

FINAL REPORT

CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings

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Mathematica Policy Research

Mary Harrington
Kimberly Smith
Christopher Trenholm
Sean Orzol
Sheila Hoag
Joseph Zickafoose
Claire Dye
Connie Qian
Tyler Fisher
Lauren Hula

The Urban Institute

Genevieve M. Kenney
Lisa Clemans-Cope
Ian Hill
Stacey McMorrow
Jennifer Haley
Timothy Waidmann
Sarah Benatar
Matthew Buettgens
Victoria Lynch
Nathanial Anderson

ASPE

Kenneth Finegold

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200 Independence Avenue, SW
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Project Officer: Rose Chu

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Submitted by:

Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-1912
Telephone: (734) 794-1120
Facsimile: (734) 794-0241

Project Director: Mary Harrington

Reference Number: 06873.140

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EXECUTIVE SUMMARY

Passed with bipartisan support in the Balanced Budget Act of 1997, the Children’s Health Insurance Program (CHIP) celebrated its 16th anniversary in August 2013. 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. A total of 8.13 million children were enrolled in CHIP at some point in FFY 2013.

Congress mandated in CHIPRA that the Secretary of the U.S. Department of Health and Human Services conduct an independent comprehensive evaluation of CHIP patterned after an earlier evaluation Congress mandated in the Balanced Budget Refinement Act (BBRA) of 1999.¹ Mathematica Policy Research and its partner the Urban Institute were awarded the contract in 2010 to conduct the current evaluation, which is being overseen by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). An interim report was sent to Congress in 2011 that described the status and evolution of state CHIP programs throughout the United States as of 2010 and summarized the evidence available at that time about the role and impacts of CHIP. This final report synthesizes evidence collected through the CHIPRA evaluation of CHIP.

What Did the Evaluation Find?

As summarized in Table ES.1, the evaluation found CHIP to be successful in nearly every area examined. CHIP succeeded in expanding health insurance coverage to the population it is intended to serve, particularly children who would otherwise be uninsured, increasing their access to needed health care, and reducing the financial burdens and stress on families associated with meeting children’s health care needs. These positive impacts were found for children and families in states with different CHIP program structures and features, across demographic and socioeconomic groups, and for children with different health needs. Medicaid and CHIP have worked as intended to provide an insurance safety net for low-income children during economic hard times. Awareness of both Medicaid and CHIP was high among low-income families, most newly enrolling families found the application process at least somewhat easy, and the vast majority of children remained enrolled through the annual renewal period.

The evaluation also identified a few areas where there is room for improvement. One in four children in CHIP had some type of unmet need, and although most CHIP enrollees received annual well-child checkups, fewer than half received key preventive services such as immunizations and health screenings during those visits, and fewer than 40 percent had after-hours access to a usual source of care provider. While most CHIP enrollees received annual dental checkups, a significant share of them did not get recommended follow-up dental treatment. There is also room for improvement in reducing the percentage of children who cycle off and back on to Medicaid and CHIP, and reducing gaps in coverage associated with moving

¹ Appendix A contains copies of the relevant sections of the CHIPRA (P.L. 111-3) and BBRA (H.R. 3426) legislation.

between Medicaid and separate CHIP programs. And while participation rates have grown to high levels in most states, further effort could be targeted to the 3.7 million children who are eligible for Medicaid or CHIP but remain uninsured.

Table ES.1. Major Findings from the CHIPRA Mandated Evaluation of CHIP

1. CHIP contributed greatly to the decline in uninsured rates among low-income children, which fell from 25 percent in 1997 to 13 percent in 2012. Since CHIP was enacted, coverage rates improved for all ethnic and income groups and coverage disparities narrowed significantly for Hispanic children.
2. Medicaid and CHIP participation rates increased even as the number of eligible children has grown. The number of children eligible for Medicaid or CHIP yet uninsured fell from 4.9 million in 2008 to 3.7 million in 2012, and 68 percent of all remaining uninsured children are eligible for Medicaid or CHIP.
3. Relatively few low-income children in CHIP have access to private insurance coverage, and direct substitution of private for public coverage at the time of CHIP enrollment was estimated to be as low as 4 percent. Even when dependent coverage is available to families with children enrolled in CHIP, affordability is likely an important barrier many parents face in accessing employer sponsored insurance coverage for their children.
4. Medicaid and CHIP programs worked as intended to provide an insurance safety net for low-income children, especially during times of economic hardship.
5. Most new CHIP enrollees stayed enrolled in public coverage for at least 28 months, and the vast majority exited because they were no longer eligible. Many children moved between Medicaid and CHIP; while most transitioned seamlessly, coverage gaps occurred for as many as 44 percent depending on the type of transition.
6. Children in Medicaid and CHIP experienced better access to care, fewer unmet needs, and greater financial protection than children who were uninsured. Compared to children with private insurance, CHIP enrollees had better access to dental benefits and their families experienced much lower financial burden and stress in meeting the child's health care needs. However, CHIP enrollees were less likely than children with private insurance to have a regular source of medical care and nighttime or weekend access to a provider at that source of care.
7. Most low-income families knew about Medicaid and CHIP, and those with children enrolled in the programs reported positive application experiences. Some barriers to enrollment remain for eligible uninsured children.

What Problem is CHIP Trying to Solve?

A series of Medicaid expansions passed by Congress beginning in the mid-1980's aimed to address the problem of rising uninsured rates throughout the 1970s and early 1980s among children in families with incomes below the federal poverty level (FPL). As these expansions unfolded during the following decade, attention began to turn toward rising uninsured rates among children with family incomes between 100 and 200 percent of the FPL, due largely to declines in private insurance coverage (Cunningham and Kirby 2004). Although attempts at national health care reform failed in 1994, Congressional leaders of both political parties supported development of legislation to help children who fell into this coverage gap. The State Children's Health Insurance Program (previously known as SCHIP, now called CHIP) passed with bipartisan support as part of the Balanced Budget Act of 1997 and became law on August 5, 1997, as Title XXI of the Social Security Act (P.L. 105-33).

How Does CHIP Work?

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 resembles options available in the commercial insurance market (Ryan 2009). States can (1) expand their existing Medicaid program (this is called a Medicaid expansion CHIP program), (2) create a separate program, or (3) blend the two approaches to create a combination program. While many states initially implemented a Medicaid expansion CHIP program, in part because that approach could be implemented quickly, over time more states began administering separate CHIP and combination programs, which offer greater flexibility in program design. Table ES.2 summarizes characteristics of each program type and the number of states with each type in 2001 and in 2013.

Table ES.2. Characteristics of CHIP Programs, FFYs 2001 and 2013

Program Type	Summary	Number of States 2001	Number of States 2013
Medicaid Expansion CHIP	Required to follow all Medicaid program rules, including benefits and cost-sharing; prohibited from capping or freezing enrollment	17	8
Separate CHIP	Allows increased flexibility in program design. 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. Prior to maintenance of effort (MOE) rules established by the American Recovery and Reinvestment Act of 2009 (and extended and broadened by the Affordable Care Act), states could cap or freeze enrollment and maintain waiting lists at any time to limit costs and coverage. Option to impose waiting periods.	16	15
Combination	States operate both Medicaid expansion CHIP and separate CHIP programs; each covers a different population based on income threshold	18	28

Sources: Mann et al. 2003; Rosenbach et al. 2003; CMS 2013.

Like Medicaid, CHIP is jointly financed by the states and the federal government. However, CHIP was designed as a block grant program with limits on federal allotments, while Medicaid is an entitlement program with no spending cap.² Also, the federal matching rate for CHIP is about 20 percent higher than Medicaid, an enhancement designed to give states an incentive to adopt

² 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). Legislation in 1999 and 2005 made adjustments to the allotments to address problems with the initial formula, which did not consider state CHIP expenditures and led to the risk of shortfalls in some states (Kenney and Chang 2004; Kenney and Yee 2007).

CHIP. States can decide on their CHIP program's upper income eligibility limit, but they receive only the Medicaid matching rate amount for children with family incomes above 300 percent of the FPL; as of late 2013, 13 states had upper income limits for CHIP above this level (Centers for Medicaid and CHIP Services 2013).³ Of the 8.13 million children enrolled in CHIP at some point in FFY 2013, 89 percent had a family income under 200 percent of the FPL (Medicaid and CHIP Payment and Access Commission 2014).⁴

What Did the Evaluation Examine?

Congress stipulated that the evaluation include 10 states with varied geographical and urban/rural representation, diverse approaches to program design, and a large proportion of the low-income, uninsured children in the United States. The 10 states selected for the evaluation (Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia) span the four census regions, reflect diverse program designs, and represented 53 percent of the nation's uninsured children and 57 percent of children enrolled in CHIP when the states were selected in 2010. (Appendix Table B.1 summarizes how the selected states met the criteria for the evaluation.)

Congress also stipulated that the evaluation survey families of CHIP enrollees and disenrollees and study low-income children likely to be eligible for Medicaid or CHIP but not enrolled. In addition to surveying CHIP enrollees and disenrollees in 10 states, and Medicaid enrollees and disenrollees in the 3 largest of these states, the evaluation included case studies in the 10 survey states and a national telephone survey of CHIP administrators. Other evaluation components included analyses of data on low-income uninsured children from the National Survey of Children's Health (NSCH) and Current Population Survey (CPS) data on coverage trends since CHIP was enacted. Data from the American Community Survey (ACS) was used to project coverage for low-income children under different assumptions about CHIP funding after major coverage provisions of the Affordable Care Act take effect.

The evaluation addressed questions about: (1) the design and evolution of CHIP programs and how they were influenced by CHIPRA policies and changes introduced through the Affordable Care Act; (2) coverage and participation rates among CHIP's target population of low-income children; (3) prior coverage experiences of new enrollees and whether CHIP substitutes for private coverage; (4) enrollment trends, how long children remain enrolled, and coverage experiences after leaving CHIP; (5) access, service use, and family well-being; and (6) family perceptions of CHIP and their experiences applying, enrolling, and renewing coverage.

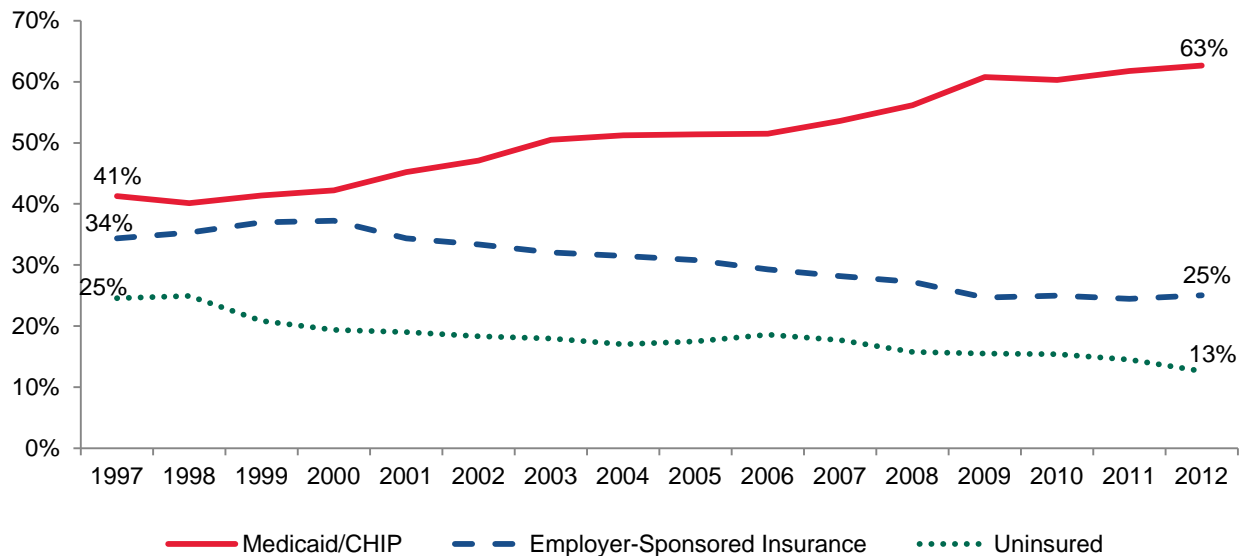
³ States with thresholds above 300 percent FPL in place when the Title XXI CHIP legislation (P.L. 105-33) was passed in 1997 were permitted to receive the higher CHIP matching rate for expenditures made for children with family incomes up to the pre-existing threshold. At that time, Tennessee was the only state with a Medicaid income threshold above 300 percent of the FPL.

⁴ Total enrollment in CHIP as of March 4, 2014 was 8,350,266 million, which includes 219,473 adults enrolled primarily through special waiver programs for low-income parents and pregnant women in some states.

Finding 1 (Chapter III): CHIP contributed greatly to the decline in uninsured rates among low-income children, which fell from 25 percent in 1997 to 13 percent in 2012. Since CHIP was enacted, coverage rates improved for all ethnic and income groups and coverage disparities narrowed significantly for Hispanic children.

The percentage of all children who were uninsured has dropped from 15 to 9 percent since CHIP was enacted in 1997, and the decline for low-income children was even greater, falling from 25 percent in 1997 to 13 percent in 2012 (Figure ES.1). These declines occurred despite recession conditions that separated many families from their connection to employer-sponsored coverage and left them with fewer resources to purchase coverage on their own. The increase in Medicaid and CHIP coverage was the primary reason uninsured rates among children declined. Public coverage rates increased 15 percentage points among all children (from 20 to 35 percent) and by 26 percentage points for children in families with incomes in the primary CHIP target range of between 100 and 200 percent of the FPL.

Figure ES.1. Percentage of Low-Income Children with Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured, 1997–2012

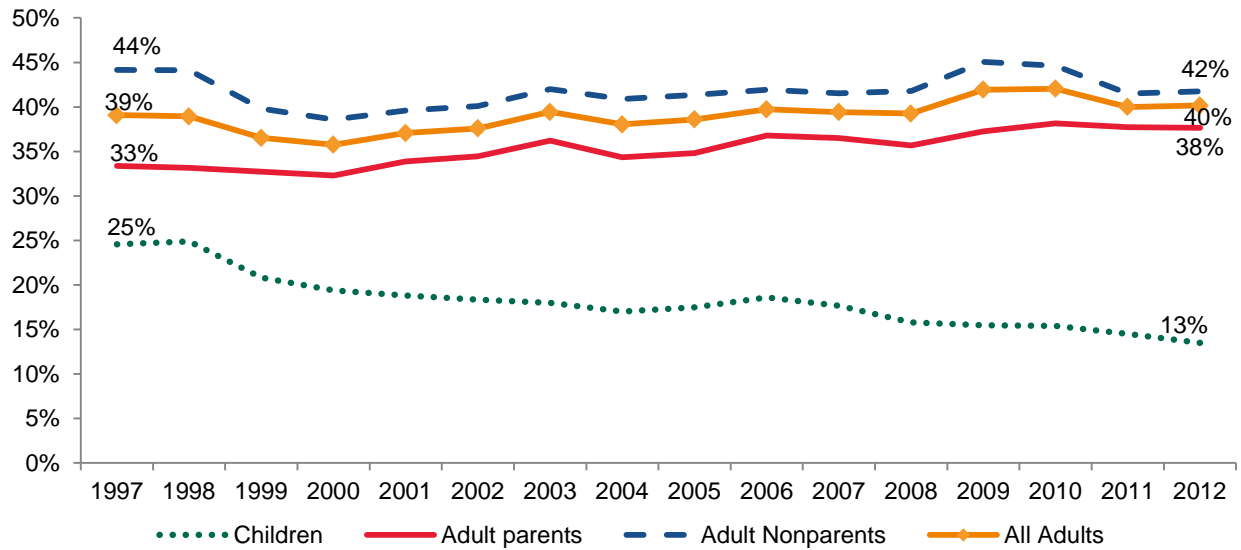


Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL.

The coverage gains for low-income children were not matched by similar gains for low-income adults, pointing to the importance of public coverage in driving the decline in uninsurance among children. Throughout the 15-year period, uninsured rates were substantially higher among low-income adults than among children (Figure ES.2). Uninsured rates were consistently highest among adults without children, who were less likely to be eligible for public coverage. In contrast, rates for children declined steadily, falling from 25 to 13 percent over the 15-year period.

Figure ES.2. Percentage Uninsured: Low-Income Children and Adults, 1997–2012



Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL.

Uninsured rates fell for all groups defined by race/ethnicity and language but the decline was greatest among Hispanic children, where the uninsured rate dropped from 34 to 17 percent and the coverage disparity between non-Hispanic white and Hispanic children narrowed from 13 percentage points in 1997 to 5 percentage points in 2012.

Finding 2 (Chapter III): Medicaid and CHIP participation rates increased even as the number of eligible children has grown. The number of children eligible for Medicaid or CHIP yet uninsured fell from 4.9 to 3.7 million, and 68 percent of all remaining uninsured children are eligible for Medicaid or CHIP.

Participation rates show the portion of the eligible population without private coverage that is enrolled, providing an indication of how successful Medicaid and CHIP programs are in reaching their target populations. Nationwide, Medicaid and CHIP participation rates among children increased from 82 percent in 2008 to 88 percent in 2012, and were above 90 percent in 21 states. Over this period, many states implemented changes in their enrollment and renewal processes and adopted new outreach strategies aimed at increasing the take-up and retention of Medicaid and CHIP coverage among eligible children (Heberlein et al. 2013; Hill et al. 2013; Hoag et al. 2013a).

Participation rates increased across all subgroups defined by income, age, race and ethnicity, immigration status, and functional status, and exceeded 90 percent for children under age 6, children with income below 138 percent of the FPL, black non-Hispanic children, non-Hispanic children with multiple or other race, and children with functional limitations. Compared to these groups, rates remained lower for adolescents, non-citizens and children without functional limitations.

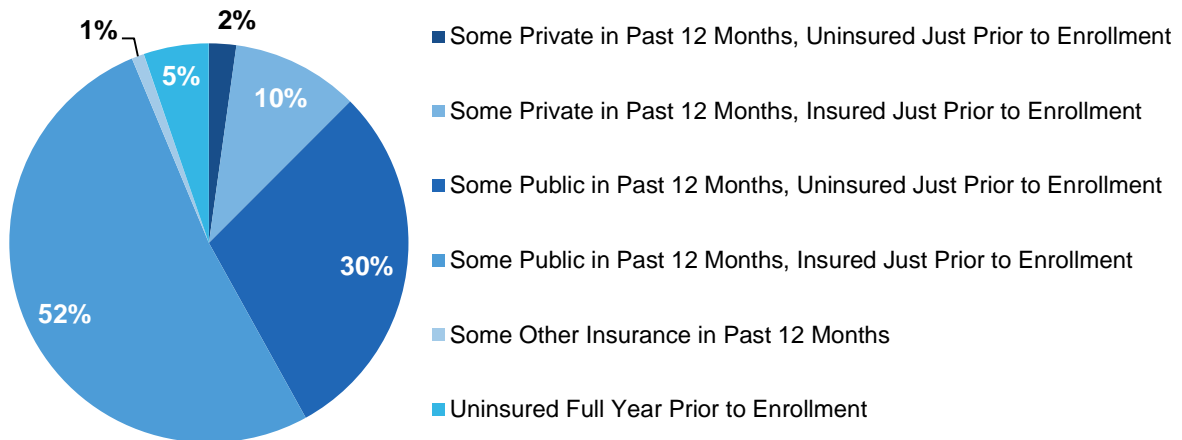
The number of children eligible for Medicaid or CHIP yet uninsured fell from 4.9 to 3.7 million between 2008 and 2012 – all the more impressive because 4.5 million more children became

eligible for Medicaid or CHIP during that period. As of 2012, an estimated 68 percent of all uninsured children were eligible for Medicaid or CHIP but not enrolled; others were not eligible because of their immigration status (21 percent) or income level (79 percent).

Finding 3 (Chapter IV): Relatively few low-income children in CHIP have access to private insurance coverage, and direct substitution of private for public coverage at the time of CHIP enrollment was estimated to be as low as 4 percent. Even when dependent coverage is available to families with children enrolled in CHIP, affordability is likely an important barrier many parents face in accessing employer sponsored insurance coverage for their children.

More than 80 percent of new CHIP enrollees had a period of public insurance coverage in the 12 months before enrolling in CHIP (Figure ES.3). Just over half (52 percent) were covered continuously and another 30 percent had public coverage earlier in the year but were uninsured just prior to enrolling. A much smaller share of new CHIP enrollees (13 percent) had private coverage in the 12 months before enrolling in CHIP, including 2 percent that had a gap in coverage before enrolling and 10 percent that enrolled directly after private coverage.⁵

Figure ES.3. Coverage of New CHIP Enrollees in 12 Months Prior to Enrollment



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

Note: New enrollees are those enrolled in CHIP for three months following at least two months without CHIP coverage.

Survey information on the reason private coverage ended was used to differentiate between private coverage dropped voluntarily and coverage lost due to circumstances beyond the family's control; 28 percent of the reasons private coverage ended were classified as voluntary. With 13 percent of new enrollees reporting any prior private coverage during the 12 months prior to

⁵ The estimates in Figure ES.1 of children with prior private coverage with and without a gap in coverage do not sum to the total estimate of children with prior private coverage due to rounding.

enrolling in CHIP, and 28 percent ending this coverage for voluntary reasons, the estimate of direct substitution at the time of enrollment was 4 percent.

A broader measure of access to private coverage finds that roughly 43 percent of CHIP enrollees had a parent with access to employer-sponsored insurance (ESI), but only 20 percent were reported to have access to dependent coverage. An even smaller portion of CHIP enrollees (12 percent) were reported to have access to dependent coverage where the employer contributes something toward the premium, suggesting that even when dependent coverage is available, affordability is likely an important barrier many parents face in accessing ESI coverage for their children. Access to ESI for low-income uninsured children and Medicaid enrollees was also very limited. And uninsured rates among parents of Medicaid and CHIP enrollees were also high. In California, Florida and Texas, 62 percent of CHIP enrollees and 54 percent of Medicaid enrollees had at least one uninsured parent.⁶

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

Analysis of enrollment data from the 10 study states for a five-year period shows that enrollment in both Medicaid and CHIP grew steadily from 2007 to 2012, with the strongest growth in 2009, the second year of the recent recession. Enrollment growth was driven primarily by increases in Medicaid, which is by far the largest program, covering roughly 80 percent of all publicly insured children during the five-year period.

Medicaid and CHIP play an essential role in ensuring that low-income children have health insurance, and enrollment trends demonstrated a counter-cyclical safety-net system working as intended. The first year of the recent recession (2008) coincided with the largest increases in CHIP enrollment; as higher income families faced unemployment and cuts in employer sponsored coverage, families turned to CHIP programs for coverage. As the economy continued on its downward trend and family incomes continued to drop, new enrollment in Medicaid began to spike and disenrollment in both programs fell, with the greatest increases in Medicaid enrollment occurring in 2009 and 2010.

Finding 5 (Chapter VI): Most new CHIP enrollees stayed enrolled in public coverage for at least 28 months, and the vast majority exited because they were no longer eligible. Many children moved between Medicaid and CHIP; while most transitioned seamlessly, coverage gaps occurred for as many as 40 percent depending on the type of transition.

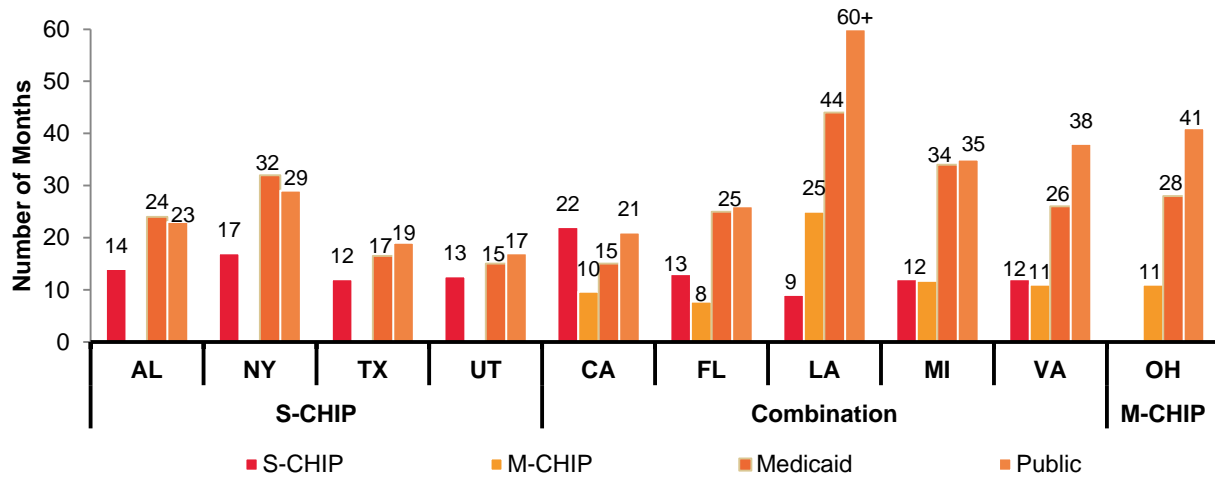
Several factors influence the length of time a child remains enrolled in Medicaid or CHIP coverage, including whether the child continues to meet program eligibility guidelines, whether the family completes the renewal process, and the degree of coordination that characterizes the transfer from one program to another if family income or other conditions of eligibility change.

