M		--			
Idaho			B	B	X	X	X	X
Illinois	[b]	[b]		B	--	X	--	X
Indiana					--	X	--	X
Iowa		[b,c]			--		--	
Kentucky					--	X	X	X
Louisiana*	B[d]	B[d]	B	B	NA	X	NA	X
Maine			B	B	--	X	--	X
Massachusetts					X	X	--	X
Michigan						X	--	
Minnesota[a]					--	X	--	

Table A. 13 (*Continued*)

State	Data Coordination for Eligibility Redetermination				Coordination Between CHIP and Medicaid			
	Use of ELE for Renewal		Ex Parte Renewal		Same Renewal Form for Medicaid and Separate CHIP Programs		Same Eligibility System for Medicaid and Separate CHIP Programs	
	2009 (N=50)	2010 (N=51)	2009 (N=50)	2010 (N=49)	2006 (N=16)	2011 (N=43)	2006 (N=10)	2010 (N=43)
Missouri*			B	B	NA	X	NA	X
Montana*							--	
New Hampshire					--	X	X	X
New Jersey	B	B	B	B	X	X	--	X
North Carolina					X	X	--	X
North Dakota					--	X	X	X
Oklahoma*[a]					NA	X[f]	NA	X
Rhode Island[a]					--	X	--	X
South Dakota			B	B	X	X	X	X
Tennessee			M	M	--		--	
Virginia				M	--	X	--	
Wisconsin[a]			--		--	X	--	X

Sources: FFY 2010 CARTS reports, accessed June 2, 2011, and August 25, 2011, Section IIIC. Subpart B: “Are you utilizing the Express Lane option in making eligibility determinations and/or renewals for both Medicaid and CHIP?” “Does the State do Ex Parte renewal?”; Section IIIC: Subpart A: 1. Does the State use a joint application for establishing eligibility for Medicaid or CHIP?", 2. Please explain the process that occurs when a child’s eligibility status changes from Medicaid to CHIP and from CHIP to Medicaid. Have you identified any challenges? If so, please explain; Heberlein et al. 2011; CMS 2011d.

Notes: CHIP=Children’s Health Insurance Program; CARTS=CHIP Annual Reporting Template System; Combo=combination program; ELE=Express Lane Eligibility;"--" denotes nonresponse or insufficient information provided by State; NA = Not applicable; *State changed program type between 2006 and 2010. Louisiana, Missouri, and Oklahoma had Medicaid-expansion CHIP programs, Maryland had a combination program, and Montana had a separate CHIP program in 2006. North Carolina had a combination program in 2008 and 2009 only.

[a] Separate CHIP program only covers pregnant women. Renewal policies, as they pertain to separate CHIP, may therefore not be applicable.

[b] Responded positively in CARTS reports, but does not have an approved State plan amendment to conduct ELE at renewal (may conduct ELE at enrollment, however.)

[c] State uses ELE at eligibility determination, but not at renewal.

[d] Did not respond positively in CARTS, but uses ELE at renewal according to their approved State plan amendments.

[e] California and Wyoming's CHIP and Medicaid renewal forms are different, but each is accepted by either program.

[f] Children applying for Oklahoma's premium assistance program must use a separate application form.

Table A.14. Specifications and Data Sources Used to Report Child Health Quality Measures, FFYs 2006 to 2010

Year	Number of States Reporting	Percentage of States Using HEDIS Specifications to Report	Percentage of States Using Each Data Source			
			Administrative (claims data)	Hybrid (claims and medical record data)	Survey Data	Other/Not Specified
Well-Child Visits in the First 15 Months of Life						
2006	45	87	60	31	0	9
2007	39	87	56	33	0	10
2008	44	82	70	25	0	5
2009	44	89	73	23	0	5
2010	40	93	70	23	0	5
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
2006	45	88	60	31	0	9
2007	40	88	60	30	0	10
2008	47	89	74	23	0	2
2009	47	97	72	26	0	2
2010	42	93	71	24	0	5
Children Who Had a Visit with a PCP						
2006	44	84	73	14	2	11
2007	39	90	79	8	3	10
2008	42	93	83	5	7	2
2009	45	93	91	7	0	2
2010	40	95	90	3	3	3

Source: FFYs 2006 to 2010 CARTS reports, accessed June 30, 2011.

Notes: CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; FFY = Federal fiscal year; HEDIS = Health Plan Employer Data and Information Set; PCP = primary care practitioner.