⁶ Among CHIP enrollees across the 10 survey states, 57 percent had at least one uninsured parent.

Enrollment data from each of the 10 study states was used to examine how long children remained enrolled in Medicaid and CHIP and movement between Medicaid and CHIP. Survey data provided insight into why children disenrolled and their coverage status after leaving.

Across the 10 states, new spells of Medicaid enrollment tended to last about twice as long (26 months) as new spells of CHIP (13 - 14 months), and when we included seamless movement between Medicaid and CHIP, the median duration of new spells of public coverage increased to 28 months. Median duration varied considerably across states, especially for Medicaid (Figure ES.4). The length of new Medicaid enrollment spells ranged from 15 months in California and Utah and 17 months in Texas to 44 months in Louisiana. Louisiana adopted several simplifications to largely automate the renewal process and limit the steps families need to take. In contrast, Texas and Utah required redeterminations more frequently than every 12 months. The renewal process in California’s Medicaid program is not automated and relies on county social service offices to process renewals.

Figure ES.4. Median Duration of New Coverage Spells, by State and Program Type, 2007-2012



Source: Mathematica analysis of state-provided Medicaid/CHIP administrative data.

M-CHIP = Medicaid expansion CHIP; Public = Medicaid and CHIP combined; S-CHIP = separate CHIP; Combination CHIP = state administers both M-CHIP and S-CHIP.

Most children (90 percent) leave CHIP because they gain another type of coverage or no longer meet the program’s eligibility criteria.

For 64 percent of disenrollees, CHIP ended because the child obtained some other coverage. Another 26 percent were no longer eligible because of income (14 percent), age (11 percent) or some other eligibility-related reason (1 percent). Only 5 percent left because of missing paperwork or some other problem with the renewal process. After leaving CHIP, most children transferred to Medicaid (49 percent) or were uninsured (32 percent). Six months later, 41 percent were in Medicaid, 13 percent had returned to CHIP, 14 percent had private coverage and the rest (32 percent) were uninsured.

Churning out of and back into the same program was more common in Medicaid than in separate CHIP programs

Over a four-year period, 21 percent of children leaving Medicaid returned to Medicaid within seven months, and the churn rate for separate CHIP programs was 10 percent. Churn rates

remained fairly constant over the period, but varied across the 10 study states. Anywhere from 8 to 36 percent of Medicaid disenrollees churned back into the program within seven months, with the corresponding separate CHIP rates ranging between 2 and 19 percent.

It was common for children to move between Medicaid and CHIP; transitions between Medicaid and separate CHIP programs often lead to gaps in coverage.

During a one-year period, 28 percent of children in separate CHIP programs and half of those in Medicaid expansion programs also were enrolled in Medicaid at some point during the year. Over a three-year period, the likelihood of an enrollment period in both programs increased markedly: 74 percent of Medicaid expansion CHIP enrollees and 52 percent of separate CHIP enrollees also had at least one enrollment period in Medicaid. Many children moving between Medicaid and separate CHIP programs experience a coverage gap of two to six months. In terms of the median percentage across the states, 40 percent of transitions from Medicaid to separate CHIP programs and 33 percent of those from Medicaid expansion to separate CHIP programs resulted in such a coverage gap; gaps were less common for transitions in the other direction, occurring for 16 and 11 percent of transitions from separate CHIP to Medicaid or Medicaid expansion programs, respectively. These findings point to the importance of continued program coordination and policies to streamline transitions between programs, especially transitions from Medicaid to separate CHIP programs. Premium or enrollment fee requirements and waiting periods unique to separate programs may be a factor for some transitions to separate CHIP programs.

Finding 6 (Chapter VIII): Compared to being uninsured, children in Medicaid and CHIP experienced better access to care, fewer unmet needs, and greater financial protection. Compared to having private insurance, CHIP enrollees had better access to dental benefits and their families had much lower financial burdens and stress in meeting the child’s health care needs. CHIP enrollees were less likely than children with private insurance to have a regular source of medical care and nighttime or weekend access to a provider at that source of care.

Overall, CHIP enrollees experienced good access to providers; nearly all had seen a medical and dental provider within the past year, and parents of CHIP enrollees reported being very confident that their child is able to get needed health care. More than 85 percent of children enrolled in CHIP had seen a doctor or health care professional in the past 12 months, and 80 percent had a well-child visit. Parents of CHIP enrollees also reported positive care experiences with their child’s providers at high rates on most aspects of patient-centered care, though only 47 percent of parents of CHIP enrollees reported positive care experiences on all six dimensions of family-centered care. Most parents (96 percent) of CHIP enrollees reported being confident that they could get health care to meet their child’s needs, with more than 80 percent reporting having little or no stress about meeting these needs. In addition, only 8 percent of parents reported that they had any problem paying their child’s medical care bills in the past year.

A large majority (89 percent) of parents reported they did not have trouble finding a dentist to see their child, and 90 percent of CHIP enrollees had a usual source of dental care. More than 80 percent of CHIP enrollees had received a dental cleaning or checkup in the past year, and 54 percent of children over age 6 were reported to have had dental sealants placed on their back teeth—a rate exceeding “Healthy People 2020” targets (US DHHS).

CHIP enrollees had better access and service use outcomes, and the financial burden on their families was lower than for children who were uninsured.

Compared to being uninsured, the experiences of children enrolled in CHIP were more positive in nearly all areas examined. The parents of children enrolled in CHIP reported substantially more confidence in their ability to get needed health care for their children, their children were more likely to have received a range of health services, and they reported fewer financial burdens associated with the child's health care. The largest positive differences were found for having a usual source of dental care and a dental checkup or cleaning, obtaining referrals when needed, lower stress and greater confidence about meeting the child's health care needs, fewer problems paying medical bills for the child's care, and receipt of preventive care or well-child checkup. Rates of use for emergency department (ED) care and hospital stays were comparable among children enrolled in CHIP and uninsured children, and children in CHIP were just as likely as uninsured children to have had a dental procedure after a dentist recommended dental follow-up care.

Compared with private coverage, access and service use for CHIP enrollees was comparable for many measures but not as good for some. Financial burdens were substantially lower and dental access was better in CHIP.

CHIP enrollees were more likely than children with private coverage to have dental benefits and a regular source of dental care and to have their medical care coordinated effectively. The parents of children enrolled in CHIP also reported having had substantially less trouble paying their child's medical bills and much lower out-of-pocket spending levels. The greater financial protection provided by CHIP coverage likely contributed to findings that parents of CHIP enrollees reported being more confident about meeting their children's health care needs and feeling less stress about doing than parents of children with private insurance. CHIP enrollees were less likely than children with private insurance to have a regular source of medical care and access to that source of care at night or on weekends.

Greater improvements could be achieved in a few areas.

Only 28 percent of CHIP enrollees had a usual source of care that offered appointments at night or on the weekend, and only 37 percent had after-hours access to a provider at their usual source of care. Nearly 25 percent of CHIP enrollees had some type of unmet need, most commonly for dental care (12 percent) and physician services, prescription drugs, or specialty care (5 percent). Also, many children were not receiving recommended health screenings and anticipatory guidance. For example, 60 percent had their vision screened in the past year, but slightly less than half received a flu vaccination and only about one-third received anticipatory guidance on all four key health topics examined, or a developmental screening (among children under age 6). Finally, a substantial share (68 percent) of CHIP enrollees did not get follow-up dental treatment when it was recommended by a dentist. Similar gaps in care were also found among children with private coverage, which suggests that there are broader issues with systems of care serving children.

Finding 7 (Chapter IX): Most low-income families knew about Medicaid and CHIP and those with children enrolled in the programs reported positive application experiences. Some barriers to enrollment remain for eligible uninsured children.

Based on national survey data for 2011/2012, nearly all low-income families with an uninsured child (95 percent) had heard of Medicaid or CHIP, and many (59 percent) had been covered by at least one of these programs in the past. Of those who had heard of Medicaid or CHIP, 91 percent said that they would enroll if told that their child was eligible. But about one-third reported not knowing where to get more information about Medicaid and CHIP or how to enroll. Also, fewer than half of all parents of uninsured children reported thinking that applying to Medicaid or CHIP would be easy (43 percent of those with children who had never been enrolled in Medicaid or CHIP, and 35 percent of those with children who had been enrolled in the past).

The survey of recent CHIP enrollees asked parents about their application experience: 46 percent said it had been very easy and an additional 43 percent said it was somewhat easy. Just 11 percent reported that it was somewhat difficult. In related findings, 52 percent of parents who had experienced the CHIP renewal process reported it to be very easy and an additional 40 percent reported it to be somewhat easy. Most had applied for coverage by mail (41 percent), but the share using the internet was nearly as large (36 percent) and is likely to grow, as it was still a relatively new option in most states at the time of the survey and it is a required pathway under the Affordable Care Act starting in 2014. About half of new CHIP enrollees understood the renewal requirement for the program, a factor that could ultimately contribute to some eligible children eventually losing coverage if there are problems completing the renewal process.

POLICY IMPLICATIONS

CHIP's future will be debated in the coming months at the same time that major coverage-related changes under the Affordable Care Act are taking shape. Lessons from the evaluation can inform future decisions about CHIP and point to key areas of uncertainty.

The coming years offer the potential to build upon the coverage and access gains and financial protections for children and their families that came as a result of CHIP, due in large part to the expected gains in health insurance coverage for their parents. The Affordable Care Act coverage expansions are expected to improve the health and wellbeing of parents and other low-income adults, particularly in states that choose to expand Medicaid under the Affordable Care Act. Further reductions in uninsurance among children are also possible given the availability of Marketplace subsidies and health insurance reforms and the new outreach, enrollment, and renewal processes that are being implemented.

This study, like the prior Congressionally-mandated evaluation in ten states, has demonstrated the successful role that CHIP has played in meeting children's health care needs in very different contexts and with very different program structures, adapted to states' unique circumstances. The central question for policy makers is how to build upon CHIP's accomplishments to achieve additional coverage, access, and quality gains for children.

I. BACKGROUND AND CONTEXT FOR THE EVALUATION

This report presents findings from an evaluation of the Children’s Health Insurance Program (CHIP) mandated by the Children’s Health Insurance Program Reauthorization Act (CHIPRA) passed in February 2009. Initially authorized through the Balanced Budget Act of 1997, CHIP celebrated its 16th anniversary in August 2013. CHIPRA reauthorized the program and funded it through September 2013. The Patient Protection and Affordable Care Act of 2010 and the Health Education Reconciliation Act of 2010 (collectively referred to hereafter as the Affordable Care Act) authorized CHIP through September 2019 and extended funding for the program through September 2015. 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).⁷

Congress mandated in CHIPRA that the Secretary of the U.S. Department of Health and Human Services conduct an independent comprehensive evaluation of CHIP patterned after an earlier evaluation Congress mandated in the Balanced Budget Refinement Act (BBRA) of 1999

Congress stipulated in CHIPRA that the evaluation include 10 states with varied geographical and urban/rural representation, diverse approaches to program design, and a large proportion of the low-income, uninsured children in the United States.

Congress also stipulated that the evaluation survey families of CHIP enrollees and disenrollees, study low-income children likely to be eligible for Medicaid or CHIP but not enrolled, and address numerous questions related to the effectiveness of Medicaid and CHIP in finding, enrolling, and retaining eligible children and how Medicaid and CHIP work together to meet the health and health care needs of low-income children.

The enabling legislation for the current evaluation is contained in CHIPRA (P.L. 111-3), and the relevant legislation referenced in CHIPRA for the prior evaluation is contained in the BBRA of 1999 (H.R. 3426). (Appendix A contains copies of the relevant sections of the legislation).

Mathematica Policy Research and its partner the Urban Institute were awarded the contract in 2010 to conduct the CHIPRA evaluation of CHIP, which is being overseen by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). An interim report was sent to Congress in 2011 that describes the status and evolution of state CHIP programs throughout the United States as of 2010 and summarizes the evidence available at that time about the role and impacts of CHIP (Hoag et al., 2011). This final report synthesizes evidence collected through the CHIPRA evaluation of CHIP. The evaluation comes at an important juncture for CHIP because funding after September 2015 is not assured. Findings from the evaluation will help Congress and the nation better understand CHIP and its value as the future of the program is debated.

⁷ 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. The Affordable Care Act extended the Medicaid MOE requirements for adults to January 2014, when coverage through the Marketplaces went into effect (Hoag et al., 2011). MOE requirements for children were extended through September 2019.

Some of the evaluation findings are at the national level, while others focus on 10 states selected for more intensive study: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. As required by Congress, the evaluation included a large survey conducted in 2012 of CHIP enrollees and disenrollees in 10 states, and Medicaid enrollees and disenrollees in 3 of these states. It also included case studies conducted in each of the 10 survey states in 2012 and a national telephone survey of CHIP administrators conducted in early 2013. Insight into the experiences of children eligible for CHIP and Medicaid but not enrolled came from an analysis of data from the 2011/2012 National Survey of Children's Health (NSCH). Finally, the evaluation used data from the Current Population Survey to document national coverage trends from 1997 to 2012, and data from the American Community Survey (ACS) to estimate how coverage would be influenced in the future by different assumptions about the funding of CHIP after implementation of the Affordable Care Act.

The Problem CHIP Is Trying to Solve

Providing health insurance coverage to children has been a pressing policy issue for decades. 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 2011).⁸ 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.

The growing number of uninsured, low-income children throughout the 1970s and early 1980s led to reforms of the Medicaid program so that more children would be covered. 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 2011). Still, the gap in coverage for children continued to widen: by 1987, nearly one-quarter (24 percent) of children in families with family income under 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 below 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 the FPL were uninsured (Agency for Health Care Research 1997; Cunningham and Kirby 2004).

⁸ 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.

It was also in the 1990s that a previously overlooked trend became evident: the growing number of uninsured children with incomes above 100 percent of 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 (previously known as SCHIP, now called CHIP) passed with bipartisan support as part of the Balanced Budget Act of 1997 and became law on August 5, 1997, as Title XXI of the Social Security Act (P.L. 105-33).⁹ Congress appropriated \$40 billion to support CHIP's first 10 years (FFYs 1998 through 2007) (Wooldridge et al. 2003).

How CHIP Works

Like Medicaid, CHIP is jointly financed by states and the federal government, and the Centers for Medicare & Medicaid Services (CMS) administers both programs for the federal government. However, CHIP was designed as a block grant program with limits on federal allotments, while Medicaid is an entitlement program with no spending cap.¹⁰ Medicaid targets the poorest children (along with certain poor adults), generally those with family income up to 133 percent of the FPL (for children under age 6) or up to 100 percent of the FPL (for children ages 6 to 18).¹¹ CHIP picks up where a state's Medicaid eligibility thresholds end, with most states offering coverage to children with family incomes up to at least 200 percent of the FPL.¹² The federal matching rate for CHIP is about 23 percent higher than Medicaid, an enhancement designed to give states an incentive to adopt CHIP. States can decide on their CHIP program's upper income eligibility limit, but they receive only the Medicaid matching rate amount for

⁹ CHIPRA renamed the program the Children's Health Insurance Program (CHIP); for clarity we use the CHIP acronym throughout the report.

¹⁰ 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). Legislation in 1999 and 2005 made adjustments to the allotments to address problems with the initial formula, which did not consider state CHIP expenditures and led to the risk of shortages in some states (Kenney and Chang 2004; Kenney and Yee 2007).

¹¹ 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 (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). The Affordable Care Act changed the Medicaid income threshold for children ages 6 to 18 to 133 percent of the FPL starting in January 2014, and at that time states are required to transition children with income under that threshold from CHIP to Medicaid, and states may continue to claim the higher CHIP match for these children.

¹² 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. States may still cover pregnant women under CHIP.

children with family incomes above 300 percent of the FPL; as of late 2013, 13 states had upper income limits for CHIP above this level (Centers for Medicaid and CHIP Services 2013).¹³

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 products in the commercial insurance market (Ryan 2009). States decide how they administer CHIP: they can (1) expand their existing Medicaid program (this is called a Medicaid expansion CHIP program), (2) create a separate program, or (3) blend the two approaches to create a combination program. While many states initially implemented a Medicaid expansion CHIP program, in part because they could do so fairly quickly, over time more states began administering separate CHIP and combination programs, which offer greater flexibility in program design. Table I.1 summarizes characteristics of each program type and the number of states with each type in 2001 and in 2013.

Table I.1. Characteristics of CHIP Programs, FFYs 2001 and 2013

Program Type	Summary	Number of States 2001	Number of States 2013
Medicaid Expansion CHIP	Required to follow all Medicaid program rules, including benefits and cost-sharing; prohibited from capping or freezing enrollment	17	8
Separate CHIP	<p>Allows increased flexibility in program design.</p> <p>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.</p> <p>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.</p> <p>Provides no federal entitlement to coverage. Prior to maintenance of effort (MOE) rules established by the American Recovery and Reinvestment Act of 2009 (and extended and broadened by the Affordable Care Act), states could cap or freeze enrollment and maintain waiting lists at any time to limit costs and coverage.</p> <p>Option to impose waiting periods.</p>	16	15
Combination	States operate both Medicaid expansion CHIP and separate CHIP programs; each covers a different population based on income threshold	18	28

Sources: Mann et al. 2003; Rosenbach et al. 2003; CMS 2013.

Within certain limits established in the law, states also can design the CHIP benefit package and cost-sharing requirements to be consistent with public or private insurance in the state, and they can choose the program’s delivery system (managed care, fee for service, or primary care case

¹³ States with thresholds above 300 percent FPL in place when the Title XXI CHIP legislation (P.L. 105-33) was passed in 1997 were permitted to receive the higher CHIP matching rate for expenditures made for children with family incomes up to the pre-existing threshold. At that time, Tennessee was the only state with a Medicaid income threshold above 300 percent of the FPL.

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 (Williams and Rosenbach 2007).¹⁴ Because of the flexibility CHIP affords, the characteristics of CHIP programs vary across states (Rosenbach et al. 2007). As shown in Table I.2, 8.13million children were enrolled in CHIP programs at some point in FFY 2013; of these, 89 percent had a family income under 200 percent of the FPL.¹⁵ Most (80 percent) children enrolled in CHIP receive care through a managed care delivery system. Total spending on the program amounted to \$13.2 billion in FFY 2013, with the federal government contributing 70 percent of those expenditures.

Table I.2. CHIP at a Glance, FFY 2013

Children ever enrolled in CHIP during the year	8.13 million
CHIP children with family incomes below 200% of the Federal Poverty Level (FFY 2013)	89%
Number of children in separate CHIP programs	5.7 million
Who obtained care through managed care plan enrollment	4.5 million (80%)
Who obtained care on a fee-for-service basis	0.9 million (16%)
Who obtained care through primary care case management	0.2 million (4%)
Government spending on CHIP	\$13.2 billion
Federal spending on CHIP	\$9.2 billion (70%)
State spending on CHIP	\$4.0 billion (30%)

Sources: Medicaid and CHIP Payment and Access Commission (MACPAC) March 2014.

Notes: CHIP = Children's Health Insurance Program; FFY = federal fiscal year.

CHIP's Evolution

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 (Ellwood et al. 2003; Wooldridge et al. 2003). The program has continued to grow, albeit at a slower pace, in the past decade. For example, between 2006 and 2012, CHIP enrollment increased by about 20 percent (Appendix Tables B.2 and B.3 provide trend data on the number of children ever enrolled by state from 1998 through 2012).

Even before CHIPRA passed, Congress made changes to various aspects of CHIP. 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 experienced shortfalls (Congressional Research Service 2006 and 2008).¹⁶ 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

¹⁴ Marketing efforts were not part of the Medicaid program.

¹⁵ Total enrollment in CHIP for FFY 2013 reported as of March 2014 was 8,350,266 million, which includes 219,473 adults enrolled primarily through special waiver programs for low-income parents and pregnant women in some states.

¹⁶ Allotments were based on the number of low-income children without health insurance (100% in FFY 1998 and FFY 1999, 75% in FFY 2000, 50% in FFY 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.

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.

Attempts to reauthorize CHIP failed in the fall of 2007 and Congress instead extended it through March 2009, funding it at \$5 billion per year and appropriating some additional funds to help states with projected funding shortfalls. CHIPRA then passed in February 2009, providing \$44 billion in new funding (in addition to the \$25 billion in baseline funding appropriated through September 2013), establishing a performance bonus fund to encourage states to pursue innovations in enrolling children and keeping them enrolled, providing \$100 million in new outreach grant funding, and establishing an enhanced match rate for translation and interpretation services (Kaiser Commission on Medicaid and the Uninsured 2009b; PL 111-3, Section 104). CHIPRA also made several policy changes: requiring states to offer dental services and mental health parity in CHIP, giving them 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), permitting states to provide premium assistance to children and families with employer-sponsored coverage, prohibiting states from covering parents in CHIP unless a waiver was approved by HHS to provide such coverage, and requiring documentation of citizenship for children enrolled in CHIP (as in Medicaid) (Hoag et al 2011). CHIPRA also provided funds to study and improve access and quality of care for children and address other issues, and gave states 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.¹⁷

Among other things, the Affordable Care Act extended CHIP funding through September 2015 and MOE provisions through September 2019, gave states the option to cover low-income children of state employees if certain conditions are met, and specified a new “no wrong door policy” effective in 2014 that requires CHIP, Medicaid, and new Marketplaces to screen each child and adult who applies for coverage and enroll them in the insurance appropriate for their income (Medicaid, CHIP, or the Marketplace).

Evaluation Design

Congress specified that states selected for the evaluation should represent varied geographic areas and urban/rural populations, diverse approaches to program design, and a large proportion of the low-income, uninsured children in the United States (CHIPRA Section 603 and BBRA 1999 Sec. 703 (c)(2)). Together, the 10 states selected (Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia) cover the four census regions, reflect diverse program designs, and represented 53 percent of the nation’s uninsured children and 57 percent of children enrolled in CHIP when selected in 2010. (Appendix Table B.1 summarizes how the selected states met the criteria for the evaluation).

¹⁷ 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).

The evaluation had five major components:

1. A large **survey of CHIP enrollees and disenrollees** conducted during 2012 in the 10 states selected for the evaluation. Administered to the parents or guardians of children with current or recent CHIP coverage, the survey provided information not otherwise available on the characteristics of CHIP children and their families; perceptions of and experiences with application and renewal processes; coverage experiences prior to and after enrollment; the health status and health care needs of CHIP enrollees; enrollee experiences with accessing health care; and program impacts on access, use, and family wellbeing. A complementary **survey of Medicaid enrollees**, administered in 3 of the 10 CHIP survey states (California, Florida, and Texas), contributed similar types of findings on children and families enrolled in Medicaid.
2. A second major component involved qualitative data from **CHIP case studies** conducted in 2012 in the same 10 states selected for the survey. Featuring **site visits** to various state and local stakeholders (such as program administrators, providers, and child advocates) and **focus groups** with families of CHIP-enrolled children, the case studies examined the design of CHIP programs and how this evolved over time, and how programs were affected by CHIPRA and the Affordable Care Act.
3. The third component was a **nationwide survey of CHIP program administrators**, conducted in early 2013. This telephone survey provided information about the implementation and influence of key CHIPRA provisions and how the Affordable Care Act had affected CHIP programs to date and how it was expected to influence programs in the future.
4. The fourth component made use of **state program data**—CHIP annual reports and related data submitted by states, as well as administrative data from state eligibility and enrollment systems—to analyze enrollment and retention trends and dynamics and identify program features and other factors influencing these outcomes. We explored enrollment and retention trends, including transitions between CHIP and Medicaid, and churning out of and back into the program.
5. The final component drew on data from several **national surveys** (the NSCH module of the State and Local Area Integrated Telephone Survey [SLAITS], CPS, and ACS), to explore how low-income families with uninsured children perceive CHIP and Medicaid, study coverage trends since CHIP was enacted, examine Medicaid and CHIP program participation rates, and simulate future coverage under different assumptions about future funding and eligibility for Medicaid and CHIP.

Survey of CHIP and Medicaid Enrollees and Disenrollees

Since the survey of CHIP and Medicaid enrollees and disenrollees is a major focus in this final report, additional information about its design is provided here. The survey was fielded in 2012

and included 12,100 CHIP enrollees in 10 states and 3,400 Medicaid enrollees in 3 of these states.¹⁸ The CHIP and Medicaid samples were drawn from three distinct enrollment domains:

- **Recent enrollees** were children who had been enrolled in the given program for 3 consecutive months, preceded by a gap in coverage of at least 2 months, at the time of sampling.
- **Established enrollees** were children who had been enrolled in the program for at least 12 consecutive months at the time of sampling.
- **Recent disenrollees** were children who were disenrolled from the program for at least 2 months, and who were previously enrolled for at least 3 months prior to their month of disenrollment, at the time of sampling.

The types of questions asked and the reference period for the questions varied depending on the sample domain for the child. As summarized in Table I.3, recent enrollees were asked about experiences before enrolling in CHIP or Medicaid, established enrollees were asked about experiences while enrolled, and recent disenrollees were asked about experiences since leaving CHIP or Medicaid. Questions about enrolling in the program were asked only of recent enrollees and questions about the reasons for leaving CHIP or Medicaid were asked only of recent disenrollees. A core set of demographic and health status questions were asked of all sample members.

Table I.3. Survey Content by Sampled Group

Content Area	Survey Content and Timeframe for Sample Group		
	Recent Enrollees	Established Enrollees	Recent Disenrollees
Enrollment	Reason for enrolling in CHIP or Medicaid Application experiences	Renewal experiences	Renewal experiences
Access, Use, Family Wellbeing	Access, Use, Family Wellbeing 12 months before enrollment	Access, Use, Family Wellbeing past 12 months (while enrolled)	Access, Use, Family Wellbeing since disenrollment
Insurance Coverage	Child's coverage during 12 months prior to enrollment	Parent's coverage and access to coverage at time of interview	Child's coverage after disenrollment
Disenrollment			Reason for leaving CHIP or Medicaid

The survey was conducted by telephone with an in-person follow-up component for households that could not be located or contacted by phone. For all sample members, the interview was conducted with the person most knowledgeable about the health care needs and services received

¹⁸ For the CHIP survey, the target population included current and former enrollees in separate CHIP and Medicaid expansion CHIP components. For the Medicaid survey, the target population included only enrollees and disenrollees in the “traditional” (Title XIX-funded) Medicaid program and not those in the Medicaid expansion CHIP component. Further details on the methods (including variable construction and sample sizes for different analyses) are part of a separate report on the survey (Smith et al. 2014). That document also includes the survey instrument and a detailed description of the sampling and data collection approach to the survey of CHIP and Medicaid enrollees and disenrollees.

for the sampled child. Typically, that person was either a parent or a legal guardian of the child. For in-person interviewing, the field locator provided the individual with a cell phone for completing the interview with Mathematica's survey operations center, thus ensuring a consistent mode of interview (phone) for all sample members. Each sample member was weighted to reflect the population represented and also to correct for nonresponse.

The analyses combined bivariate and regression methods using appropriate sample weights and took into account the demographic and socioeconomic characteristics of sampled children and their families. The analysis of impacts of CHIP and Medicaid on access, service use and family wellbeing employed a comparison group design. The survey methods report provides additional details on the design and content of the survey as well as on the methods used in the analysis of the survey data (Smith et al. 2014)

Findings were integrated across the various evaluation components to address a number of overlapping research questions, as summarized in Table I.4.¹⁹ While this final report summarizes the main findings, individual reports provide further details on the methods employed and detailed findings for each evaluation component (see Appendix Exhibit B.1 for a full listing of evaluation reports).

¹⁹ Further details on the design are contained in the design report for the evaluation, Harrington et al. (2011).

Table I.4. Summary of Key Research Questions and Data Sources

Research Topics/Questions	Data Sources				
	Surveys of CHIP (10 states) and Medicaid (3 states) Enrollees and Disenrollees	Case Studies in 10 states	Survey of CHIP Program Administrators (47 states)	National Survey Data (NSCH, CPS, ACS)	State Enrollment Data (10 states); other State Program Data (all states)
Program Context and Design Features					
<ul style="list-style-type: none"> • Key CHIP design features • How and why these features changed over time • How design features influence key program outcomes 	X	X	X	X	X
Outreach, Application, Enrollment and Renewal					
<ul style="list-style-type: none"> • Effective and ineffective outreach strategies • Awareness of Medicaid and CHIP among low-income families • Enrollee experiences with application and renewal • Trends in program enrollment and factors influencing trends 	X	X	X	X	X
Retention and Disenrollment					
<ul style="list-style-type: none"> • Trends in duration/retention, churning, and transitions between Medicaid and CHIP • Why children disenroll, and whether they obtain other coverage after leaving 	X	X	X	X	X
Access, Utilization, Content of Care, and Family Wellbeing					
<ul style="list-style-type: none"> • Experiences of CHIP enrollees seeking and obtaining care. • How this compares with experiences before enrollment • CHIP's impact on the type of care received, content of care, and family well-being 	X	X	X		
Relationship Between CHIP and Other Coverage					
<ul style="list-style-type: none"> • How CHIP alters or factors into the movement of low-income children between public coverage, private coverage, and uninsurance 	X	X		X	
Impact on Uninsured Children					
<ul style="list-style-type: none"> • Coverage trends among CHIP's target population • Participation in public coverage among eligible low-income children 				X	
Implications for Health Reform					
<ul style="list-style-type: none"> • Influence of reforms on CHIP programs, to date and expected in future 	X	X	X	X	

Notes: CHIP=Children's Health Insurance Program; CPS=Current Population Survey; ACS=American Community Survey.

Road Map for the Report

The remainder of this report presents findings in 9 chapters and ends with overall conclusions and policy implications. Chapter II summarizes findings on CHIP program design, based largely on the case studies and survey of state program administrators. Chapter III draws on national survey data to present findings on coverage trends since CHIP was enacted and participation in

Medicaid and CHIP among eligible children. Chapter IV examines prior coverage experiences and access to employer-sponsored insurance among CHIP and Medicaid enrollees. Chapters V and VI draw largely on Medicaid and CHIP enrollment data from the 10 study states to present findings on trends in enrollment and retention, movement between programs, and the experiences of disenrollees after leaving CHIP. Chapters VII through IX draw primarily on the evaluation's 2012 survey of enrollees and disenrollees: Chapter VII describes the characteristics of children enrolled in CHIP; Chapter VIII presents findings on access, use and financial well-being among CHIP and Medicaid enrollees and how their experiences compare with those of children who are uninsured or who have private insurance; and Chapter IX focuses on the characteristics and experiences of low-income uninsured children, and the application and renewal experiences of CHIP and Medicaid enrollees. Chapter X focuses on findings from the survey of state program administrators to describe how the Affordable Care Act had influenced CHIP programs as of early 2013.

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II. PROGRAM DESIGN

KEY FINDINGS:

- Despite the recent recession, which persisted during much of the study period, many states expanded children’s coverage, by either raising upper income eligibility limits, covering legally residing immigrant children and pregnant women—groups newly eligible because of CHIPRA—or covering dependents of state employees as permitted by the Affordable Care Act.
- Simplifying rules and procedures for both enrollment and renewal continued to be a major priority for CHIP programs and CHIPRA played a direct role in spurring innovation. Similarly, CHIPRA’s outreach grants played an important role in supporting and supplementing state outreach efforts.
- Important legacies of CHIPRA are the law’s mandatory requirements for comprehensive dental benefits coverage and mental health parity for all CHIP programs; while most states already offered generous coverage of these benefits, the mandate may have protected them from cuts during the economic downturn.
- Federal Maintenance of Effort (MOE) rules, which prohibit states from cutting eligibility and enrollment policies for Medicaid and CHIP to levels more restrictive than those in place in March 2010, were viewed by some CHIP administrators as crucial protection for CHIP, especially given how the recent recession weakened state economies and pressured policymakers to look for places where they could cut state budgets.

This chapter draws findings about CHIP from two key data sources: (1) case studies in the 10 study states, conducted between February and September 2012; and (2) a national survey of CHIP state program administrators, conducted between January and April 2013.²⁰ Through both efforts, evaluators documented perceptions from state officials and other key informants about whether and how CHIP programs had changed in response to CHIPRA. The case studies included consumer focus groups that allowed parents to describe how well CHIP was meeting the needs of their children.

States have taken advantage of flexibility embedded in the CHIP statutes to design CHIP programs that emulate private insurance coverage.

From the outset, a fundamental feature of CHIP was the flexibility granted to states with regard to program design, and many states used that flexibility to create separate CHIP programs that were designed to feel more like private insurance to consumers. As early as 2001, 35 states

²⁰ The data collection methods and findings from the case studies were documented in Hill et al. (2013a); the data collection methods and findings from the state program administrator survey were documented in Hoag et al. (2013).

operated separate CHIP programs—either alone or in combination with (typically smaller) Medicaid expansions—with attractive names (like Healthy Families in California and Child Health Plus in New York). These programs typically included cost sharing arrangements similar to (though typically lower than) private plans and service-delivery networks built around mainstream managed care plans. At its peak, the number of states with separate CHIP programs reached 43, but recently, at least partly in response to anticipated changes under the Affordable Care Act, six states have eliminated their separate CHIP programs. As of January 2014, 37 states operated a separate CHIP (either alone or in combination with a Medicaid expansion CHIP) and 13 states and the District of Columbia operated only a Medicaid expansion CHIP (Centers for Medicaid and CHIP Services 2013b).

States continued to extend broad coverage to children in working poor families through CHIP, while also simplifying both enrollment and renewal policies and procedures.

Since its inception, CHIP has been a fertile testing ground for state innovations related to eligibility policy and the simplification of enrollment and renewal procedures. The federal financial stability and administrative flexibility that CHIPRA provided, among other factors, led many states to further expand eligibility for children in working poor families and to adopt additional simplification strategies to facilitate enrollment and renewal.

- CHIPRA allowed states to cover children in families with incomes above 250 percent of the federal poverty level; as of January 2014, 19 states had done so (Centers for Medicaid and CHIP Services 2013).
- In addition, 24 states expanded CHIP coverage to legally residing immigrant children or pregnant women, as permitted by CHIPRA, while an additional three states used rules permitted by CHIPRA Section 111 to expand coverage for pregnant women.
- Sixteen states extended CHIP coverage to children of state employees; half of these states completed this expansion because of an option in the Affordable Care Act to cover these children (the other eight states had previously covered these children in other ways, such as through a Section 1115 waiver).

Maintenance of effort (MOE) rules established by the American Recovery and Reinvestment Act of 2009 (and extended and broadened by the Affordable Care Act) protected these and other gains by prohibiting states from cutting eligibility and enrollment policies for Medicaid and CHIP to levels more restrictive than those in place in March 2010. In the survey of state CHIP administrators, officials from 30 states (of 46 responding to the question) reported that these rules were important in safeguarding CHIP and Medicaid from cuts in recent years, especially as state budgets came under pressure during the recent recession.

CHIPRA performance bonuses played a direct role in spurring states' continued interest in pursuing enrollment and renewal simplification strategies.

States that adopted at least five of eight approved simplification strategies (listed in Table II.1) and that met Medicaid enrollment growth targets qualified for performance bonuses that were quite substantial: over \$1 billion has been awarded to states between 2009 and 2013 (InsureKidsNow.gov 2013). Administrators from 29 states interviewed as part of the survey of state program administrators—including states that did not receive a bonus—thought the

CHIPRA performance bonuses were an effective incentive to adopt simplifications. Seven of the 10 case study states (Alabama, Louisiana, Michigan, New York, Ohio, Virginia, and Utah) qualified for CHIPRA performance bonuses between fiscal years 2009 and 2013, totaling over \$243 million. As shown in Table II.1, some other case study states, such as California, have been leaders in simplifying enrollment and renewal, but did not achieve enrollment targets needed to qualify for the bonus.

Table II.1. CHIPRA Performance Bonus Simplification Strategies, by State, as of 2012

State	12-Month Continuous Eligibility	No Asset Test	No In-Person Interview	Same Application and Renewal Forms in Medicaid and CHIP	Administrative or Ex Parte Renewal	Presumptive Eligibility	Express Lane Eligibility	Premium Assistance
Alabama	X	X	X	X	X		Medicaid	
California	X	X	X	X		X		
Florida	CHIP	X	X	X	X			CHIP
Louisiana	X	X	X	X	X		Medicaid	
Michigan	X	X	X	X		X		
New York	X	X	X	X		X	X	
Ohio	X	X	X	X		X		
Texas	CHIP		X	X				
Utah	CHIP	CHIP	X	X	X	X	CHIP	CHIP
Virginia	CHIP	X	X	X	X			CHIP

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Notes: X denotes implementation in both Medicaid and CHIP. To qualify for a performance bonus, states had to implement at least five of these eight policies and increase children's enrollment in Medicaid above a baseline established for each fiscal year. Administrative or ex parte renewal means states can access government or commercial databases to verify family income electronically to allow renewal in CHIP or Medicaid without any paperwork required from families.

The case studies identified numerous creative, multipronged strategies to streamline enrollment and renewal procedures and achieve high rates of participation among eligible children (Table II.2). All but one of the case study states offered online applications for their CHIP programs and most of the study states had designed more-integrated data systems—some capable of linking across public benefits programs and others with the ability to verify applicants' income, employment, health insurance status, and citizenship.

- Four of the case study states (Alabama, Louisiana, New York, and Utah) added Express Lane Eligibility (ELE) to their toolbox of simplification strategies, a new option permitted by CHIPRA that allows states to use the findings of other need-based programs to establish or renew eligibility for children in Medicaid and CHIP (see Hoag et al. 2013a for final findings from the evaluation of ELE).²¹

²¹ ELE is set to expire on September 30, 2015 unless Congress acts to extend it.

- A majority of study states also used a range of community-based application-assistance models that bolstered traditional outreach by enabling staff of local agencies, providers, and health plans to provide application assistance to families with uninsured children. Key informants described these staff assistors, who often reflected the ethnicities of the communities in which they worked, as “trusted” and “culturally competent” and, therefore, particularly successful in helping “hard-to-reach” populations to access coverage. Families participating in the study’s focus groups widely praised the ease with which they were able to apply for and obtain health coverage for their children, and particularly noted how valuable the help of application assistors was in enrolling.

States also focused considerable attention on simplifying renewal processes, recognizing that high retention rates are crucial to reducing churn and maintaining gains in reducing the ranks of uninsured children.²² Generally, states applied many of the same types of strategies to renewal that they did to initial enrollment. In the study’s focus groups, parents described how easy most CHIP renewal processes were for them.

Table II.2. CHIP Enrollment and Renewal Strategies, by State, 2012

State	Mail-In Enrollment and Renewal	Online Enrollment and Renewal	Community-Based Application Assistance	Active or Administrative Renewal	Preprinted Renewal Form	Self-Declaration of Income
Alabama	X	X	X	Active	X	X
California	X	X	X	Active	X	
Florida	X	X		Active	X	X
Louisiana	X	X	X	Administrative		X
Michigan	X	X	X	Active		X
New York	X		X	Active		X
Ohio	X	X	X	Active		
Texas	X	X	X	Active	X	X
Utah	X	X		Active	X	
Virginia	Enrollment Only	X	X	Active	X	X

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Note: Active renewal means enrollees have to take steps to renew their coverage. Administrative renewal means families may maintain their coverage without providing another form or more income documentation as long as no family member’s income has changed.

Administrators’ concerns about substitution of CHIP for private group coverage have diminished over time.

During the initial development of CHIP, policymakers worried that the new coverage program would encourage families to substitute government-sponsored health insurance for existing employer-sponsored coverage for their children. Many were also concerned that employers

²² Churn refers to the phenomenon whereby children lose eligibility for administrative reasons and subsequently re-enroll into coverage a short time later.

might stop offering dependent health coverage if their employees' children became eligible for CHIP. In response to these concerns, the original CHIP legislation mandated that all states have "reasonable procedures" in place to protect against these types of substitution. Most states devised a range of strategies to prevent or discourage substitution, but primarily relied on waiting periods during which children must be uninsured before they can enroll in CHIP.

Officials interviewed in the 10 case study states reported that substitution of CHIP for private coverage was not a major concern; state officials generally expressed the belief that provisions to prevent substitution had effectively deterred families from dropping private coverage.²³ This perception by state administrators echoed that of the first CHIP evaluation (Hill et al. 2003). When the case studies were conducted in 2012, 9 of the 10 study states imposed waiting periods (ranging from 3 to 12 months) and maintained a range of other provisions designed to discourage substitution of public for private coverage. Affordable Care Act regulations stipulate that states with separate CHIP programs cannot impose waiting periods longer than 3 months starting in 2014; this rule led numerous states to change their waiting period policies after the case studies were completed. All of the case study states with separate CHIP programs have now done so, with Virginia eliminating its waiting period as of July 1, 2014.

- During the study period, only Louisiana and New York increased the length of waiting periods under CHIP—and did so only when they significantly expanded eligibility to higher-income families (those with incomes up to 250 percent of the FPL in Louisiana and 400 percent of the FPL in New York).
- More often, states relaxed their anti-substitution provisions by either decreasing the length of a waiting period (as in Florida) or adding more exceptions to the waiting period for families in need of coverage for their children (as in New York, which permits an exception to the waiting period for children in households with income between 251 and 400 percent of the FPL when the cost of dependent coverage is more than five percent of the gross household income).

In recent years, states cut CHIP outreach budgets and relied more heavily on grass roots and community-based outreach efforts.

Aggressive outreach was a hallmark of CHIP programs in the late 1990s and early 2000s, when states launched strategic efforts to market CHIP to eligible populations. States publicized the availability of health insurance coverage through initiatives that involved both broad, statewide marketing to create a strong brand identity for their programs and more targeted, community-based efforts to attract hard-to-reach families (Hill et al. 2003; Williams and Rosenbach 2007). Between 2006 and 2012, CHIP outreach efforts in the 10 study states evolved in response to state budget constraints and as the program became more established. States typically moved away from broad marketing campaigns and instead relied more on community-based efforts.

²³ Chapter IV provides information from a formal analysis of the extent of substitution in the study states based on data from the 2012 survey of CHIP enrollees and disenrollees.

- Although marketing budgets have dwindled or been eliminated over the years in most of the study states, three of the states—Texas, Utah, and Virginia—continued to dedicate some state funds to supporting outreach.
- More commonly, outreach is supported through robust community-based outreach efforts, which have persisted in 9 of the 10 study states—all but Alabama, where all outreach was halted in late 2011 in an attempt to curtail enrollment as the program faced severe budget constraints. Many key informants acknowledged that the shift to community-based outreach was appropriate given that states had already enrolled a large proportion of eligible children; the remaining eligible but not enrolled children were likely harder-to-reach populations who would more apt to be identified by trusted community allies.
- In states like New York, health plans have also played a major role in CHIP outreach and marketing, filling some of the void left as states reduced and/or eliminated outreach budgets.

CHIPRA also emphasized a focus on outreach through the authorization of new outreach grants—each lasting up to two years—designed to fund activities that support enrollment, renewal, and outreach.

Nationally, CHIPRA outreach grant funding amounts ranged from \$70,000 to \$2.5 million per awardee. In some cases, projects supported by CHIPRA outreach grants have coordinated with the states to ensure the most effective use of these additional resources. In some states, such as Louisiana, the state agency was a grantee, allowing them to directly support outreach efforts.

- In the survey of state program administrators, CHIP administrators from 43 states (of 47 responding to the question) reported that organizations in their states—typically state and local governments and/or community-based and nonprofit organizations—received CHIPRA outreach grants.
- In the evaluation’s case studies, officials reported that CHIPRA outreach grants had been particularly helpful in bolstering otherwise underfunded outreach efforts, and played a significant role in supporting and sustaining community-based groups involved in outreach.

Regardless of whether or not they received a grant, administrators from 30 states that participated in the survey of CHIP administrators thought that CHIPRA outreach grants should be continued past September 2013. Common reasons given by officials for continuing the grants included the lack of other sources for outreach funding and the ability to use grant money to fund grassroots campaigns and other efforts to target harder-to-reach populations within their states.²⁴

²⁴ On July 2, 2013 DHHS awarded \$32 million to fund Connecting Kids to Coverage Outreach and Enrollment grants (Cycle III), awarding 41 grants in 22 states; an addition \$4 million will be awarded in 2014 to Indian health care providers and tribal entities. (<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-02.html>).

CHIPRA required comprehensive dental benefits and mental health parity in CHIP programs; according to a survey of CHIP administrators, 12 states reported modifying their dental benefits and 19 reported modifying their mental health benefits in order to comply.

Since CHIP began, states with separate CHIP programs have had a degree of flexibility in designing their benefit packages, whereas states that implement Medicaid expansions must extend the full Medicaid benefit package to enrollees. To help ensure that separate programs offered adequate benefits, however, Title XXI requires that states meet certain minimum benchmark standards. Despite not being required to achieve parity with Medicaid, most states with separate programs went beyond benchmark minimums to add broad coverage of dental care and mental health benefits, seeking to closely align benefits between separate CHIP programs and Medicaid. Key informants and parents participating in the study's focus groups consistently praised the generosity of the CHIP benefit packages, although a few deficiencies were noted, such as the lack of nonemergency transportation and EPSDT protections.²⁵ Many child health advocates believe the lack of an EPSDT requirement is a weakness of many separate CHIP programs because EPSDT requires states to cover any service a child needs that is identified during an EPSDT screen. However, some separate states have elected to offer EPSDT protections.

CHIPRA introduced two new mandatory benefits in CHIP: comprehensive dental benefits and mental health parity.

- In the survey of CHIP administrators, a dozen states reported having to remove limits on preexisting dental benefits or increase their coverage of particular dental benefits; the addition of medically necessary orthodontia was the most frequently reported benefit increase, by administrators from 7 states.
- Meanwhile, administrators from 28 states reported that they did not need to make any changes to conform to CHIPRA's mental health parity provisions; if federal regulations are issued, this could change. Among the 19 states that made some changes, 14 reduced or eliminated limits previously imposed on mental health and substance abuse services, and 2 implemented a limit on physical health services to comply with parity rules.

States have continued to offer generous benefits in CHIP despite increased budget pressures in recent years. This is notable given that, in light of MOE restrictions, benefits were one of the few program areas where policymakers had the ability to enact cuts. CHIPRA may have had a protective effect on these benefits, as without the CHIPRA benefit mandates, dental and mental health might have been cut in response to state budget constraints.

²⁵ The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a special component required of Medicaid programs that extends comprehensive preventive, diagnostic, and treatment services to child enrollees. EPSDT is not required under CHIP.

CHIP programs continued to utilize managed care service delivery networks, viewing the model as one that offers good access to care.

Earlier CHIP evaluations found mandatory enrollment in risk-based managed care plans to be the dominant form of service delivery for separate CHIP programs, more so than for Medicaid (Hill et al. 2003). This trend continued during the current study period (although Medicaid programs have generally increased their reliance on risk-based managed care over the last decade). CHIP program officials reported various reasons for choosing risk-based managed care, but primarily they viewed the delivery model as one that helps to ensure good access to care through provider networks that resemble commercial insurance networks. Among the 10 study states, only Alabama used discounted fee-for-service reimbursement with a single insurer—Blue Cross/Blue Shield of Alabama—for its separate CHIP program. The remaining states all used risk-based managed care statewide by 2012.

CHIPRA required that CHIP beneficiaries be offered a choice of at least two health plans when risk-based managed care is mandatory (a requirement that also exists for Medicaid managed care). This created challenges for states such as Florida and New York that previously contracted with single plans in certain rural areas. Both of these states complied with the new requirement, but not without considerable effort, as it can be difficult to develop networks in sparsely populated areas.

Most CHIP (and Medicaid) managed care programs in the study states carved out behavioral health and dental care and delivered these services through other arrangements. The exceptions were New York, where health plans were responsible for all care, including behavioral health and dental services; Utah, where plans were responsible for behavioral health care but not dental care; and Ohio, where plans must provide dental care but not behavioral health services.

- Key informants generally agreed that carve-outs for dental care work well, because specially designed dental plans have wider networks than traditional FFS programs and are more experienced with managing the provision of dental services compared to health plans.
- Key informants had mixed opinions of behavioral health carve-outs: some thought that they resulted in more effective, specialized service provision for people with mental health and substance abuse needs, but others were concerned that they fragmented care across physical health and behavioral health systems.

Key informants and parents expressed broad satisfaction with access to care in separate CHIP programs. Access to primary care was viewed as particularly strong, because of high levels of participation by pediatricians. These generally positive comments about access were less frequently made by key informants and parents in reference to Medicaid expansion programs. Provider reimbursement rates were reportedly lower, on average, in Medicaid expansions than in separate CHIP programs, and key informants suggested that, as a consequence, provider participation and access to care were generally more limited, particularly in the case of dental care.

Cost-sharing remained a prominent feature of CHIP programs, in part because CHIP was intended to mirror private coverage.