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Table A.15. CHIPRA Quality Measure Reporting by States in FFY 2010 CARTS Reports

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Fewer Than 2,500 Grams (#3)	Caesarean Rate for Nulliparous Singleton Vertex (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Weight Assessment and Counseling for Nutrition (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well- Child Visits in the First 15 Months of Life (#10)	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (#11)	Adolescent Well-Care Visits (#12)	Total Eligibles that Received Preventive Dental Services (#13)	Children and Adolescents' Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion - Avoidance of Inappropriate Use of Systemic Antimicrobials (#16)	Total Eligibles that Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Bloodstream Infections (#19)	Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visit (#20)	Follow-Up Care for Children Prescribed ADHD Medication (#21)	Annual Pediatric Hemoglobin Testing and Control (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	CAHPS Health Plan Survey 4.0H, child version (#24)[d]
States Reporting		**15**	**12**	**3**	**2**	**20**	**12**	**10**	**2**	**21**	**40**	**42**	**29**	**22**	**40**	**20**	**1**	**19**	**15**	**0**	**5**	**15**	**8**	**11**	**1**
Alabama	13									X	X	X	X	X	X	X		X	X		X	X	X	X	
Alaska	14			X	X					X	X	X	X	X	X	X		X	X		X	X		X	
Arizona	8					X				X	X	X	X	X	X			X							
Arkansas[b]	0																								
California	9					X				X	X	X	X	X	X	X		X							
Colorado	5					X		X			X	X	X												
Connecticut	10	X	X						X	X	X	X	X		X				X				X		
Delaware[c]	0																								
Dist. Of Col.	12	X	X			X	X			X	X	X	X	X	X	X		X							
Florida	12		X					X		X	X	X	X	X	X	X			X			X		X	
Georgia	18	X	X	X	X	X		X		X	X	X	X	X	X	X		X	X		X	X		X	
Hawaii[b]	0																								
Idaho[b]	0																								
Illinois	7	X	X			X			X		X	X			X										
Indiana	14	X	X			X	X			X	X	X	X	X	X	X		X				X		X	
Iowa	3										X	X			X										
Kansas[b]	0																								
Kentucky	13	X	X			X	X	X		X	X	X	X	X	X	X		X							
Louisiana	5										X	X	X	X	X										
Maine	11									X	X	X	X	X	X			X	X		X	X	X		
Maryland	12	X	X			X	X			X	X	X	X	X	X	X		X							
Massachusetts[b]	0																								
Michigan	12	X				X	X	X		X	X	X	X		X	X						X	X		
Minnesota	3										X	X			X										
Mississippi	8					X				X		X	X		X	X						X		X	
Missouri	12	X				X	X			X	X	X	X	X				X	X					X	X
Montana	7										X	X		X	X	X		X	X						
Nebraska	5										X	X		X	X			X							
Nevada	3										X	X			X										
New Hampshire	5										X	X	X		X	X									

Table A.15 (*Continued*)

	Number of Measures Reported by State[a]	Prenatal and Postpartum Care: Timeliness of Prenatal Care (1)	Frequency of Ongoing Prenatal Care (#2)	Percentage of Live Births Weighing Fewer Than 2500 grams (#3)	Cesarean Rate for Nulliparous Singleton Vertex (#4)	Childhood Immunization Status (#5)	Immunizations for Adolescents (#6)	Weight Assessment and Counseling for Nutrition (#7)	Developmental Screening in the First Three Years of Life (#8)	Chlamydia Screening (#9)	Well- Child Visits in the First 15 Months of Life (#10)	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (#11)	Adolescent Well-Care Visits (#12)	Total Eligibles that Received Preventive Dental Services (#13)	Children and Adolescents' Access to Primary Care Practitioners (#14)	Appropriate Testing for Children with Pharyngitis (#15)	Otitis Media with Effusion - Avoidance of Inappropriate Use of Systemic Antimicrobials (#16)	Total Eligibles that Received Dental Treatment Services (#17)	Ambulatory Care: Emergency Department Visits (#18)	Pediatric Central-Line Associated Bloodstream Infections (#19)	Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visit (#20)	Follow-Up Care for Children Prescribed ADHD Medication (#21)	Annual Pediatric Hemoglobin Testing and Control (#22)	Follow-Up After Hospitalization for Mental Illness (#23)	CAHPS Health Plan Survey 4.0H, child version (#24)[d]
States Reporting		**15**	**12**	**3**	**2**	**20**	**12**	**10**	**2**	**21**	**40**	**42**	**29**	**22**	**40**	**20**	**1**	**19**	**15**	**0**	**5**	**15**	**8**	**11**	**1**
New Jersey	6	X				X					X	X	X		X										
New Mexico	15	X	X			X	X	X		X	X	X	X	X	X	X		X	X			X			
New York	9					X		X			X	X	X		X	X			X			X			
North Carolina	2											X			X										
North Dakota	2											X			X										
Ohio	3										X	X			X										
Oklahoma	4										X	X	X		X										
Oregon[b]	0																								
Pennsylvania	9					X	X				X	X	X		X	X			X			X			
Rhode Island	15	X	X			X	X	X		X	X	X	X	X	X	X		X				X		X	
South Carolina	9	X								X	X				X	X			X			X	X	X	
South Dakota	4										X	X		X	X										
Tennessee	15	X	X			X	X	X		X	X	X	X		X	X			X			X	X	X	
Texas[b]	0																								
Utah	3										X	X			X										
Vermont	9	X	X	X							X	X	X	X	X			X							
Virginia	3										X	X			X										
Washington	6										X	X	X	X	X			X							
West Virginia	15					X	X	X		X	X	X	X	X	X			X	X		X	X	X	X	
Wisconsin	2										X	X													
Wyoming	13					X	X			X	X	X	X	X	X	X	X	X	X				X		