Federal law permits states to impose various forms of cost-sharing on families enrolled in CHIP—including premiums, copayments, deductibles, and coinsurance—as long as total cost-sharing remains under 5 percent of a family’s income. Cost-sharing for children with family incomes below 150 percent of the FPL is limited. The first CHIP evaluation found that separate CHIP programs established premiums and copayments at levels that both administrators and families viewed as fair and affordable. At that time, many key informants believed that such cost-sharing had a beneficial effect in that it made CHIP feel more like private insurance, instilling a sense of pride and responsibility in families that contributed to the cost of their children’s coverage (Hill et al. 2003). Most key informants interviewed for this evaluation continued to view cost-sharing as a positive component of CHIP; the vast majority of parents participating in the study’s focus groups saw CHIP cost-sharing as both fair and affordable, and much less expensive than private insurance. CHIPRA’s requirement that states allow a 30-day grace period before disenrolling children for nonpayment of premiums was cited as an important new protection for families.

When the case studies were conducted in 2012, Ohio (a Medicaid expansion-only state) was the only case study state without some form of cost sharing. Cost-sharing policies varied from state to state and included annual enrollment fees (in two of the study states), monthly or quarterly premiums (six states), copayments (seven states), and deductibles and coinsurance (two states). Six of the 10 study states increased premiums between 2006 and 2010, mostly in response to worsening state budget conditions. Of the nine states with cost sharing, seven required copayments (Table II.3).

- Copayments were tied to income level and varied depending on the type of service. For example, copayments for medical office visits ranged from \$2 in Virginia for families between 101 and 150 percent of FPL, to \$25 in Utah and Texas for families with higher incomes.
- Prescription drug copays also varied greatly, as states charge different amounts for generic and brand name medications. In Texas, for instance, families with incomes up to 150 percent of FPL receive free generic prescriptions, while families in California in the same income bracket pay \$10 per generic prescription.
- Emergency room visit copayments were generally the most expensive across the seven states, particularly for non-emergency use: families between 151 and 200 percent of FPL pay between \$25 in Virginia to \$300 in Utah for a visit to the emergency room.

Table II.3. Copayment and Deductible Amounts for Selected Services, Case Study States, 2012

State	Program	% FPL	Medical Office Visits Amount (Non-Preventive)	Generic Prescription Drug	Brand Prescription Drug	ER	Deductible
Alabama	ALL Kids	101-150%	\$3	\$1	\$5	\$6	NA
		151-300%	\$13	\$5	\$25	\$60	NA
California	Healthy Families	all eligible	\$10	\$10	\$15	\$15	NA
Florida	Healthy Kids	all eligible	\$5	\$5	\$5	\$10 (if inappropriate)	NA
Louisiana	LaCHIP Affordable Plan	all eligible	Enrollees pay 10% of the fee-for-service rate in-network and 30% out-of-network	Enrollees pay 50% of costs or a maximum of \$50 for a 30 day supply	Enrollees pay 50% of costs or a maximum of \$50 for a 30 day supply	\$150 (waived if admitted)	\$200 for mental health/substance abuse services
Texas	CHIP	0-100%	\$3	\$0 generic	\$3	\$3 nonemergency	NA
Texas	CHIP	101-150%	\$5	\$0 generic	\$5	\$5 nonemergency	NA
Texas	CHIP	151-185%	\$20	\$10 generic	\$35	\$75 nonemergency	NA
Texas	CHIP	186-200%	\$25	\$10 generic	\$35	\$75 nonemergency	NA
Utah	CHIP Plan A	<100%	\$3	\$1 generic	\$1	\$3	None
Utah	CHIP Plan B	101-150%	\$5	\$5 generic	5% of approved amount	\$5 \$10 nonemergency	\$40/family
Utah	CHIP Plan C	151-200%	\$25	\$15 generic	25% of approved amount	\$300 after deductible	\$500/child; \$1500/family max
Virginia	FAMIS	134-150%; ages 6-18	\$2	\$2	\$2	\$2 (\$10 nonemergency)	NA
Virginia	FAMIS	151-200%; ages 6-18	\$5	\$5	\$5	\$5 (\$25 nonemergency)	NA

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

Although some states increased beneficiary cost-sharing during the study period, cost-sharing generally was perceived as affordable.

Given weak state budget environments in recent years, states increasingly looked to increase enrollee cost-sharing as a lever to address budget pressures as well as to discourage inappropriate utilization. Cost-sharing increases have not come without some controversy. State legislators in some of the study states expressed the belief that increasing cost-sharing was the “last, best option” for preserving CHIP, whereas advocates and other policymakers expressed concern that such increases could deter families from enrolling their children in CHIP, maintaining coverage in the program, or utilizing services when needed.

- Though no hard data were available, informants in Louisiana, for example, blamed high premiums for low enrollment in *LaCHIP Affordable Plan* and advocates in Utah believed that “expensive” premiums for higher-income families had led to adverse selection.
- Similarly, in Texas, CHIP copayments have risen substantially in recent years reportedly to offset the increased costs of implementing the CHIPRA mental health parity and expanded dental benefit requirements; for example, children in families with income from 186 – 200% of the FPL now have a \$25 copayment for an office visit and a \$125 copayment for an inpatient facility. Some stakeholders in Texas worried that such high copayments may have prevented families from seeking timely care.

Despite these concerns, the majority of key informants reported they perceived cost-sharing levels in CHIP as relatively modest, especially compared with commercial coverage. Furthermore, state officials reported that relatively few families were known to have incurred out-of-pocket costs approaching the 5 percent of income limit.

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III. ROLE OF MEDICAID AND CHIP COVERAGE IN DECLINING UNINSURANCE AMONG CHILDREN

KEY FINDINGS

- Medicaid and CHIP have succeeded in reaching the target population of uninsured children and have contributed greatly to the reduction in uninsurance among low-income children from 25 percent in 1997 to 13 percent in 2012.
- During the same period, uninsurance rates rose among adults, who were less likely to qualify for Medicaid and CHIP.
- All racial and income groups experienced gains in coverage, but the gains have been particularly striking among Hispanic children.
- Participation in Medicaid and CHIP among eligible children increased nationwide from 82 percent in 2008 to 88 percent in 2012; by 2012, 21 states had achieved participation rates of 90 percent or higher while just 5 states had rates of 80 percent or lower.
- The number of children eligible for Medicaid or CHIP yet uninsured fell from 4.9 to 3.7 million between 2008 and 2012, and 68 percent of all remaining uninsured children are eligible for Medicaid or CHIP.

Previous research has documented substantial declines in uninsurance among low-income children following CHIP's implementation. Those declines stand in 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; Howell and Kenney 2012; Blavin et al. 2012a). Studies also show that CHIP expansions have contributed to a reduction in racial and ethnic disparities in coverage among low-income children (Shone et al. 2005; Currie et al. 2008; Choi et al. 2011; Blavin et al. 2012b; Coyer and Kenney 2013; Kenney, Coyer, and Anderson 2013).

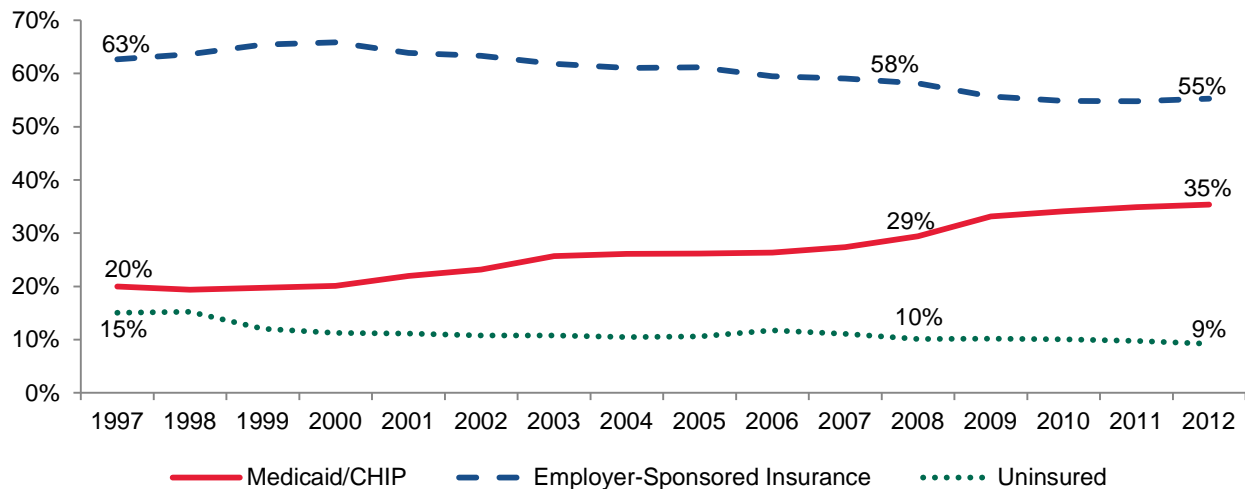
In this chapter, we present coverage trends since CHIP's enactment, including trends in the proportion of children without health insurance. We use a consistent time series of data from the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), the most widely cited source of information about health insurance coverage; the CPS-ASEC covers the 15-year period—1997 through 2012—since CHIP's enactment. We also include in this chapter an analysis of data from the ACS for 2008 and 2012 to show changes over time as well as variation across states and key subpopulations in the rate of Medicaid and CHIP participation among eligible children. Overall, the findings suggest that Medicaid and CHIP have succeeded in reaching the target population of uninsured children and have contributed greatly to the reduction in uninsurance among low-income children from 25 percent in 1997 to 13 percent in 2012.

Children’s Health Insurance Coverage In The CHIP Era, 1997–2012

Medicaid and CHIP coverage offset declines in employment-based coverage, fueling a substantial decline in uninsurance among children.

Between 1997 and 2012, most children (all incomes) had coverage from a parent’s employer, although the proportion with such coverage dropped from 63 to 55 percent over the period (Figure III.1).²⁶ Meanwhile, Medicaid and CHIP coverage among all children increased from 20 to 35 percent over the same period.²⁷ Increased public coverage more than offset the loss of employer-sponsored coverage so that the percentage of all children who were uninsured fell by 6 percentage points (from 15 to 9 percent) despite recession conditions that separated many families from their connection to employer-sponsored coverage and left families with fewer resources to purchase coverage on their own.

Figure III.1. Percentage with Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured: All Children, 1997–2012



Source: CPS-ASEC.

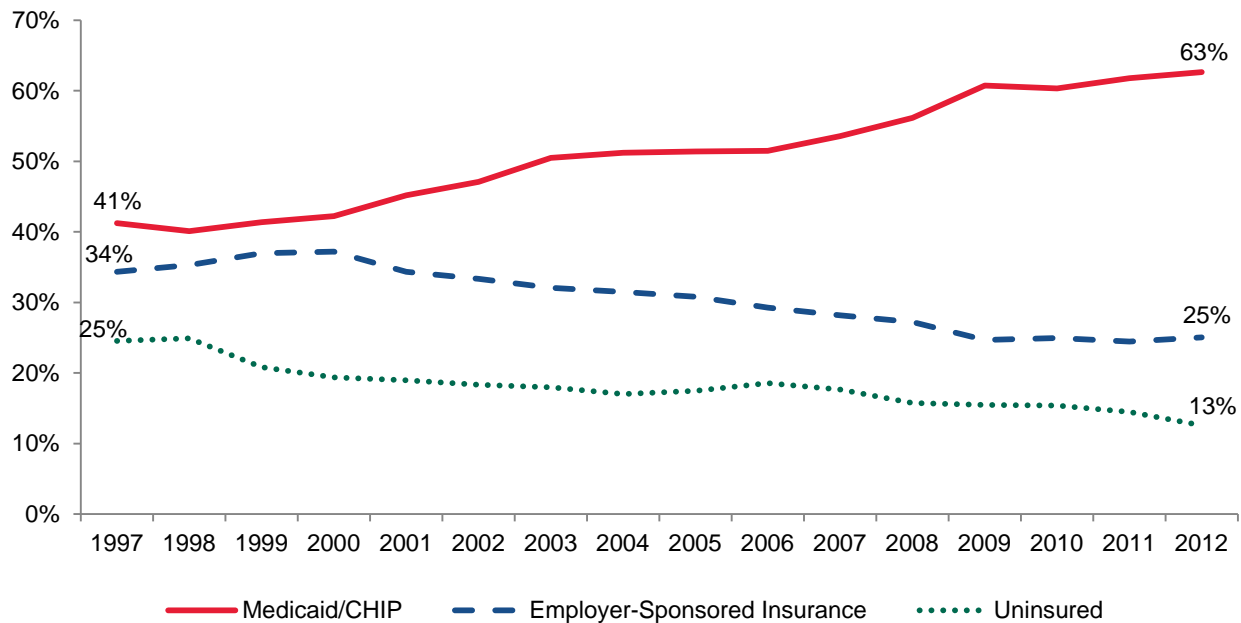
Notes: Children are ages 0 to 18.

²⁶ Interpretation of CPS-ASEC health insurance data is subject to several caveats. Research matching CPS-ASEC responses with Medicaid and CHIP administrative data shows that significant percentages of respondents in all age groups who are enrolled in Medicaid or CHIP do not report such coverage on the survey. Consequently, coverage reported through the survey is lower than totals in administrative data, and uninsurance estimates from survey data are inflated. Introduction of verification questions in the survey, in which respondents who said no when asked about all coverage types were asked to confirm that they were uninsured, increased reported 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).

²⁷ The CPS-ASEC asks 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.

Given that both CHIP and Medicaid are means-tested programs, their impact is even more visible when low-income children (in families with income below 200 percent of the FPL) are the focus, as in Figure III.2. Among low-income children, Medicaid and CHIP coverage exceeded employer-sponsored coverage throughout the period, rising from 41 percent in 1997 to 63 percent in 2012. The proportion of low-income children who were uninsured fell from 25 percent in 1997 to 13 percent in 2012.

Figure III.2. Percentage with Medicaid/CHIP, Employer-Sponsored Insurance, and Uninsured: Low-Income Children, 1997–2012

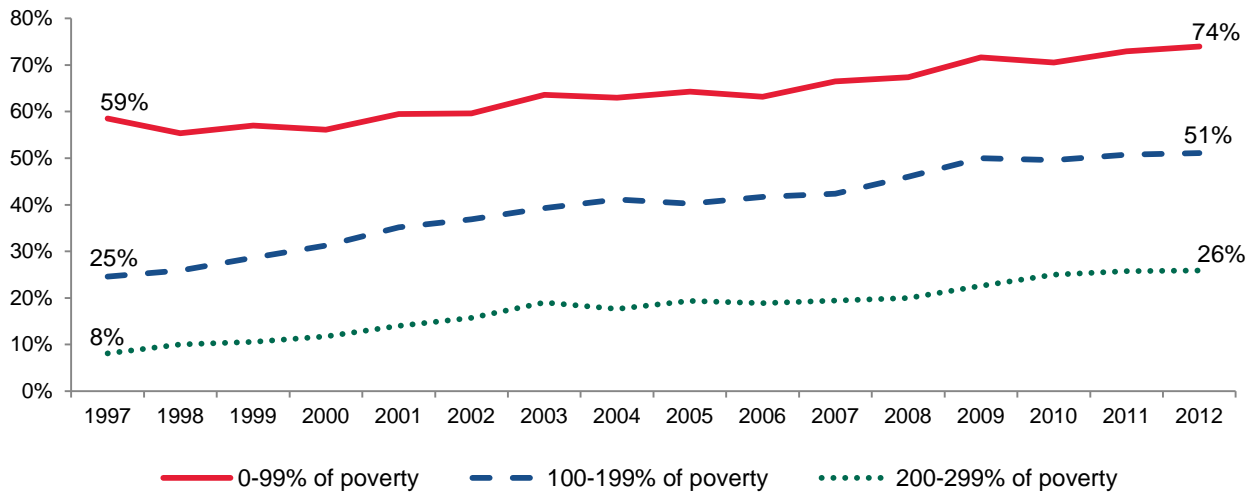


Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL.

Although public coverage rates are consistently highest among children with the lowest incomes, the gains in public coverage among children in families with incomes in the range targeted by CHIP—between 100 and 300 percent of the FPL—were even greater (Figure III.3). Over the 15-year period since CHIP’s inception, public coverage rates for children in families with income between 100 and 200 percent of the FPL increased by 26 percentage points; rates for children in families with income between 200 and 300 percent of the FPL increased by 18 percentage points; and rates for children with income in the Medicaid range of under 100 percent of the FPL increased by 15 percentage points.

Figure III.3. Percentage of Children Covered by Medicaid/CHIP, by Poverty Level: 1997–2012



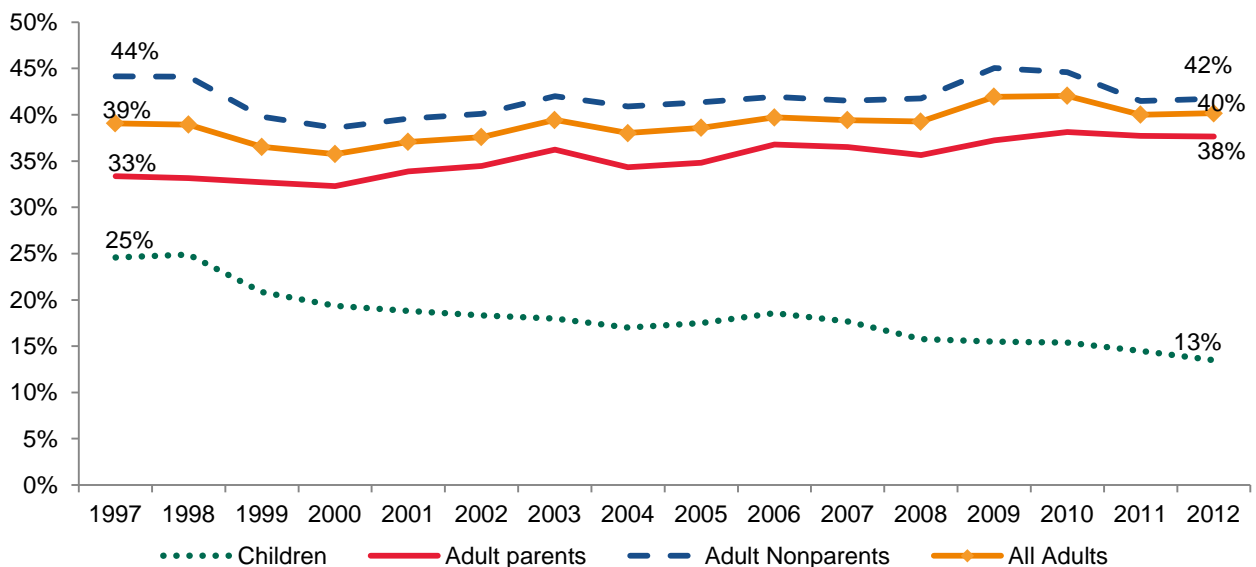
Source: CPS-ASEC.

Note: Children are ages 0 to 18.

The coverage gains for low-income children were not matched by similar gains for low-income adults, pointing to the importance of public coverage in driving the decline in uninsurance among children.

Throughout the 15-year period, uninsured rates were substantially higher among low-income adults than among children (Figure III.4). Uninsured rates were consistently highest among adults without children, who were less likely to be eligible for public coverage. Uninsurance among low-income adults without children remained fairly constant during the period, while rates for adult parents increased from 33 to 38 percent. In contrast, rates for children declined steadily, falling from 25 to 13 percent over the 15-year period.

Figure III.4. Percentage Uninsured: Low-Income Children and Adults, 1997–2012



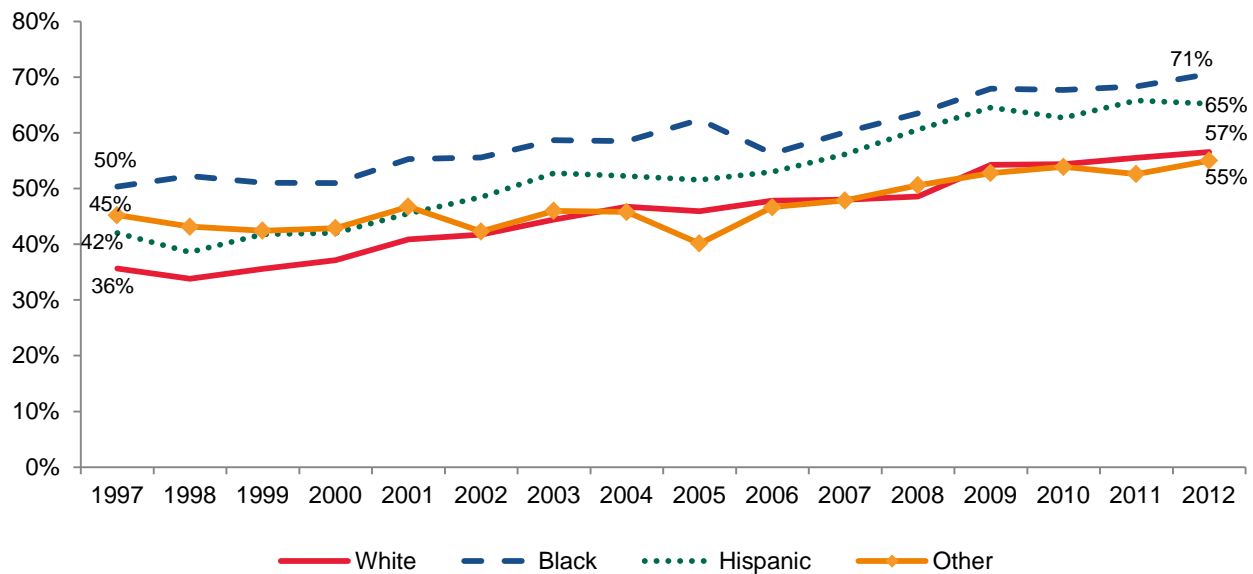
Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL.

Public coverage gains were similar across groups of children defined by race and ethnicity, helping to narrow disparities in uninsured rates, especially for Hispanic children.

The coverage trends for low-income children show similar patterns across racial and ethnic groups. Medicaid and CHIP coverage increased (Figure III.5), and uninsurance fell (Figure III.6) for Hispanics, non-Hispanic whites, non-Hispanic blacks, and other groups of children (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: the uninsured rate was cut in half, falling from 34 percent in 1997 to 17 percent in 2012. The improvement was driven by the increase in Medicaid and CHIP coverage, from 42 percent in 1997 to 65 percent in 2012.

Figure III.5. Percentage of Low-Income Children Covered by Medicaid/CHIP Coverage, by Race and Ethnicity, 1997–2012

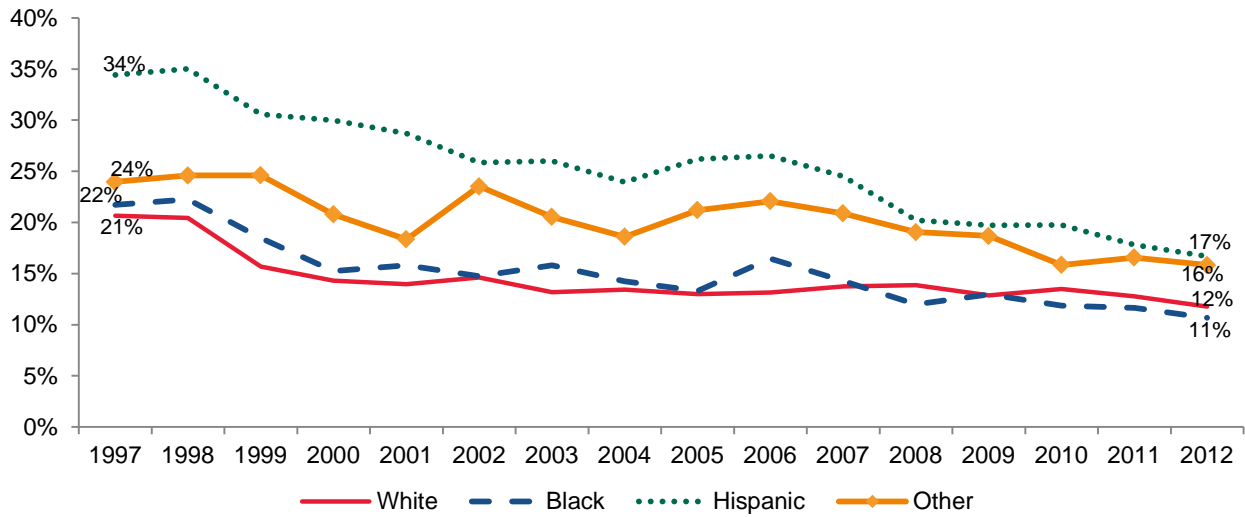


Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL. 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 based on a hierarchy originally developed for ASPE's TRIM3 microsimulation model. Prior to March 2003, individuals could only report one race.

By 2012, the uninsured rate had fallen by 10 percentage points for non-Hispanic black and non-Hispanic white children and by 17 percentage points for Hispanic children (Figure III.5). Disparities in coverage for Hispanic children also declined sharply; the differential between non-Hispanic white and Hispanic children narrowed from a 13 percentage points in 1997 to 5 percentage points in 2012.

Figure III.6. Percentage of Low-Income Children Uninsured, by Race and Ethnicity, 1997–2012



Source: CPS-ASEC.

Notes: Children are ages 0 to 18. Low income is below 200 percent of the FPL. 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.

Participation in Medicaid and CHIP, 2008 and 2012²⁸

Medicaid and CHIP participation rates for children increased substantially overall and in most states and for all major subpopulations examined.

Nationally, the estimated number of uninsured children and the proportion of children uninsured fell between 2008 and 2012, from 7.2 to 5.4 million and from 9.2 to 7.0 percent, respectively, according to data from the ACS (Table III.1).²⁹ Decreases in uninsured rates were widespread among children, with statistically significant declines in 33 states. As a result, the distribution of uninsured rates narrowed across states, although a differential of 14.5 percentage points persisted in the uninsured rates among children; in 2012, Nevada had an uninsured rate of 15.8 percent among children compared to a rate of 1.3 percent among children in Massachusetts. In 2008, a differential of 18 percentage points existed between Nevada and Massachusetts, the states with the highest and lowest uninsured rates for children, respectively.

²⁸ We analyze trends between 2008 and 2012 because 2008 is the first year that the American Community Survey included questions on health insurance coverage and 2012 was the most recent year that was available when these analyses were being performed.

²⁹ Reported estimates of uninsurance from the ACS are lower than the CPS estimates of uninsurance presented earlier in this chapter (Figure III.1). Even though the ACS coverage estimates released by the Census Bureau are generally considered reliable and align fairly well with those from other surveys, the estimates presented here reflect a set of logical coverage edits that are applied if other information collected in the ACS implies that coverage for a sample case likely has been misclassified (Lynch et al. 2011). The edits bring the ACS estimates closer to distributions reported in other national surveys, such as the National Health Interview Survey (NHIS), and bring the Medicaid/CHIP coverage estimates from the ACS more in line with administrative totals. For more details, see Kenney et al. (2011).

Table III.1. Medicaid/CHIP Eligibility, Participation, and Uninsurance of Children (Ages 0 to 18) by State, 2008 and 2012

	Uninsured		Medicaid/CHIP Eligibles		Medicaid/CHIP Participation	
	2008	2012	2008	2012	2008	2012
	Rate (%)	Rate (%)	Number (1,000s)	Number (1,000s)	Rate (%)	Rate (%)
Nation	9.2	7.0 ++	41,548	46,025	81.7	88.1 ++
Alabama	7.6**	4.0**++	651	855	85.4**	92.6**++
Alaska	12.1**	12.8**	86	93	70.4**	81.7**++
Arizona	14.8**	12.5**++	909	976	76.3**	81.8**++
Arkansas	8.3	5.5**++	444	452	87.8**	93.9**++
California	10.0**	7.8**++	5,687	6,010	81.4	87.0**++
Colorado	12.9**	8.1**++	519	681	69.3**	85.0**++
Connecticut	5.0**	3.6**++	389	419	85.8**	93.0**++
Delaware	8.0	3.6**++	101	110	81.2	93.9**++
District of Columbia	2.8**	2.7**	78	74	95.6**	97.1**
Florida	16.6**	10.6**++	2,082	2,385	69.8**	85.5**++
Georgia	10.7**	8.6**++	1,538	1,644	81.0	85.8**++
Hawaii	2.9**	2.9**	200	230	91.5**	92.6**
Idaho	12.6**	7.6 ++	216	237	73.6**	86.3 ++
Illinois	5.4**	4.0**++	2,004	2,012	88.0**	93.8**++
Indiana	9.1	7.6**++	981	1,032	78.5**	84.4**++
Iowa	4.7**	4.1**	545	587	85.9**	89.8 +
Kansas	7.8**	6.8	342	431	81.4	86.4++
Kentucky	5.7**	5.9**	579	613	89.5**	90.2**
Louisiana	7.4**	5.5**++	747	773	88.3**	92.5**++
Maine	5.4**	4.7**	136	149	91.0**	94.0**
Maryland	5.2**	3.8**++	704	749	86.3**	91.9**++
Massachusetts	1.6**	1.3**	685	723	95.0**	97.4**++
Michigan	4.9**	4.2**++	1,230	1,299	89.6**	92.2**++
Minnesota	5.6**	5.5**	646	687	81.3	85.3**++
Mississippi	12.0**	7.2 ++	514	537	81.4	90.3**++
Missouri	6.6**	7.1	968	1,002	85.3**	85.5**
Montana	14.1**	11.2**	114	150	67.9**	81.0**++
Nebraska	6.9**	5.4** +	205	238	80.8	88.4 +
Nevada	20.0**	15.8**++	318	392	56.1**	70.6**++
New Hampshire	5.0**	4.1**	146	149	85.5	89.7
New Jersey	6.8**	5.0**++	1,089	1,159	82.4	88.7++
New Mexico	12.8**	8.2++	344	389	81.6	89.3++
New York	5.3**	3.9**++	2,432	3,214	89.2**	92.4**++
North Carolina	9.5	7.1++	1,181	1,368	84.6**	89.6**++
North Dakota	7.3	7.4	47	44	75.9	84.5
Ohio	6.7**	5.4**++	1,366	1,494	83.3**	89.5++
Oklahoma	11.8**	10.0**++	542	579	81.2	85.8**++
Oregon	11.7**	5.4**++	402	621	74.9**	90.2**++
Pennsylvania	5.7**	4.8**++	1,757	1,828	86.1**	89.4**++
Rhode Island	5.3**	5.7**	111	120	85.1	90.4 +
South Carolina	10.9**	7.9**++	596	686	79.4**	87.5++
South Dakota	8.4	3.9**++	106	102	83.2	92.1**++
Tennessee	6.7**	5.6**+	945	1019	86.3**	90.3**++
Texas	16.3**	12.2**++	3,756	4,142	74.6**	84.3**++
Utah	12.0**	9.4**	362	446	65.8**	95.8**++

Table III.1 (Continued)

	Uninsured		Medicaid/CHIP Eligibles		Medicaid/CHIP Participation	
	2008	2012	2008	2012	2008	2012
	Rate (%)	Rate (%)	Number (1,000s)	Number (1,000s)	Rate (%)	Rate (%)
Vermont	3.7**	2.9**	81	84	93.5**	95.2**
Virginia	7.2**	5.5**++	752	824	80.0**	87.5++
Washington	7.7**	5.4**++	831	1,025	82.5	89.4*++
West Virginia	6.1**	4.1**++	241	288	89.3**	91.1**
Wisconsin	4.7**	4.7**	784	839	86.2**	88.7
Wyoming	8.9	9.3*	58	65	76.4	81.5+

Source: Analysis of the Urban Institute's Health Policy Center's ACS Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2008 and 2012.

Notes: See text for definitions of eligibility, participation, and uninsurance. Since eligibility estimates reflect potential eligibility based on meeting the income, asset, and immigration requirements, they include some children with ESI coverage who do not necessarily qualify for Medicaid/CHIP coverage. Eligibility estimates do not take into account waiting periods which vary by state.

**(*) indicates estimate is statistically different from national estimate at the 0.05 (0.1) level.

++(+) indicates 2012 estimate is statistically different from 2008 estimate at the 0.05 (0.1) level.

Increased take-up of Medicaid and CHIP coverage among eligible children was associated with a decrease in the number of uninsured children eligible for but not enrolled in Medicaid or CHIP (Table III.I). The decline in the number of uninsured children who were eligible for Medicaid or CHIP but not enrolled occurred even as states expanded eligibility to additional groups of children over that period and as more children became eligible for public coverage due to the economic downturn. Of the ten states that saw the largest decreases in uninsured rates for children between 2008 to 2012, seven saw the largest increases in Medicaid and CHIP participation rates for children over the same period (Colorado, Delaware, Florida, Idaho, Nevada, Oregon, and Texas) and seven were one of the ten states in 2008 with the highest uninsured rates (Colorado, Florida, Idaho, Mississippi, New Mexico, Nevada, and Texas).

Between 2008 and 2012, participation in Medicaid and CHIP rose nationally among eligible children, with statistically significant increases in 37 states.³⁰ Nationwide, Medicaid and CHIP participation rates among children increased from 82 percent in 2008 to 88 percent in 2012; by 2012, 21 states had participation rates of 90 percent or higher and just two states had rates of 80 percent or lower (Table III.1).³¹ The 21 states that had participation rates above 90 percent draw from all four regions and include states that differ in terms of the demographic and socioeconomic composition of the children who are targeted by Medicaid and CHIP. Over the four-year period, many states implemented changes in their enrollment and re-enrollment

³⁰ Participation rates are the ratio of eligible children enrolled in Medicaid or CHIP to that number plus eligible children not enrolled in Medicaid or CHIP. We exclude the small number of children with both Medicaid/CHIP and employer-provided/union-based, military, or private nongroup coverage; we also exclude the children with Medicaid/CHIP coverage without a known eligibility pathway since we cannot include them in a consistent way.

³¹ Although six states showed a slight increase in uninsured rates for children over this period (AK, KY, MO, ND, RI and WY), the increases were not statistically significant.

processes and adopted new outreach strategies aimed at increasing the take-up and retention of Medicaid and CHIP coverage among eligible children (Heberlein et al. 2013; Hoag et al. 2013). Participation rates increased in Medicaid programs as well as in separate CHIP and Medicaid expansion CHIP programs (data not shown).³²

Medicaid and CHIP participation rates increased across many subpopulations but still vary across groups.

Medicaid and CHIP participation rates increased among children across subgroups defined by income, age, race and ethnicity, immigration status, and functional status (Table III.2).³³ In 2012, participation rates exceeded 85 percent across most subgroups, with the exception of American Indian children (78 percent), children with income above 138 percent of the FPL (80 to 81 percent depending on the income group), children ages 13 to 18 (83 percent), noncitizen children (83 percent), and citizen children with no parents in the household (83 percent). Participation rates exceeded 90 percent for children under age six (92 percent), children with income below 138% percent of the FPL (90 percent), black non-Hispanic children (92 percent), non-Hispanic children with multiple or other race (90 percent), and children with functional limitations (94 percent). Despite these gains, participation rates remained lower for some groups of children—for adolescents compared to younger children; for non-citizen compared to citizen children, and for children without functional limitations compared to children with functional limitations. For example, children ages 13 to 18 had participation rates that were nearly ten percentage points lower than children under age six.

³² There is substantial error in the measurement of program type based on the information available on the ACS which is why we do not provide participation rates for children who are eligible for different types of programs.

³³ The Indian Health Service (IHS) is not typically counted as health insurance coverage because of limitations in the scope of available services and the geographic reach of IHS facilities. For most states, the participation rates do not change in a meaningful way when IHS was considered a source of health insurance coverage; however, in six states—Alaska, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota—the participation rate increased by more than 2 percentage points when IHS was reclassified as insurance coverage when using data from 2009, with a particularly noticeable impact in Alaska. The other estimate sensitive to how IHS was treated was the participation rate among American Indian/Alaska Native children, which increased from 74.5 to 91.8 percent when the IHS was classified as health insurance coverage.

Table III.2. Medicaid/CHIP Participation Rates for Children by Subgroup, 2008 and 2012

	Participation Rates	
	2008	2012
Nation	81.7%	88.1%
Income		
Less than 138 percent of FPL	84.4%**	90.1%**++
Between 138 and 200 percent of FPL	74.2%**	81.2%**++
Greater than 200 percent of FPL	71.6%**	79.8%**++
Age		
0 to 5	85.6%**	91.5%**++
5 to 12	82.4%**	88.9%**++
13 to 18	75.5%**	82.8%**++
Sex		
Male	81.6%	88.0%++
Female	81.7%	88.2%++
Race/Ethnicity		
Hispanic	78.8%**	87.2%**++
White, non-Hispanic	81.4%	87.0%**++
Black, non-Hispanic	86.8%**	92.2%**++
Asian, non-Hispanic	79.2%**	85.8%**++
American Indian, non-Hispanic	68.4%**	78.4%**++
Other/multiple, non-Hispanic	86.4%**	90.3%**++
Citizenship		
Citizen with no citizen parents	78.5%**	88.8%**++
Citizen with at least one citizen parent	83.3%**	88.8%**++
Noncitizen	78.5%**	82.9%**++
Citizen with no parents in household	75.5%**	82.8%**++
Functional Limitation		
Yes	91.0%**	94.2%**++
No	78.2%**	85.6%**++

Source: Analysis of the Urban Institute's Health Policy Center's ACS Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2008 and 2012.

Notes: See text for definitions of eligibility, participation, and uninsurance.

**(*) indicates estimate is statistically different from national estimate at the 0.05 (0.1) level.

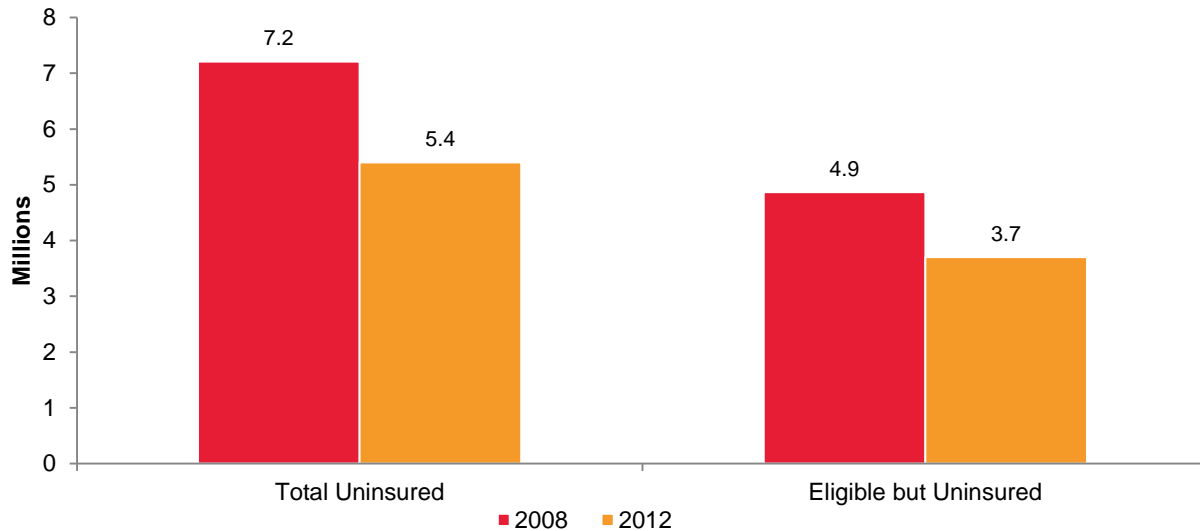
++(+) indicates 2012 estimate is statistically different from 2008 estimate at the 0.05 (0.1) level.

The number of uninsured children eligible for public coverage has been declining but most remaining uninsured children are eligible for Medicaid or CHIP.

Between 2008 and 2012, the number of children eligible for Medicaid or CHIP but uninsured fell by about 1.2 million to 3.7 million and the estimated number of uninsured children fell from 7.2 to 5.4 million (Figure III.7). Over that period, more than a third of the states expanded coverage

to new groups of children.³⁴ Altogether, an additional 4.5 million children became eligible for Medicaid or CHIP between 2008 and 2012 as a consequence of a combination of the following: expansions of eligibility to new groups of children, increases in the total number of children, and shifts in the income distribution that made more children eligible for public coverage.

Figure III.7. Estimated Number of Uninsured Children (Ages 0 to18), 2008 and 2012 (in millions)



Source: Urban Institute's Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2008 and 2012.

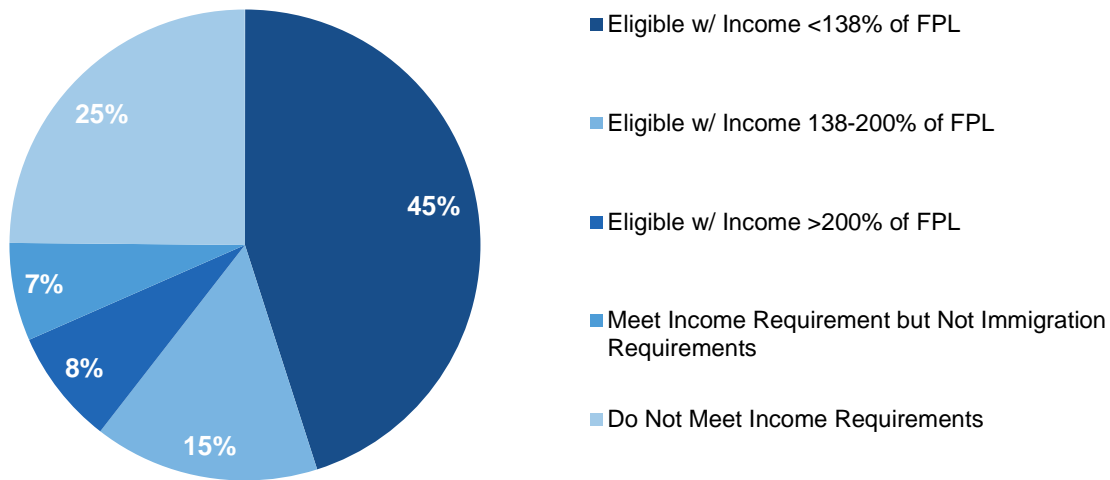
Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS (see Footnote 28).

As of 2012, an estimated 68 percent of uninsured children were eligible for Medicaid or CHIP but not enrolled in either program (Figure III.8). The remaining 32 percent of uninsured children were not eligible for Medicaid or CHIP coverage because of their immigration status (7 percent of all uninsured children, and 22 percent of the uninsured children who are not eligible for Medicaid or CHIP) or because their income levels exceeded Medicaid and CHIP eligibility levels (25 percent of all uninsured children, and 78 percent of the uninsured children who are not eligible for Medicaid or CHIP).

³⁴ By 2011, 25 states and the District of Columbia had eligibility levels at or above 250 percent of the FPL; of those, 17 had thresholds of 300 percent of the FPL or higher, and nearly half of states covered lawfully residing immigrant children who had been in the country fewer than five years. See Heberlein et al. (2013) for more information.

Figure III.8. Profile of Medicaid and CHIP Eligibility Among Uninsured Children, 2012

68 Percent of Uninsured Children are Eligible for Medicaid or CHIP



Source: Analysis of the Urban Institute's Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

The high participation rates achieved in a large and growing number of states and for many subgroups of children suggest that there is the potential for additional increases in Medicaid and CHIP coverage among the remaining 3.7 million eligible but uninsured children, particularly among the states and groups that are lagging behind. As discussed later in Chapter IX, the vast majority of low-income parents reported that they would enroll their uninsured child in Medicaid or CHIP if told their child was eligible, but many of these families did not know that their child was eligible or how to apply for coverage, or they thought the enrollment and renewal processes were difficult to navigate. Moreover, evidence presented in Chapter VI on the extent of churning in public coverage and gaps in coverage between Medicaid and separate CHIP programs suggests that state policy choices can have substantial effects on how successful states are at enrolling and retaining children in Medicaid and CHIP and transferring them seamlessly between programs.

IV. ACCESS TO PRIVATE COVERAGE AMONG LOW-INCOME CHILDREN

KEY FINDINGS:

- Direct substitution of CHIP coverage for private insurance at the time of enrollment was estimated to occur for only 4 percent of new enrollees. About 13 percent of new enrollees had any private coverage in the 12 months before enrolling in CHIP and only 28 percent of those ended that coverage for potentially voluntary reasons.
- A broader measure of access to ESI finds that 43 percent of CHIP enrollees had a parent with access to ESI, but only 20 percent were reported to have access to dependent ESI coverage. Access to ESI for low-income uninsured children and Medicaid enrollees was also very limited.
- Even when dependent coverage is available, affordability is likely an important barrier many families face in accessing ESI for their children.
- CHIP and Medicaid enrollees had high levels of parental uninsurance. In California, Florida and Texas, 62 percent of CHIP enrollees and 54 percent of Medicaid enrollees had at least one uninsured parent.

Since CHIP expanded eligibility for public insurance to children in 1997, there has been considerable concern that the program would encourage families to substitute public coverage for their existing employer-sponsored insurance (ESI) coverage. Although concern about this substitution is common for many government programs, it has been particularly pronounced for CHIP because the program extended eligibility to children of parents with incomes higher than the traditional eligibility threshold for Medicaid or other safety net programs. Moreover, many have feared that employers would make dependent coverage less available if children of employees had an alternative source of coverage. As a result, the original CHIP legislation required states to incorporate strategies into their programs to prevent the substitution of CHIP for private group coverage.

In this chapter, we use data from the 2012 congressionally mandated CHIP and Medicaid survey of enrollees and disenrollees as well as from the 2011/2012 National Survey of Children's Health (NSCH) to provide information on the potential substitution of public for private coverage.³⁵ The chapter begins with a description of the type of coverage held by children before they enrolled in CHIP, including the share with prior private coverage. We then examine the extent to which children covered by CHIP had access to private coverage while they were enrolled, and conclude by presenting evidence on access to ESI coverage among low-income uninsured children.

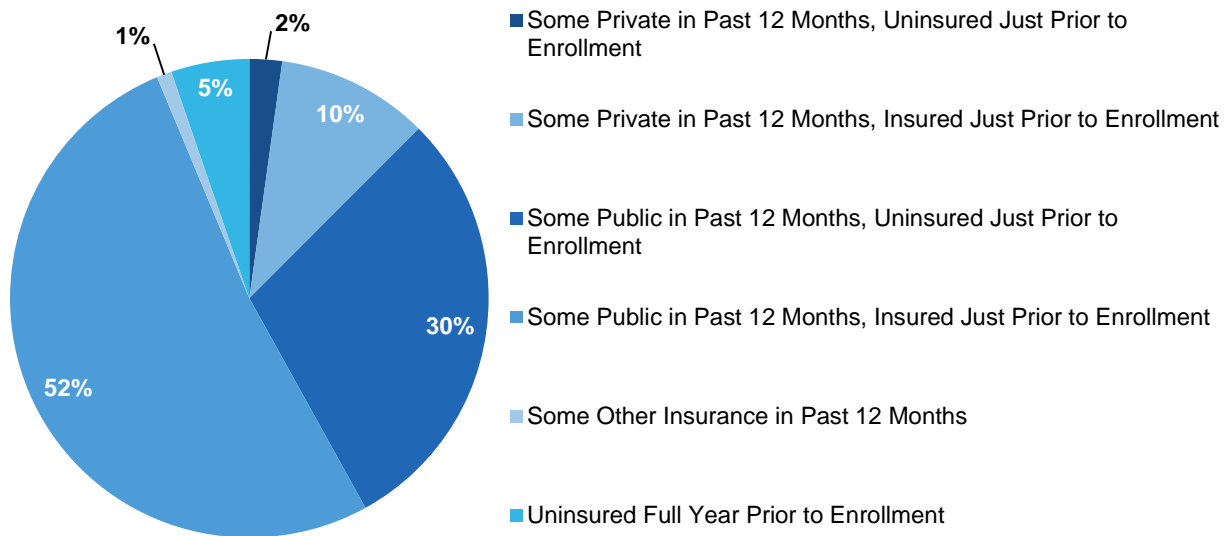
³⁵ Further details on findings reported in this chapter are contained in memos and issue briefs prepared for the evaluation. For relevant findings from the analysis of data from the 2012 congressionally mandated survey of CHIP and Medicaid enrollees and disenrollees, see McMorrow et al. (2013a) and McMorrow et al. (2013b), contained in Harrington and Kenney et al. (2014). For relevant findings from the analysis of the 2011/2012 National Survey of Children's Health, see Haley et al. (2013).

Most new enrollees were covered by Medicaid or CHIP before their most recent CHIP enrollment; only 13 percent had any private coverage before enrolling in CHIP.

The vast majority of new enrollees (82 percent) had a period of public insurance coverage in the 12 months before enrolling in CHIP (Figure IV.1). Just over half of new enrollees (52 percent) had Medicaid or CHIP coverage in the 12 months before they enrolled in CHIP, with no period of uninsurance just prior to enrollment.³⁶ Another 30 percent of new enrollees had public coverage in the year before but were uninsured just prior to enrolling.

A much smaller share of new CHIP enrollees (13 percent) had private coverage in the 12 months before enrolling in CHIP, including 2 percent that had a gap in coverage before enrolling and 10 percent that enrolled directly after private coverage without a gap in insurance.³⁷ The rest of the new enrollees were uninsured the full year before enrolling in CHIP (5 percent) or had other insurance (such as Medicare or military-based coverage) before enrolling (1 percent). The low rate of private coverage prior to enrolling suggests a relatively low level of direct substitution of CHIP for private coverage.

Figure IV.1. Coverage of New CHIP Enrollees During the 12 Months Prior to Enrolling



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

Note: New enrollees are those enrolled in CHIP for three months following at least two months without CHIP coverage.