Source: Mathematica analysis of CARTS FFY 2010 reports, as of June 30, 2011, and as reported in the 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP, September 2011.

Notes: ADHD = attention deficit hyperactivity disorder; AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program.

[a] "X" indicates that a State reported a performance rate for the measure for the Medicaid population, CHIP population, or both.
[b] Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted CARTS reports for FFY 2010, but did not submit data on any of the performance measures.
[c] Delaware did not complete a CARTS report for FFY 2010.
[d] For measure 24, States had the option of attaching a CAHPS report to their CARTS report or submitting the report to AHRQ. Missouri is the only State that attached a CAHPS report in CARTS.

Table A.16. Reasons for Not Reporting CHIPRA Quality Measures in FFY 2010 CARTS Reports

Measure	Number of States Reporting	Reasons for Not Reporting: Number of States Not Reporting	Data Not Available	Population Not Covered	Sample Size Too Small	Other	Not Specified
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (#11)	42	9	2	0	0	0	7
Well-Child Visits in the First 15 Months of Life (#10)	40	11	2	1	2	0	6
Child and Adolescent Access to Primary Care Practitioners (#14)	40	11	4	0	0	0	7
Adolescent Well-Care Visits (#12)	29	22	8	1	0	2	11
Total Eligibles Who Received Preventive Dental Services (#13)	22	29	8	1	0	7	13
Chlamydia Screening (#9)	21	30	16	0	0	2	12
Childhood Immunization Status (#5)	20	31	13	1	0	3	14
Appropriate Testing for Children with Pharyngitis (#15)	20	31	18	0	0	1	12
Total Eligibles Who Received Dental Treatment Services (#17)	19	32	12	1	0	6	13
Prenatal and Postpartum Care: Timeliness of Prenatal Care (#1)	15	36	15	3	2	5	11
Ambulatory Care: Emergency Department Visits (#18)	15	36	21	0	0	2	13
Follow-Up Care for Children Prescribed ADHD Medication (#21)	15	36	20	1	0	1	14
Frequency of Ongoing Prenatal Care (#2)	12	39	18	4	1	5	11
Immunizations for Adolescents (#6)	12	39	21	0	0	3	15
Follow-Up After Hospitalization for Mental Illness (#23)	11	40	23	1	0	1	15
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents (#7)	10	41	22	0	1	2	16
Annual Pediatric Hemoglobin A1C Testing (#22)	8	43	21	0	2	2	18
Annual Number of Asthma Patients with > 1 Asthma-Related Emergency Room Visits (#20)	5	46	26	0	0	3	17
Percent of Live Births Weighing Less Than 2,500 grams (#3)	3	48	27	4	0	3	14
Cesarean Rate for Nulliparous Singleton Vertex (#4)	2	49	26	5	1	2	15
Developmental Screening in the First Three Years of Life (#8)	2	49	29	0	0	6	14
Otitis Media with Effusion—Avoidance of Inappropriate Use of Systemic Antimicrobials in Children—Ages 2—12 (#16)	1	50	29	0	1	2	18
CAHPS 4.0 (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (#24)	1	50	0	0	0	0	50
Pediatric Central-Line Associated Blood Stream Infections—NICU and PICU (#19)	0	51	29	0	1	4	17

Sources: FFY 2010 CARTS reports, accessed June 30, 2011, and as reported Sebelius 2011.

Notes: Delaware did not complete a CARTS report for FFY 2010. To report measure 24, States have the option of attaching their CAHPS results to the CARTS report or submitting the data directly to AHRQ; ADHD = attention deficit disorder; AHRQ = Agency for Healthcare Research and Quality; BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CARTS = CHIP Annual Reporting Template System; CHIP = Children's Health Insurance Program; CHIPRA

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