³⁶ Most transferred from Medicaid, but some reported continuous CHIP enrollment on the survey.

³⁷ The estimates in Figure IV.1 of children with prior private coverage with and without a gap in coverage do not sum to the total estimate of children with prior private coverage due to rounding.

Direct substitution of CHIP for private coverage at the time of enrollment was estimated to occur for only 4 percent of new enrollees.

Table IV.1 describes the reasons that a child’s private coverage ended, as reported by the child’s parent. This information helps to refine further the estimate of the direct substitution of CHIP for private coverage, by considering whether private coverage was dropped voluntarily to enroll in CHIP or whether it was lost due to circumstances beyond the family’s control. The results suggest that the vast majority lost their private coverage involuntarily. An estimated 69 percent of children who enrolled in CHIP after some period of private coverage were reported to have lost that coverage due to a parent’s job loss or loss of benefits from an employer. An additional 3 percent lost private coverage due to an involuntary change in family circumstances, such as a death or divorce. Of children who had private coverage before enrolling, only about 5 percent appear to have lost this coverage for voluntary reasons based on a preference for CHIP.

Table IV.1. Direct Substitution of CHIP for Private Coverage

	Percentage
Private Coverage in the Year Prior to Enrolling	13
Reason Private Coverage Ended	
Employment or Benefit Loss/Change (Involuntary)	69
No longer works for employer, lost/changed jobs	63
Employer no longer offers coverage	6
Family Circumstances (Involuntary)	3
Parent got divorced	2
Child custody changed	1
Preference for CHIP/Dislike Other Insurance (Voluntary)	5
Dropped plan to qualify for CHIP	3
Employer plan changed/less desirable/employer switched to less generous plan	1
[CHIP/Medicaid] costs less	1
[CHIP/Medicaid] has better benefits	0
Insurance not needed/child does not get sick	0
Affordability (Indeterminate)	18
Cost of insurance or dependent coverage went up	9
Family income changed	5
Financial or affordability reasons	4
Miscellaneous (Indeterminate)	5
Total	100
Upper-Bound Estimate of Direct Substitution of CHIP for Private Coverage	
Voluntary + indeterminate reasons	28
Involuntary reasons	72
Direct substitution (voluntary + indeterminate) * share with prior private coverage)	4

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

Note: New enrollees are those enrolled in CHIP for three months following at least two months without CHIP coverage.

Another 18 percent of children with a recent history of private coverage were reported to no longer have that coverage due to affordability, including changes in income, the cost of insurance, or other financial reasons. It is not possible to classify these cases as either strictly voluntary or involuntary coverage losses. In some cases, the child might have maintained the

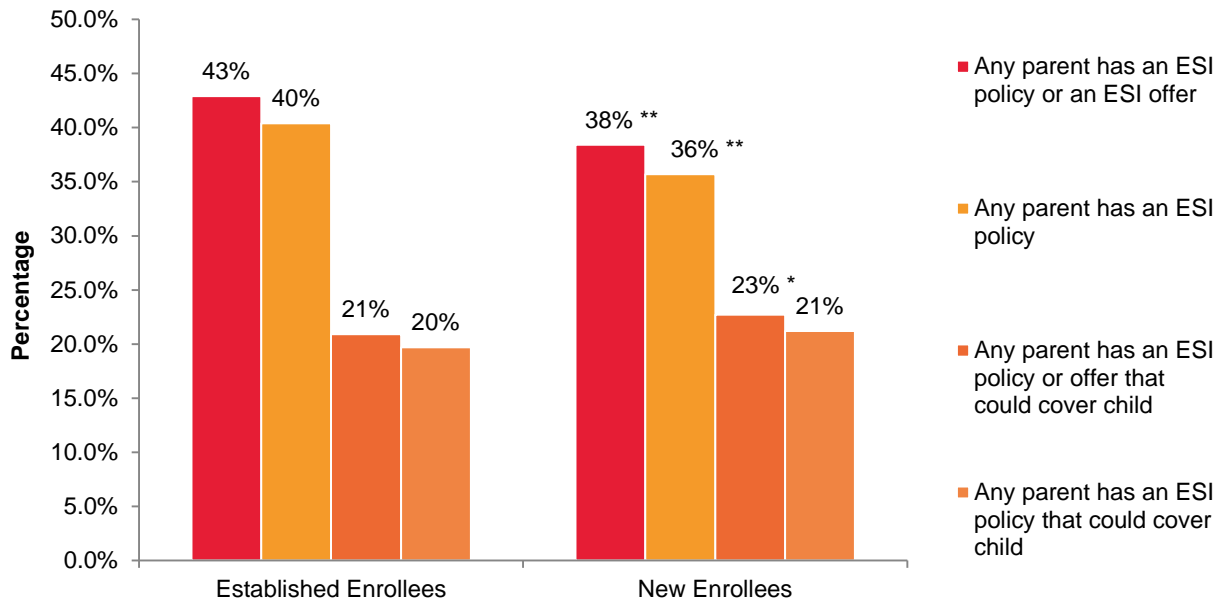
coverage in the absence of CHIP, whereas in others the financial strain on the family would have left the child uninsured. An additional 5 percent of children lost coverage for other miscellaneous reasons, such as move-related issues and logistical problems with insurance forms, which cannot be classified as voluntary or involuntary.

We estimated a direct substitution rate by calculating the proportion of children who lost coverage due to voluntary or indeterminate reasons and multiplying it by the share of children who had prior private coverage. This approach assumes that all of those reporting affordability or other miscellaneous reasons would have maintained their coverage in the absence of CHIP, resulting in an estimated 28 percent classified as voluntarily substituting CHIP for private coverage. With only 13 percent of new enrollees reporting any prior private coverage, this results in an upper-bound direct substitution estimate of 4 percent. This estimate is substantially smaller than those found in past research on the extent of substitution occurring in CHIP (LoSasso and Buchmueller 2004; Davidoff et al. 2005; Hudson et al. 2005; Sommers et al. 2007; Dubay and Kenney 2009; Howell and Kenney 2012; Gresenz et al. 2012, 2013). A couple of factors likely contribute to this finding. First, the survey of CHIP enrollees was administered during the sluggish recovery from the recession, which likely contributed to the limited evidence of prior private coverage among these children. Second, the growth in Medicaid and CHIP coverage has resulted in a large proportion of children having public coverage prior to their most recent CHIP enrollment. These children may have substituted public for private coverage at some point in the past which we cannot observe. Findings on access to employer coverage through a parent may be more indicative of the potential for CHIP and Medicaid to substitute for private coverage and are discussed in the next section.

Approximately 40 percent of established CHIP enrollees had a parent with ESI coverage, but only half of them reported that the ESI policy could cover the child.

For both new and established enrollees, access to dependent ESI coverage was considerably more limited than access to any ESI coverage. Among established CHIP enrollees, an estimated 43 percent have a parent who was either offered ESI or had an ESI policy (Figure IV.2). While 40 percent of established CHIP enrollees had a parent with an ESI policy, only about half of them (20 percent) had a parent with a policy that reportedly could cover the child. The estimates of available dependent coverage based on the survey of CHIP families may be lower than what is reported on employer surveys for several reasons. First, the sample of families may have been concentrated in firms or jobs that do not offer dependent coverage. Second, respondents may have understood the question to be about whether dependent coverage would have been affordable rather than simply about whether it was offered. Finally, respondents may have been concerned that their access to CHIP could be at risk if they reported that they had access to ESI for their child. Thus, we interpret the estimates of plans that could cover the child with caution and consider the broader estimates of any access to ESI for parents as an upper bound on potential access for children. Potential access to ESI coverage was slightly more limited for new enrollees than for established enrollees; 38 percent of new enrollees had a parent with an ESI offer or policy compared with 43 percent of established enrollees.

Figure IV.2. Potential Access to ESI Among CHIP Enrollees



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

Notes: ESI is employer-sponsored insurance. Established enrollees are those enrolled for at least 12 months at the time of sampling. New enrollees are those enrolled for 3 months at the time of sampling who did not transfer from Medicaid or prior CHIP coverage in the previous four months. */** indicates that the estimate is significantly different from the established enrollees estimate at the .05/.01 level.

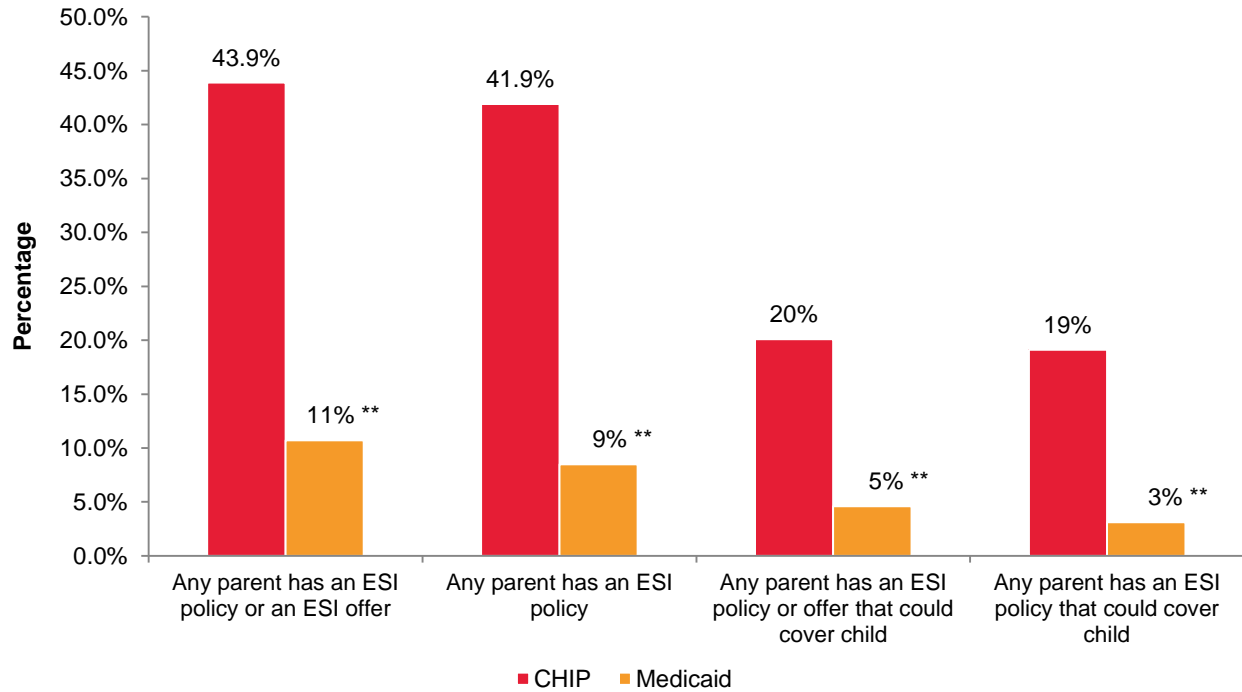
For established enrollees with access to dependent ESI coverage, affordability concerns may prevent children from being covered in the absence of CHIP.

While about 40 percent of established CHIP enrollees had a parent with ESI coverage, several factors could prevent them from being covered by a parent’s plan. First and foremost, only 20 percent of children were reported to have access to a plan that could cover them. Furthermore, as Table IV.2 shows, among those children with access to dependent coverage, the parents of 57 percent of them would be responsible for the entire premium and the parents of 39 percent would have to contribute some portion of the premium. Of children with access to a dependent ESI policy to which an employer contributes anything, the main reasons reported by parents for not joining were that the premiums were too high (55 percent), that CHIP/Medicaid costs less (8 percent) or that out-of-pocket costs in the employer plan were unaffordable (7 percent).

Access to ESI was more limited for children covered by Medicaid than it was in CHIP.

We also estimated potential access to ESI among children with Medicaid coverage in three states (California, Florida, and Texas). Figure IV.3 presents data suggesting that CHIP enrollees were more likely to have access to ESI than Medicaid enrollees: 11 percent of established Medicaid enrollees had a parent who had or was offered ESI, compared with 44 percent of established CHIP enrollees in the three states. The proportion of Medicaid children with reported access to dependent coverage was very low (3 percent).

Figure IV.3. Potential Access to ESI Among CHIP and Medicaid Established Enrollees in California, Florida, and Texas



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

Notes: ESI is employer-sponsored insurance. These estimates are for three states with Medicaid enrollee sample (CA, FL, TX). Established enrollees are those enrolled for at least 12 months at the time of sampling. **/** indicates that the estimate is significantly different from CHIP estimate at the .05/.01 level.

CHIP and Medicaid enrollees had high levels of parental uninsurance.

While access to ESI varied considerably for Medicaid versus CHIP enrollees, the proportion of children with uninsured parents was similar in the two groups. Among Medicaid enrollees in California, Florida and Texas, 54 percent had at least one uninsured parent, and 45 percent had only uninsured parents, compared with 62 percent and 44 percent for CHIP enrollees in the same three states (data not shown).³⁸ This suggests that the Affordable Care Act coverage expansions have the potential to benefit low-income children by addressing high levels of uninsurance among their parents.

³⁸ Among CHIP enrollees in all 10 survey states, 57 percent had at least one uninsured parent and 42 percent had only uninsured parents.

Table IV.2. Employer Contributions and Plan Choice Among Parents of Established CHIP Enrollees with Access to Dependent ESI Coverage

	Percent
Any Parent with ESI Policy That Covers Child	20
Employer pays none for child	57
Employer pays some for child	39
Employer pays all for child	4
Reason Child is Not Covered by the Parent's Plan [Asked of Those Where Employer Pays Some/All for Child]	
Affordability: Premium	55
CHIP/Medicaid costs less	8
Affordability: Out of Pocket	7
CHIP/Medicaid better benefits	6
Cannot see needed providers	1
Services do not meet needs	1
Other Reasons	21
Don't Know/Refused	1

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

Notes: ESI is employer-sponsored insurance. Established enrollees are those enrolled for at least 12 months at the time of sampling. Reason child is not covered is only asked of families with ESI that could cover the child and for which the employer would pay all or some of the premium.

Most low-income uninsured children lacked access to ESI.

Analysis using the 2011/2012 NSCH indicates that few uninsured children in families with incomes below 400 percent FPL had access to ESI through their parents' employment (Table IV.3). Most uninsured children with family incomes below 400 percent of FPL lived in families where neither the parent nor the child had access to employer-sponsored coverage. The largest group of uninsured children in both income groups (66 percent of uninsured children with family income below 200 percent of FPL and 58 percent of uninsured children with family income between 200 and 400 percent of FPL) lacked ESI access because their parents were uninsured and had no ESI offer. Thus, most uninsured children who could be enrolling in Medicaid/CHIP would not be substituting CHIP for available employer-sponsored insurance.

Just 16 percent of uninsured children with family income below 200 percent of FPL and 29 percent of those between 200 and 400 percent of FPL could potentially get ESI through their parents' employment. In total, more than 16 percent of uninsured children in both of these income groups live in families in which the parent has access to ESI but either the available ESI coverage cannot include dependents (11 percent of those below 200 percent of FPL and 8 percent of those between 200 and 400 percent of FPL) or the employer contributes nothing toward coverage for dependents (7 percent of those below 200 percent of FPL and 10 percent of those between 200 and 400 percent of FPL).

Additional analysis of the NSCH (not shown) indicates that 59 percent of uninsured children below 200 percent of the FPL had been previously enrolled in Medicaid or CHIP, and more than 4 in 10 of these had been enrolled in the prior year. Another 14 percent of low-income uninsured children had never been enrolled in the programs but had attempted to enroll. Thus, while most low-income uninsured children had no access to ESI, the majority had prior experience with Medicaid/CHIP.

Table IV.3. Access to ESI Among Uninsured Children (0–17) in the United States, by Income Group, 2011/2012

	Percent	
	<200% FPL	200–400% FPL
Access to ESI Through Parents	16	29
Parent has insurance that could cover child	6	13
Employer pays ALL/SOME of child's premium	3	9
Employer pays NONE of child's premium	3	4
Parent has offer of insurance that could cover child	10	16
Employer pays ALL/SOME of child's premium	6	10
Employer pays NONE of child's premium	4	6
No Access to ESI Through Parents	83	69
Parent has ESI that does not cover child	6	5
Parent has offer of ESI that does not cover child	5	3
Parent has insurance, but not employer- or union-based (and has no employer offer)	8	3
Parent is uninsured and has no employer offer	66	58
Unknown Access to ESI	1	2
Parent has insurance or eligible for insurance but unknown whether it could cover child	1	0
Parent has insurance through former employer but unknown whether it could cover child	0	0

Source: Urban Institute Analysis of the 2011/2012 National Survey of Children's Health.

Notes: ESI is employer-sponsored insurance. Shares do not add up to 100 percent due to missing information (row not shown).

V. MEDICAID AND CHIP ENROLLMENT TRENDS IN THE 10 STUDY STATES, 2007 - 2012

KEY FINDINGS:

- Enrollment in both Medicaid and CHIP grew steadily from 2007 to 2012, with the strongest growth in 2009, the second year of the recent recession.
- While most CHIP enrollees (80 percent) in the 10 study states were enrolled in separate CHIP programs, that number is expected to decline in the future because of Affordable Care Act requirements.
- Medicaid and CHIP worked as intended to provide an insurance safety net for low-income children, particularly during times of economic hardship.

In this chapter, we report findings on Medicaid and CHIP enrollment trends for the 10 study states during the five-year period from late 2007 to late 2012.³⁹ We also show the relative influence of new enrollment and disenrollment on observed enrollment trends.

Enrollment in Medicaid and CHIP grew steadily from 2007 to 2012, with the strongest growth in 2009, the second year of the recent recession.

Across the 10 study states, the number of children enrolled in public coverage increased from 13.8 to 17.3 million over the five-year period, a 26 percent increase (Figure V.1). Growth was particularly strong during the first three years of the period, with growth rates above 5 percent in 2008, 2009, and 2010. In 2011, growth slowed to 3 percent, then to 1.7 percent in 2012 (data not shown). The growth in public coverage was driven by increases in Medicaid, which was the dominant program in each of the 10 states, covering approximately 80 percent of all publicly insured children over the period.

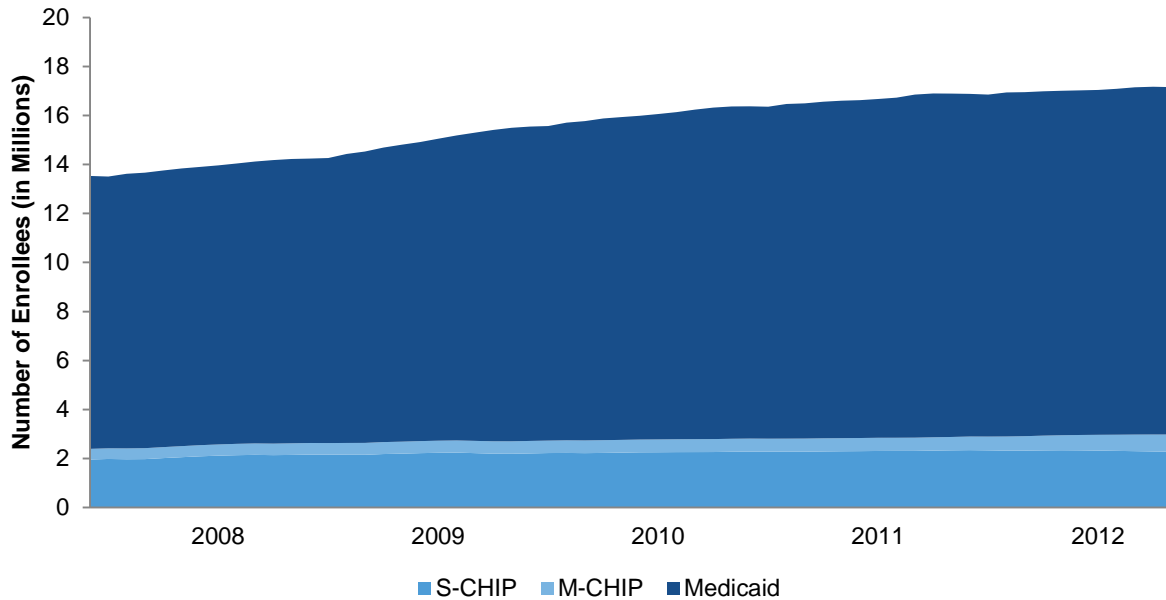
The majority of CHIP enrollees in the 10 states were enrolled in separate CHIP programs, but the proportion in separate programs is expected to decline over time as the Affordable Care Act is implemented.

Approximately 80 percent of CHIP enrollees across the 10 states were enrolled in separate CHIP programs. This ratio was consistent over the period until late 2011, when New York became the first state in our sample to implement the transition of children in families with income between 100 and 133 percent of the FPL from its separate CHIP program to its Medicaid program. As New York shifted these children during their annual renewal process, the percentage of CHIP enrollees in separate state programs dropped to 77 percent across the 10 states. We expect this trend to continue, as Affordable Care Act rules require states to cover children in these

³⁹ Further details on findings reported in this chapter appear in a memorandum submitted to ASPE by Orzol et al. (2013).

eligibility/age categories in Medicaid. California had begun doing so when this report was written, nearly eliminating its separate CHIP program for children in 2013.⁴⁰

Figure V.1. Trends in Enrollment in Public Coverage among Children for 10 Study States, by Program Type, November 2007–October 2012^a



Source: Mathematica analysis of enrollment data provided by states

Notes: S-CHIP = separate CHIP program; M-CHIP= Medicaid expansion CHIP program

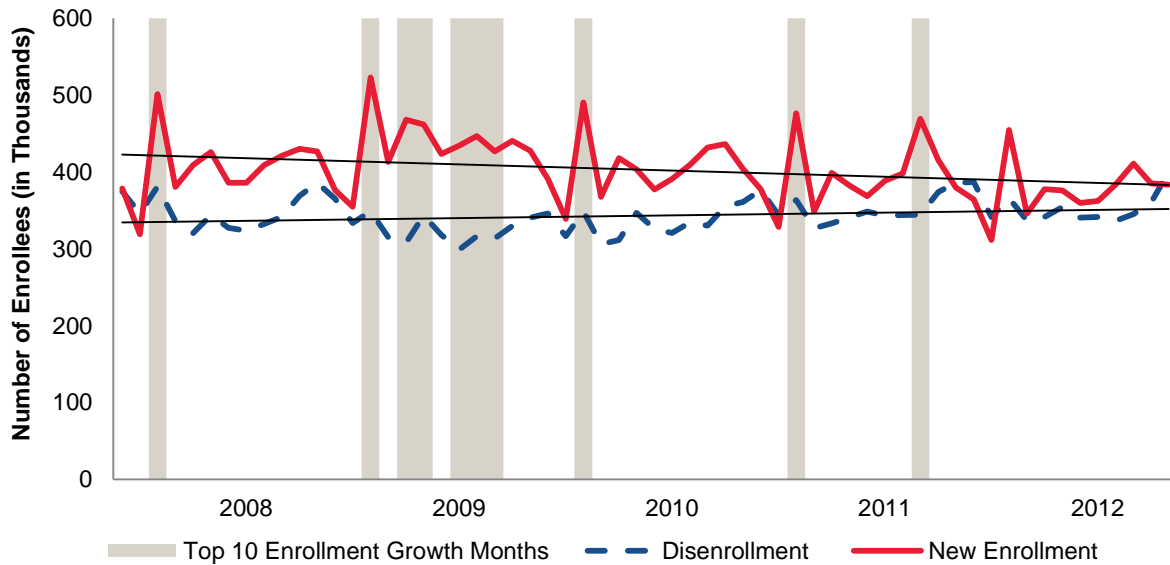
^a We used November 2007 as the starting point for all analyses because it is the earliest month for which we have consistent data for all the study states. We used October 2012 as the end point for many analyses, as many states exhibit dips in enrollment during the last quarter that are likely attributable to administrative data lags.

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

Over the five-year period, consistently more children were enrolling in rather than leaving public insurance, although this gap narrowed in 2011 and disappeared in 2012 (Figure V.2). New enrollment peaked during 2009 and largely remained above the period monthly average in new Medicaid enrollment (370,000) through 2010. The trend suggests that growth in public health insurance coverage helped counter the impact of the recession on children’s health insurance coverage. In addition to more children entering public coverage during the recession period, fewer children were exiting. We observe a corresponding dip in monthly disenrollment from public coverage in 2009, lasting through 2010.

⁴⁰ California continues to cover the conception to birth population in its separate CHIP program.

Figure V.2. Trends in New Enrollment and Disenrollment in Public Coverage Among Children for 10 Study States, November 2007–October 2012



Source: Mathematica analysis of state-provided administrative data

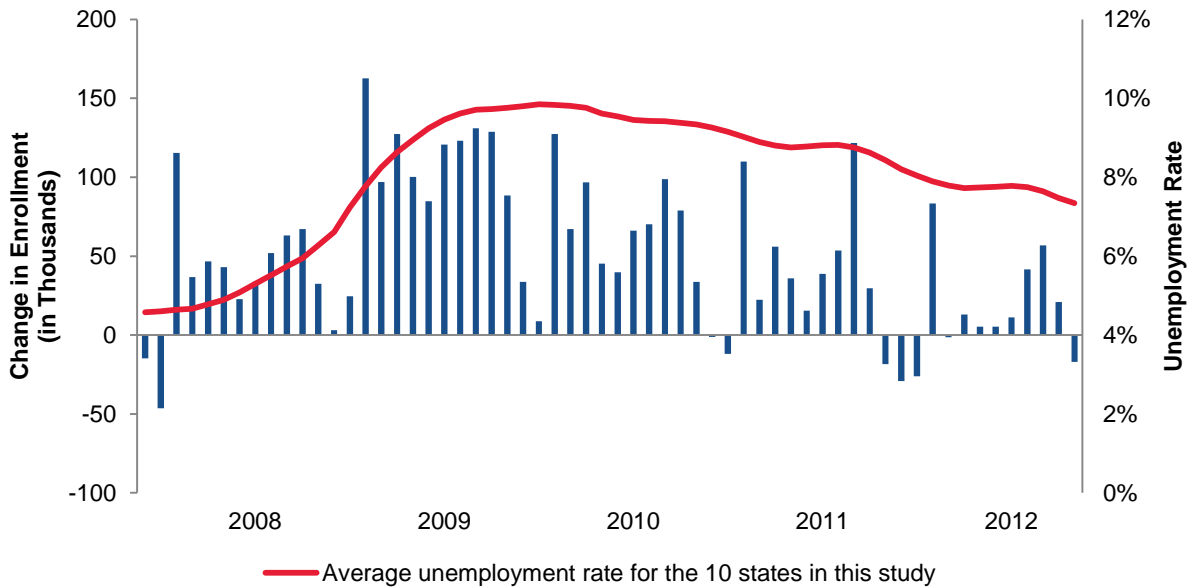
Note: Top 10 enrollment group months (shown with the grey bars) indicate the 10 months with the largest month-over-month increase (percent) in net enrollment.

Medicaid Enrollment. The monthly change in Medicaid enrollment is strikingly consistent with changes in the average unemployment across the 10 states over the five year period, as seen in Figure V.3. Medicaid enrollment in the 10 study states increased 27 percent, from 11.1 million to 14.2 million between November 2007 and October 2012.⁴¹ The largest increases occurred in early 2009, during the height of the recession, after which there was a gradual decline in the growth rate between 2010 and 2012.

CHIP Enrollment. Unlike Medicaid, in which enrollment growth was generally consistent with the trend in the unemployment rate, the monthly change in CHIP enrollment was more uneven. Between November 2007 and October 2012, CHIP enrollment in the 10 study states increased by 24 percent, with 582,129 more children enrolled in October 2012 than five years earlier. As we show in Figure V.4, the largest increase occurred during the first year of our data (a 9.5 percent yearly growth rate from November 2007 to October 2008), coinciding with the first year of the recession, after which yearly CHIP enrollment growth fluctuated between 2.4 and 3.3 percent.

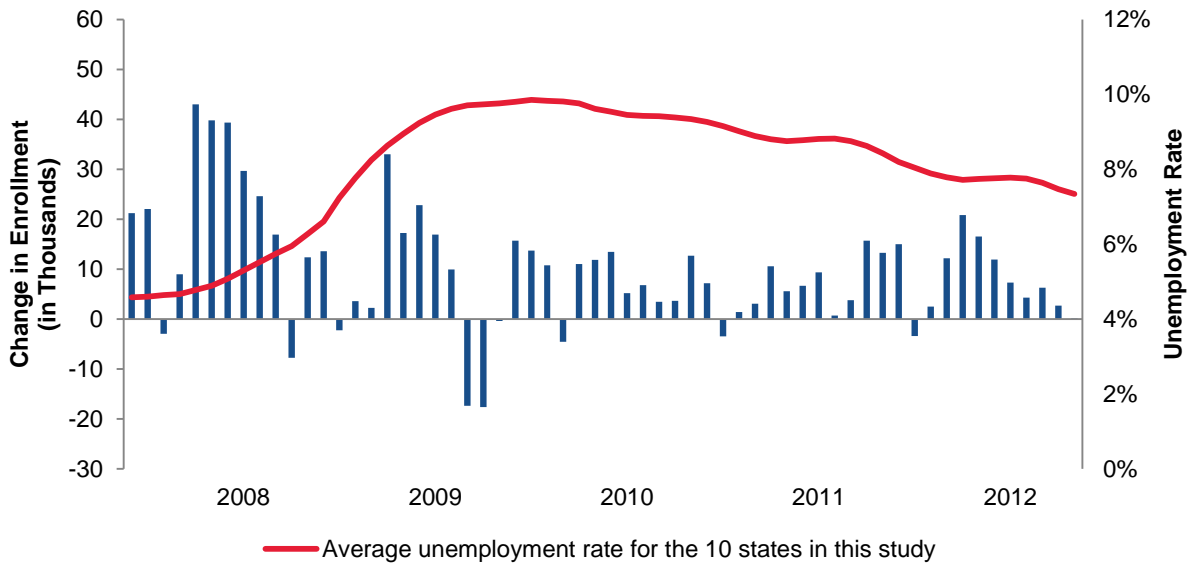
⁴¹ Together, the 10 study states represent just under 50 percent (47.9) of all children enrolled in Medicaid as of 2012 (Statistical Enrollment Data System (SEDS); these data are available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/FY-2012-Childrens-Enrollment-04_09_13.pdf).

Figure V.3. Monthly Change in Children’s Medicaid Enrollment Relative to the Unemployment Rate for 10 Study States, November 2007–October 2012



Source: Mathematica analysis of state-provided administrative data

Figure V.4. Monthly Change in Children’s CHIP Enrollment Relative to the Unemployment Rate for 10 Study States, November 2007–October 2012



Source: Mathematica analysis of state-provided administrative data

Taken together, these findings suggest that state Medicaid and CHIP programs served as an insurance safety net during this time of economic hardship. We note a pattern where the first year of the recession coincided with the largest increases in CHIP enrollment in the period studied; as higher income families faced unemployment and cuts in employer sponsored coverage, families turned to CHIP programs for coverage. Then as the economy continued on its downward trend and family incomes continued to drop, new enrollment in Medicaid began to spike and disenrollment in these programs fell, with the greatest increases in Medicaid enrollment occurring in 2009 and 2010. These patterns highlight the essential role that both Medicaid and CHIP play in ensuring that low-income children have health insurance and show a counter-cyclical safety-net system working as intended.

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VI. LENGTH OF MEDICAID AND CHIP ENROLLMENT SPELLS AND COVERAGE EXPERIENCES AFTER DISENROLLMENT

KEY FINDINGS:

- Children newly enrolling in public coverage remain enrolled on average for at least 28 months. Duration of coverage varied across states, particularly among state Medicaid programs.
- Among children who left CHIP and remained uninsured six months later, most (76 percent of the uninsured, and 24 percent of all CHIP disenrollees) left CHIP because they were no longer eligible.
- Churning is more common in Medicaid than in CHIP; approximately 18 percent of Medicaid disenrollees and 10 percent of separate CHIP disenrollees in the 10 study states returned to the same program within seven months.
- Most children enrolled in CHIP during a three-year period were also enrolled in Medicaid at some point in the same period.
- Transitions between separate CHIP and Medicaid programs often lead to gaps in public coverage, suggesting that coordination between these programs remains a concern.

Several factors influence the length of time a child remains enrolled in public (Medicaid or CHIP) coverage, including whether the child continues to meet program eligibility guidelines, whether the child completes the renewal process, and the degree of coordination that characterizes the transfer from one program to another if family income or other conditions of eligibility change. For most children, continued eligibility is primarily a function of the relevant income thresholds, which vary by state for various age groups, and the availability of employment-based coverage. Children's duration of enrollment, however, is also related to program rules (for example, the frequency and burdensomeness of the renewal process).

In this chapter, we draw on state CHIP and Medicaid enrollment data and information from the 2012 congressionally mandated survey of CHIP and Medicaid enrollees and disenrollees to examine how long children remain enrolled in CHIP and Medicaid and to investigate children's coverage experiences after disenrollment.⁴² Most of the analysis presented in this chapter focuses on the population of children ever enrolled in Medicaid or CHIP in the 10 study states during a 5-year period (November 2007 through October 2012). We use Medicaid and CHIP enrollment data on this larger population to analyze outcomes such as the duration of new coverage spells, the extent to which children return to the same program a short time after disenrollment, and transitions between Medicaid and CHIP. Movements from one program to another may be

⁴² This chapter draws on data presented in two more detailed memoranda: Harrington et al. (2013) contained in Harrington and Kenney et al. (2014), and Orzol et al. (2013).

associated with disruptions in coverage, so we also document how many people move between programs and which types of transitions are more likely to be associated with coverage gaps, something that is especially important given the Affordable Care Act's emphasis on ensuring that enrollees transition seamlessly between different coverage programs. We use the survey data to analyze the reasons children disenroll, their coverage status after leaving, and the reasons why children become uninsured.

Duration of Coverage

Children typically stay enrolled longer in Medicaid than in CHIP.

The median time that children remained enrolled in coverage varied considerably by type of program. Using data on the 10 study states together, new Medicaid spells were estimated to last about twice as long as new spells in CHIP (26 months for Medicaid versus 13 months for Medicaid expansion CHIP and 14 months for separate CHIP).⁴³ These pooled measures of duration remained fairly stable over the study period, with a slight decline in the median length of Medicaid spells toward the end of the period.⁴⁴

Duration of coverage varied across states, particularly among state Medicaid programs.

The overall trend of longer duration in Medicaid than in CHIP was consistent for all 10 states except California, where median duration in the separate CHIP—at 22 months—was higher than median duration in Medicaid (at 15 months, one of the two lowest Medicaid durations in the sample) (Figure VI.1). In most separate CHIP programs, median duration ranged from 12 to 14 months. Although California did not introduce automated renewal methods to the extent of other states during the study period, it took other steps to support renewal in its separate CHIP, including mailing preprinted renewal forms, sending reminder cards, and making telephone calls to nonresponders. The shorter median duration observed in Louisiana's small separate CHIP for children with incomes between 200 and 250 percent of FPL is consistent with the expectation that this component provides a temporary bridge between Medicaid/CHIP and private coverage.

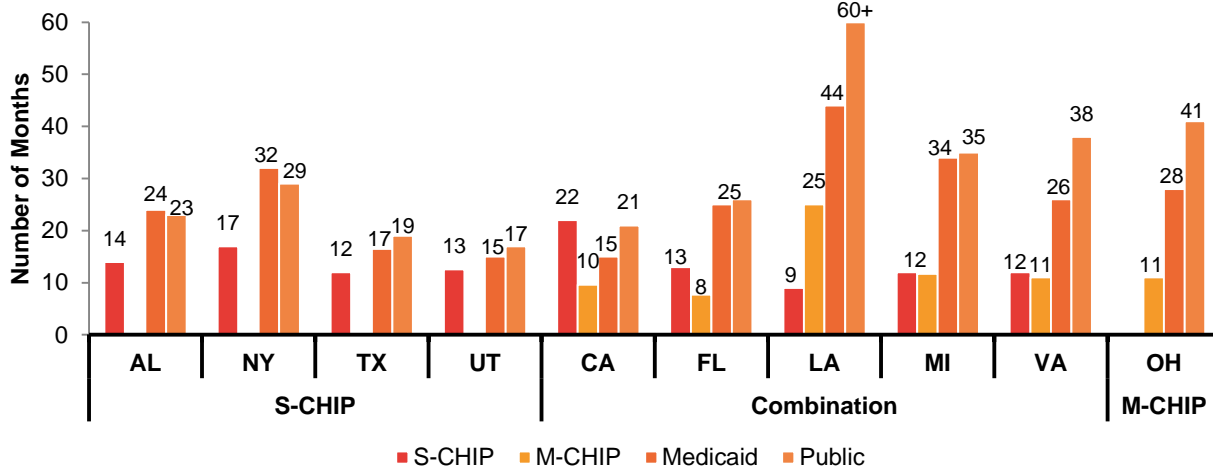
We see larger differences in the median duration for Medicaid programs, from lows of 15 months in California and Utah and 17 months in Texas to a high of 44 months in Louisiana. The higher Medicaid duration in Louisiana's Medicaid and Medicaid expansion programs likely reflects the state's use of passive renewal and other administrative processes that keep most

⁴³ The duration of Medicaid and CHIP enrollment was estimated using state administrative data on children with a new spell of enrollment anytime during the 5-year period from July 2007 to July 2012. For this analysis, a child is considered a new enrollee if he or she is enrolled in the program for two consecutive months, but not in the previous two months. The new enrollment month is the first month of the enrollment spell. New program-specific enrollees include children transferring directly from another program, whereas new public coverage enrollees are those with no public coverage in the preceding two months.

⁴⁴ The data used for this analysis span August 2007 through June 2012. Median duration may be computed only when the end dates are observed for at least 50 percent of spells. On average, we observed the end of at least 50 percent of spells for a roughly three-year period for the separate CHIP spells and just over two years for Medicaid and Medicaid expansion spells.

children enrolled unless the family reports changed circumstances. Louisiana had adopted several simplifications that, in combination, largely eliminated the need for families to fill out renewal forms (Kellenberg, Duchon and Ellis, 2010). In contrast, the Texas and Utah Medicaid programs did not offer 12-month continuous coverage and required redeterminations more frequently than once every 12 months during the study period. The lower duration of enrollment in California’s Medicaid program is likely indicative of the lack of automated renewal processes and a decentralized approach that relied on county department of social service offices to process renewals (Hill et al., 2013).

Figure VI.1. Median Duration of New Coverage Spells, by State and Program Type



Source: Mathematica analysis of state-provided Medicaid/CHIP administrative data.

Note: Duration measures are calculated by using data on spell length for new enrollment spells starting in the period August 2007 to July 2012. The numbers reported in this figure take a simple average of median duration values across months. Only months where the end data for at least 50 percent of spells can be observed in the data for each state are included.

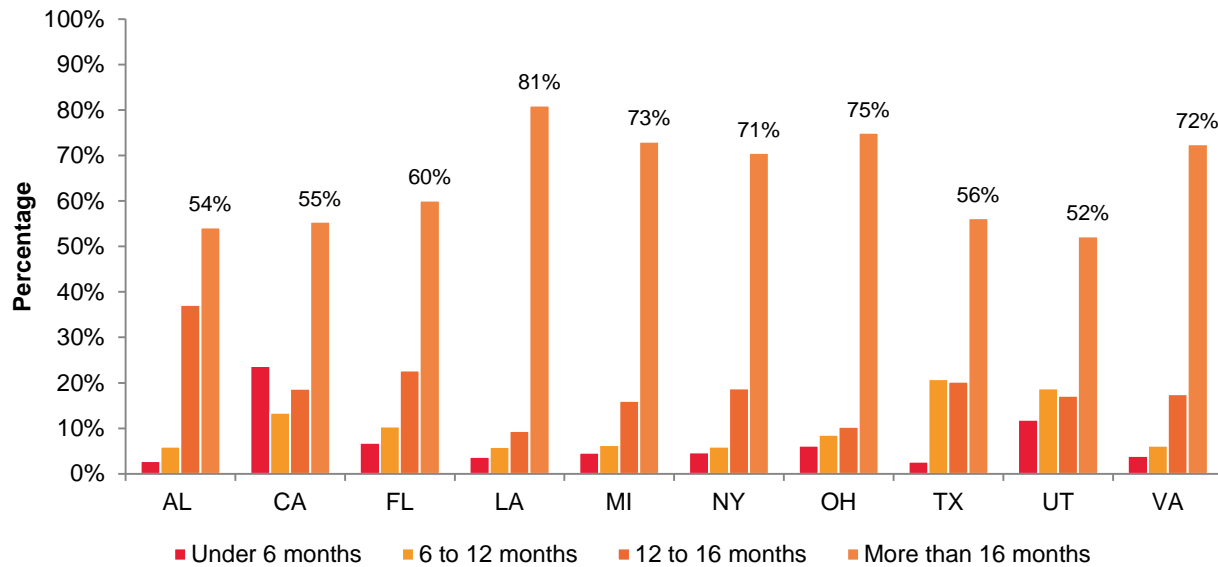
The median duration of public coverage in Louisiana is on average at least 60 months; most new spells ended after July 2012, so the end date was censored for more than 50 percent of these spells throughout the time period.

M-CHIP = Medicaid expansion CHIP; Public = Medicaid and CHIP combined; S-CHIP = separate CHIP; Combination CHIP = state administers both M-CHIP and S-CHIP.

The longer duration of public coverage in Louisiana and Ohio (on average at least 60 months in Louisiana and 41 months in Ohio) likely relates to the design of the state CHIP programs; Ohio is the only pure Medicaid expansion program among the 10 study states, and while Louisiana is a combination program, 94 percent of CHIP enrollees are in the Medicaid expansion component. Movement between Medicaid and Medicaid expansion programs is often seamless and typically associated with fewer administrative or paperwork difficulties. It is difficult to pinpoint a specific policy or program design reason that explains Michigan’s and Virginia’s longer duration (35 to 38 months, on average). Both states operate combination CHIP programs with upper income limits of 200 percent of FPL, offer 12-month continuous eligibility (in Virginia, only for CHIP), and allow enrollees to self-declare their income at renewal. Michigan offers online renewal, and Virginia uses preprinted renewal forms populated with the most recent eligibility-related information in the state’s data system. Florida and New York share many of the same characteristics and their duration rates were also higher than average for much of the study period (26 to 29 months, on average).

We gain additional insight by examining the distribution of spell length and how this varies by state (Figure VI.2). Most striking is that the majority of new spells of public coverage in every state lasted at least 16 months, typically taking the child through an annual renewal period. As expected, the percentage with longer spells is highest in the states where the median duration of public coverage is higher (Louisiana, Michigan, Ohio, and Virginia). In most states fewer than 10 percent of enrollment spells were shorter than 6 months; these short spells were more common in California (24 percent) and Utah (12 percent). Some portion of these short spells was likely cases where a child is initially presumed eligible but later found ineligible (or eligible for Medicaid instead of CHIP).

Figure VI.2. Distribution of the Average Length of New Spells of Public Coverage, by State, 2007-2011



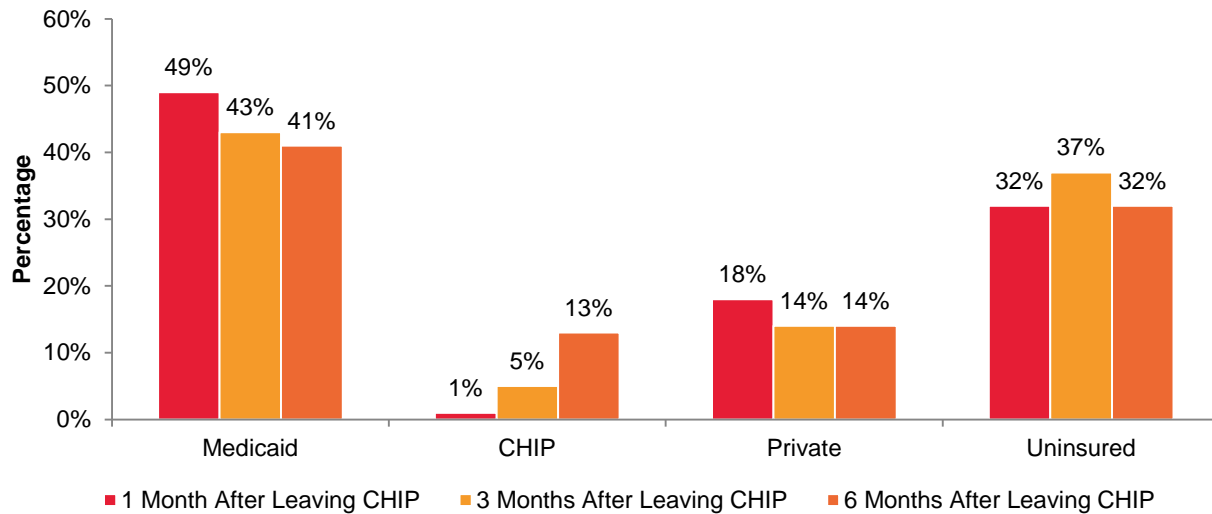
Source: Mathematica analysis of state-provided administrative data

Experiences of Disenrollees

Most children leaving CHIP transferred to Medicaid or became uninsured; few gained private coverage.

In the month after leaving CHIP, 49 percent of children across the 10 study states transferred to Medicaid, and 32 percent became uninsured (Figure VI.3). Only 18 percent of disenrollees were reported to have some form of private insurance just after leaving CHIP; the rate fell to 14 percent during subsequent months. At six months after disenrollment, 13 percent of CHIP disenrollees had returned to CHIP.

Figure VI.3. Coverage Status of CHIP Disenrollees in 10 States at Different Times After Leaving CHIP, 2012

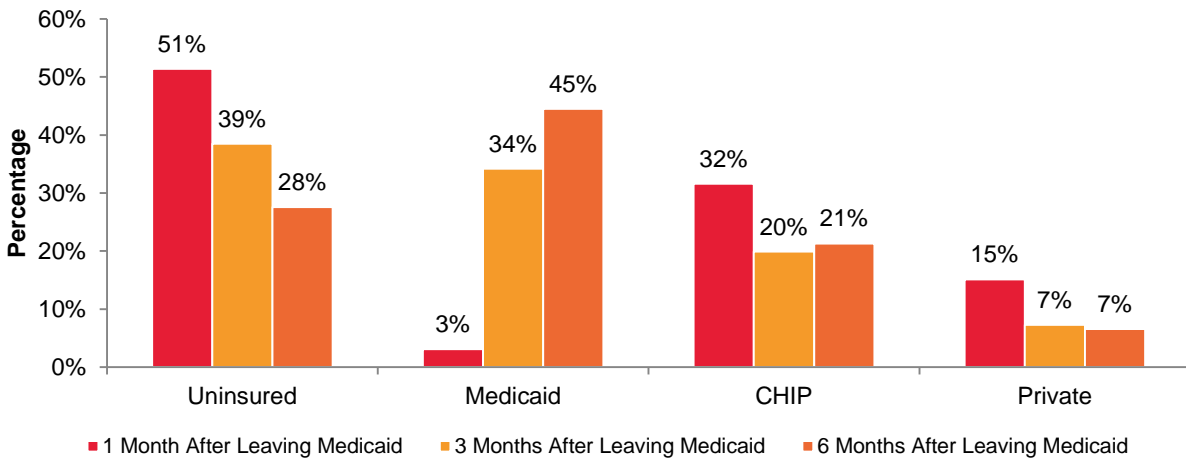


Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; CHIP disenrollees, including 2,159 survey cases and 58,025 disenrollees who transferred to Medicaid. The survey and administrative data are combined, with the survey data weighted to represent all disenrollees who did not transfer. The one month measure includes CHIP disenrollees in all 10 states (N=59,903). The 3-month and 6-month measures exclude New York because state administrative data could not be used to construct the measure of coverage at 3 and 6 months after disenrollment; the total number of cases for these measures is 56,229.

In the 3-states included in the Medicaid survey (California, Florida and Texas), 51 percent of Medicaid disenrollees were initially uninsured, but only 28 percent remain uninsured 6 months later (Figure VI.4). Nearly half (45 percent) of Medicaid disenrollees had regained Medicaid 6 months after exit, and another 21 percent were covered by CHIP at this point. Although 15 percent of parents of Medicaid disenrollees reported that the child had private coverage after leaving the program, administrative records indicated that about half of these children had Medicaid or CHIP three and six months after the child disenrolled.

CHIP disenrollees in the 3 Medicaid survey states were more likely to be uninsured 6 months after leaving CHIP (39 percent for CHIP versus 28 percent for Medicaid), mainly because they were less likely to gain public coverage after leaving CHIP (data not shown). While 66 percent of Medicaid disenrollees were covered by Medicaid or CHIP 6 months after disenrollment, only 44 percent of CHIP disenrollees had some form of public coverage at this point. Only 14 percent of CHIP disenrollees had gained private coverage 6 months after leaving CHIP.

Figure VI.4. Coverage Status of Disenrollees in 3 States at Different Times After Exiting Medicaid, 2012

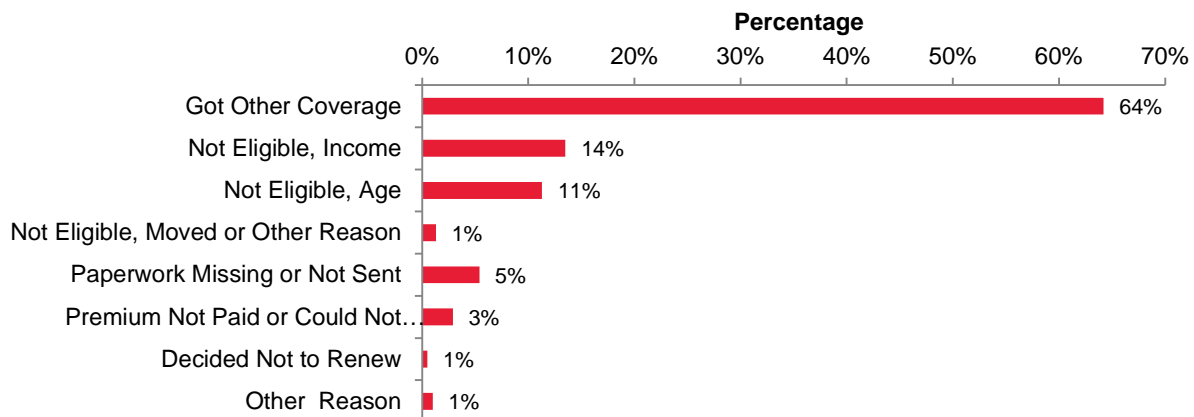


Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; Medicaid disenrollees in 3 states (California, Florida and Texas), including 355 survey cases and 38,557 disenrollees who transferred to CHIP. The survey and administrative data are combined, with the survey data weighted to represent all disenrollees who did not transfer.

In the vast majority of cases (90 percent), CHIP enrollment ended because the child obtained some other type of coverage or was no longer eligible for CHIP (because of age, income, or some other eligibility-related reason).

The main reason that CHIP ended for 64 percent of disenrollees was that the child obtained some other coverage, either Medicaid or private (Figure VI.5). For another 26 percent, eligibility-related reasons such as age or income were cited as the main reason that coverage ended. It is notable that missing paperwork and other aspects of the renewal process were cited as the main reason for the end of coverage for only 5 percent of CHIP disenrollees and that only 1 percent reported that coverage ended because the parent had decided not to renew the child’s coverage.

Figure VI.5. Reported Reason Why Child’s CHIP Coverage Ended, 2012



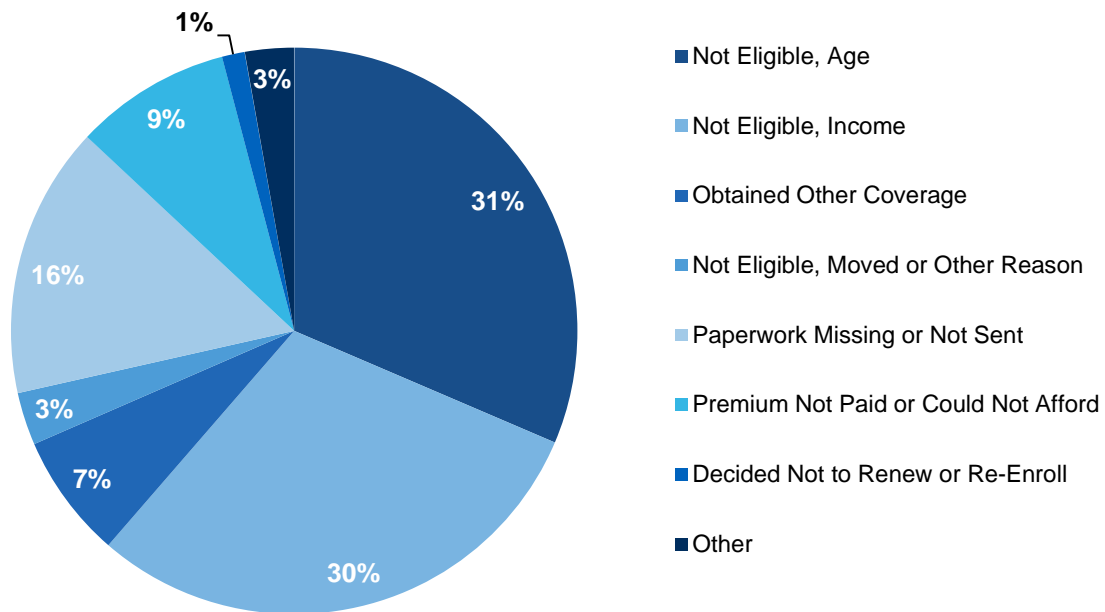
Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; CHIP disenrollee sample (n=1,878 survey cases). The percentage of disenrollees with other coverage includes 58,025 disenrollees who transferred to Medicaid. The survey data weighted to represent all disenrollees who did not transfer.

Among children who were uninsured six months after disenrolling from CHIP, only about one quarter (23 percent) disenrolled for reasons that suggest they may still be eligible.

More than 60 percent of children who were uninsured 6 months after disenrolling from CHIP were reported to have left CHIP because they no longer met the program’s age (31 percent) or income (30 percent) criteria and another 7 percent were reported to have disenrolled to obtain other coverage (Figure VI.6). We classified CHIP disenrollees as possibly eligible if they were uninsured and were reported to have left the program for reasons such as renewal paperwork was missing or incomplete or premiums were not paid. For the pool of uninsured children who might still be eligible, missing paperwork was the most common reason cited for disenrollment (16 percent), followed by reasons related to premiums (9 percent).

For the Medicaid population (data not shown), a larger share (37 percent) of disenrollees who were uninsured at six months were reported to have left Medicaid for reasons suggesting that they may still be eligible, most often (26 percent) because paperwork was missing or not submitted. Problems with premiums or affordability were cited as the reason for disenrollment among only 1 percent of Medicaid disenrollees uninsured six months later.

Figure VI.6. Reported Reasons Coverage Ended Among Children Uninsured Six Months After Exiting CHIP



Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; 10-state CHIP disenrollee sample, n=762 disenrollees who were uninsured 6 months after leaving CHIP.

Most CHIP disenrollees ages 18 and 19 were uninsured after disenrollment, a higher percentage than younger disenrollees, primarily because they age out of CHIP and Medicaid for children and were less likely to gain Medicaid coverage as an adult.

The uninsured rate for young adults aging out of public coverage is more than double that of children under age 13 (Table VI.1). Rates of private coverage were comparable across the age groups, so the higher uninsured rate for the oldest children is driven largely by lower rates of public coverage. Only 25 percent of those ages 18 to 19 had public coverage six months after CHIP disenrollment, versus 64, 63, and 51 percent of the three younger age groups, respectively.

Table VI.1. Coverage of CHIP Disenrollees 6 Months After Disenrollment, by Age Group, 2012

Coverage 6 Months After Disenrollment from CHIP	Percentage Reporting			
	Ages 0 Through 5	Ages 6 Through 12 (Reference Group)	Ages 13 Through 17	Ages 18 Through 19
Uninsured	20	24	35**	62**
Private	15	13	13	13
CHIP	12**	19	13**	1**
Medicaid	52**	44	38**	24**

Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; CHIP disenrollee sample, including include 2,159 survey cases and 54,070 CHIP disenrollees who transferred to Medicaid. Does not include disenrollees in New York because state administrative data could not be used to construct the measure of coverage at 6 months after disenrollment.

**Difference compared to the ages 0 to 5 group is statistically significant at p-value<0.01; *significant at p-value<.05.

Churning and Transitions Between Medicaid and CHIP

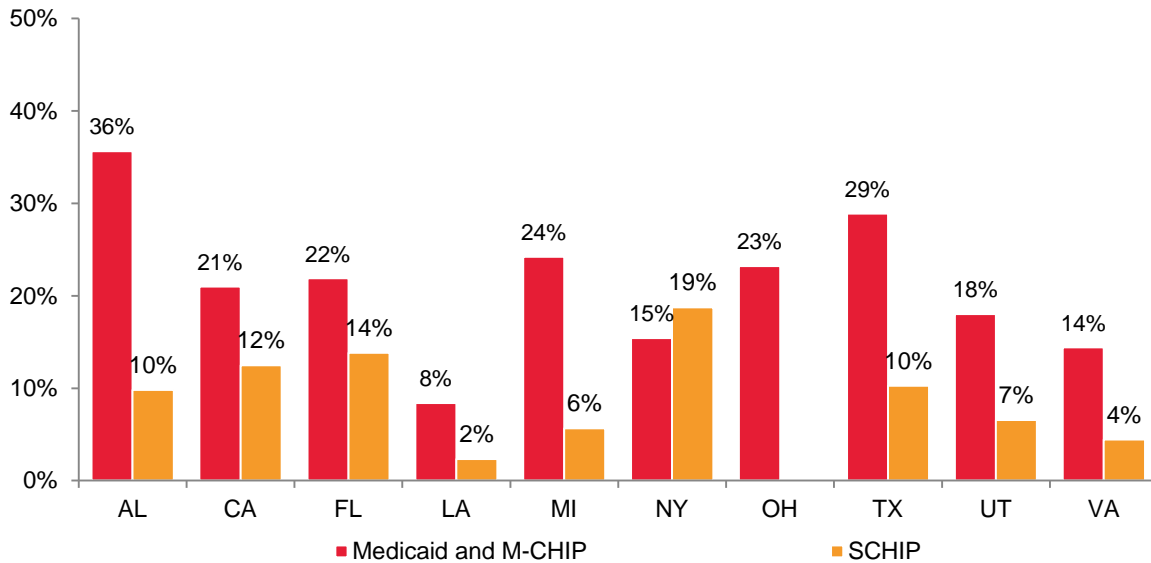
Program churning was more common among disenrollees from state Medicaid programs than among disenrollees from separate CHIP programs, with a median churn rate in Medicaid of over twice that of separate CHIP.

Overall, the proportion of disenrollees churning back onto coverage within seven months was more common among Medicaid (and Medicaid expansion CHIP) disenrollees than among children leaving separate CHIP programs.⁴⁵ Over the 4-year period examined, approximately 21 percent of exits from Medicaid returned to Medicaid within seven months, whereas just 10 percent of separate CHIP disenrollees churn back onto coverage within seven months. This finding was consistent across the 10 study states, where, in all but New York, the Medicaid churn rate exceeded that of separate CHIP disenrollees. The rate of disenrollees returning to coverage within seven months was fairly constant over the 4-year period.

Despite little variation in overall program-specific churn rates, the cross-state variation in the rates was considerable, particularly in the Medicaid program. Depending on the state, anywhere from 8 to 36 percent of Medicaid disenrollees churned back onto the program within seven months, with the corresponding separate CHIP rates ranging between 2 and 19 percent (Figure VI.7). Alabama and Texas had markedly higher churn rates in their Medicaid programs: approximately one in three disenrollees returned to Medicaid coverage within seven months. In contrast, Louisiana had little churn in both its Medicaid and separate CHIP, with rates of 8 and 2 percent, respectively. Michigan and Virginia also experienced little churn in their separate CHIP programs, with rates of 6 and 4 percent, respectively.

⁴⁵ Because Medicaid expansion CHIP is administered by state Medicaid agencies, we define both Medicaid and Medicaid expansion CHIP enrollees as Medicaid enrollees in this section.

Figure VI.7. Percentage of Disenrollees Who Re-enroll in the Same Program Within Seven Months, by State and Program Type (2008–2011)



Source: Mathematica analysis of state-provided Medicaid and CHIP enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011.

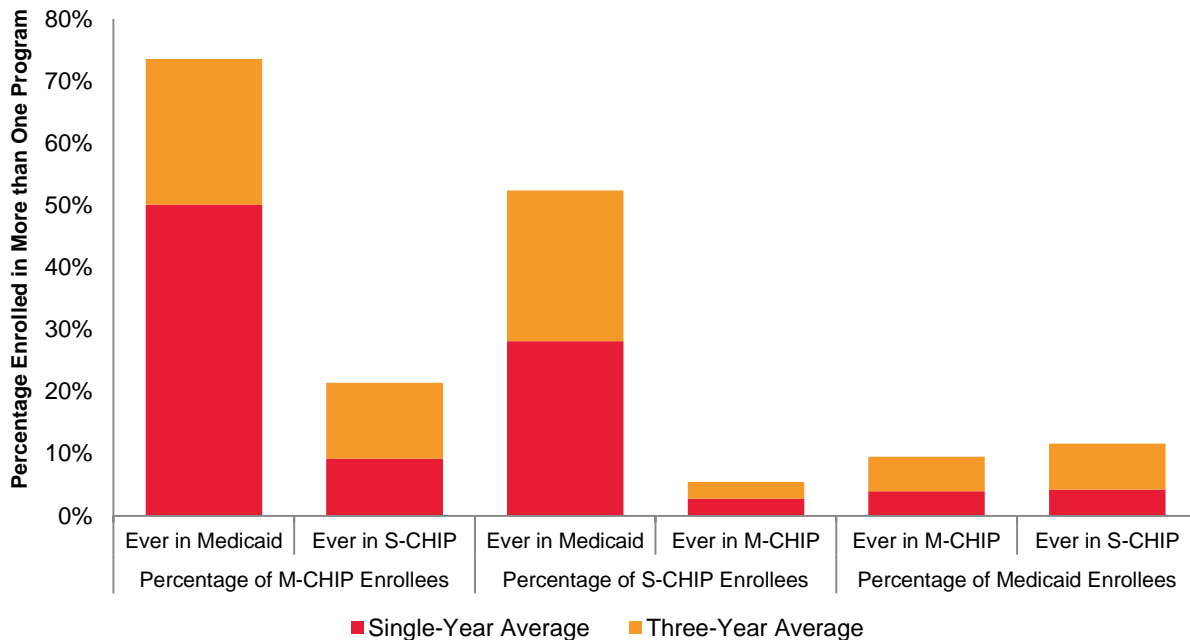
It was common for children to move between Medicaid and CHIP and to be enrolled in more than one public program during a one- or three-year time period.

A sizeable proportion of children enrolled in state CHIP programs were likely to have also had an enrollment period in state Medicaid programs over a one- or three-year time period. One in four children enrolled in separate CHIP and half of all children enrolled in Medicaid expansion CHIP had a spell of enrollment in Medicaid during the same year. Depending on the state, 29 percent (Louisiana) to 62 percent (Michigan) of children enrolled in Medicaid expansion CHIP were also enrolled in Medicaid during the same year, and between 12 percent (California) and 43 percent (Michigan) of separate CHIP enrollees were enrolled in Medicaid during the same year.

The likelihood of an enrollment period in both programs increased markedly as the period of observation extended from one to three years. The median percentage (across states) of Medicaid expansion CHIP enrollees ever enrolled in regular Medicaid increased from 50 to 74 percent between one and three years, and the median percentage of separate CHIP enrollees ever enrolled in Medicaid increased from 28 to 52 percent (Figure VI.8).

Movement between separate CHIP and Medicaid expansion CHIP was fairly limited. The median yearly percentage of Medicaid expansion CHIP enrollees ever enrolled in a separate CHIP program was 9 percent, and the reverse was 3 percent. In states running combination programs, the income eligibility band for one of the two CHIP programs is often narrow. Louisiana, which operates a small separate CHIP, accounts for the highest percentage of children enrolled in a separate CHIP who were ever enrolled in Medicaid expansion CHIP (38 percent), followed by Virginia (11 percent).

Figure VI.8. Percentage of Children Enrolled in More than One Program over a One- and Three-Year Period



Source: Mathematica analysis of state-provided Medicaid and CHIP enrollment data for children enrolled in Medicaid or CHIP during the period from January 1, 2008 to December 31, 2012.

Notes: Due to considerable variation across states, we found it useful to summarize the patterns of joint enrollment in Medicaid and CHIP based on the unweighted median averages across the states. For each state, we calculated the percentage of enrollees in multiple programs each year. We then averaged these values to determine the state-specific single-year average. We repeated this process with our three-year joint enrollment data.

S-CHIP = separate CHIP; M-CHIP= Medicaid expansion CHIP

Given that, in every state, Medicaid enrolls substantially more children than CHIP, the fraction of Medicaid enrollees also enrolled in one of the two CHIP programs during the same year (roughly 4 percent) was considerably smaller than the fraction of CHIP enrollees also enrolled in Medicaid during the year.

Transitions between separate CHIP and Medicaid often led to gaps in public coverage.

Transitions between Medicaid and Medicaid expansion CHIP tend to be seamless and largely administrative in nature. In contrast, children moving between Medicaid and a separate CHIP were more likely to lose coverage temporarily (two to six months without public coverage), with a sizable proportion of transitions resulting in a coverage gap. In terms of the median percentage across the states, 40 percent of transitions from Medicaid to a separate CHIP, and 16 percent of transitions in the reverse direction had a gap in public coverage.⁴⁶ This finding is largely driven by results in four states – California, Florida, New York, and Texas – where transitions from

⁴⁶ Analysis excludes Ohio (which does not have a separate CHIP program), and Alabama (due to concerns about the quality of the Medicaid data received from the state).

Medicaid to separate CHIP are over five times as likely to follow a short gap in coverage as corresponding transitions from separate CHIP to Medicaid. In states with combination CHIP programs, transitions between CHIP programs largely mirrored this trend—33 percent of transitions from a Medicaid expansion CHIP to a separate CHIP program and 11 percent of transitions in the reverse direction had a gap in public coverage. These findings suggest that coordination of movement from Medicaid to separate CHIP programs remains an issue and suggest that efforts continue to improve transitions between programs and the adoption of policies that simplify these transitions. These challenges may be particularly acute for states whereby CHIP and Medicaid eligibility is administered by separate agencies; among the study states, only three – Louisiana, Ohio, and Utah – administer CHIP and Medicaid out of the same agency. Premium or enrollment fee requirements and waiting periods unique to separate programs may also be a factor for some transitions to separate CHIP programs.

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VII. CHARACTERISTICS OF CHIP ENROLLEES

KEY FINDINGS:

- The 2012 CHIP survey population was largely the same as the population surveyed in 2002–2003: primarily children living in low-income households with at least one working parent. More than half of CHIP enrollees in this study were Hispanic, and a third of children had a parent who primarily speaks Spanish.
- The majority of CHIP enrollees were healthy, without increased health care needs or specific medical conditions. However, a significant minority had more extensive needs, including one in four children whose parents reported general special health care needs and one in five whose parents reported poor dental health.
- Many of the sociodemographic characteristics of CHIP enrollees varied extensively across the 10 states in this study.

This chapter describes the characteristics of children enrolled in CHIP and Medicaid, based on data from the survey of enrollees conducted in the 10 study states.⁴⁷ The findings focus on the samples of established CHIP enrollees (N=5,498) and established Medicaid enrollees (N=1,630). We used findings from the 2011/2012 National Survey of Children’s Health (NSCH) as national benchmarks for comparisons.⁴⁸ We made comparisons with the sample whose parents reported that the child was covered by public insurance (the survey does not report Medicaid and CHIP separately) and the overall sample of children in the NSCH. Additionally, we made comparisons to survey findings from 2002–2003 in the prior 10-state evaluation of CHIP (see Kenny and Trenholm et al. 2005 for the findings from the prior evaluation).

In 2012, CHIP continued to serve a population of children with diverse demographic and family backgrounds and health needs (Table VII.1). The majority of CHIP enrollees were of school age, with 86 percent ages 6 to 18 years. The low proportion of children younger than age 6 is partly reflective of this younger group being eligible for Medicaid at higher income levels during the survey period.

⁴⁷ Further details are presented in Zickafoose et al. (2103), contained in Harrington and Kenney et al. (2014).

⁴⁸ The NSCH is a nationally representative telephone survey of households with children ages 0–17 years. National estimates from the 2011/2012 NSCH reported here are based on publicly available data provided on the NSCH website and estimates generated from a publicly available data file provided by the Child and Adolescent Health Measurement Initiative: Data Resource Center for Child and Adolescent Health. “The National Survey of Children’s Health.” Available at [<http://www.childhealthdata.org/learn/NSCH>]. Accessed September 5, 2013.

Table VII.1. Characteristics of Established CHIP Enrollees, Their Caregivers, and Their Households in 10 States, 2012

Characteristics	Percent
Child	
Age in Years	
0–5	15
6–12	43
≥13	43
Race/Ethnicity	
Hispanic	54
Non-Hispanic White	28
Non-Hispanic black	10
Other	9
Child Health Status	
Excellent/Very Good	71
Good	22
Fair/Poor	7
Child Mental Health Status	
Excellent/Very Good	80
Good	16
Fair/Poor	5
Child Dental Health Status	
Excellent/Very Good	52
Good	30
Fair/Poor	18
Any Special Health Care Need ^a	
Emotional, Developmental, or Behavioral Problems	7
Asthma	10
Parent & Household	
At Least One Parent Employed	87
Highest Education Level of Parent/Guardian	
Less Than High School	23
High School or Equivalent	30
Some College, Trade School, or Other Higher Education	48
Household Income by FPL	
<150% FPL	69
150–199% FPL	22
≥200% FPL	9
Family Structure	
Two Parents	62
One Parent	29
One Parent and Stepparent/Other Guardian	8
Other	1

Table VII.1 (Continued)

Characteristics	Percent
Number of Children in Household	
1	20
2	39
≥3	40
Language^b	
English	69
Spanish	32

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

Note: CHIP enrollees include those in separate CHIP as well as Medicaid expansion CHIP programs. The 10 states included in the study were: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. More than half of CHIP enrollees in this study were Hispanic, a larger share than among CHIP enrollees nationally. Percentages may not sum to 100 due to rounding. Abbreviations: CHIP – Children’s Health Insurance Program; FPL – federal poverty level.

^a A child was identified as having a special health care need if his or her parent reported an ongoing health condition for which the child experienced one or more of the following: (1) need or use of prescription medications, (2) more than routine use of services, (3) need or use of specialized therapies or services, (4) need or use of mental health counseling, or (5) a functional limitation.

^b Based on respondents’ language of choice for survey; English and Spanish were the only languages offered.

A majority of CHIP enrollees in the 10 study states were Hispanic (54 percent). This was higher than the proportion of Hispanic children estimated nationally from the 2011/2012 National Survey of Children’s Health (NSCH) (publicly insured, 35 percent; overall, 23 percent). The large Hispanic population in our sample was driven mainly by the demographic characteristics of the four largest states (California, Florida, New York, and Texas) included in the study, based on the criteria required by Congress for the selection of study states. The next most populous group in CHIP was non-Hispanic white children (28 percent) followed by non-Hispanic black and children of other races/ethnicities (10 and 9 percent, respectively).

Like most populations of children, the majority of CHIP enrollees were characterized by their parents as healthy. When asked to rate their child’s overall health status, parents of 71 percent of established CHIP enrollees rated their child’s health as excellent or very good and only 7 percent rated it as fair or poor (on a 5-point scale: excellent, very good, good, fair, poor). Similarly, 80 percent of children were reported to have excellent or very good mental health and only 5 percent had fair or poor mental health per their parent’s report. A lower percentage of established CHIP enrollees had excellent or very good, dental health (52 percent), and 18 percent were reported to have fair or poor dental health.

A sizable minority of CHIP enrollees had substantial health impairments and health care needs. Similar to national estimates for all children from the NSCH, more than one-third of CHIP enrollees were overweight or obese (37 percent). About one in 4 enrollees had at least one special health care need (26 percent), and more than one in 10 had two or more special health

care needs (12 percent).⁴⁹ Seven percent of established CHIP enrollees had an emotional, developmental, or behavioral problem for which treatment or counseling was needed. Asthma was the most common specific health condition reported for CHIP-enrolled children in our sample (10 percent).

As expected, the CHIP enrollees surveyed were predominantly in families with at least one parent who works and has some amount of post-high school education. Over 90 percent of CHIP enrollees surveyed were in families with incomes below 200 percent of the FPL, and most (69 percent) had incomes under 150 percent of the FPL. Most CHIP enrollees lived in two-parent households (70 percent with two parents or with one parent and a stepparent), and most lived in households with more than one child (79 percent). About one-third of enrollees lived with a parent or guardian who was primarily Spanish speaking (32 percent).

CHIP enrollees in the 10 study states in 2012 had similar demographic and health characteristics when compared to children enrolled in CHIP during the prior 10-state evaluation in 2002/2003. Key differences included higher proportions of enrollees in 2012 living in a household with no parent employed (2012 survey, 17 percent; 2002/2003 survey, 8 percent) and living in urban areas (2012 survey, 93 percent; 2002/2003 survey, 86 percent).

The characteristics of CHIP enrollees differed considerably across the 10 study states. For example, the proportion of Hispanic enrollees ranged from 5 percent in Alabama to 76 percent in California and the proportion of enrollees with primarily Spanish-speaking parents ranged from 2 percent in Alabama and Michigan to 46 percent in California. The rate of CHIP-enrolled children with special health care needs ranged from highs of 42 percent in Ohio and 41 percent in Michigan to a low of 19 percent in California. There was also large variation in dental health status, with more than 20 percent of children in California having fair or poor parent-reported dental health, compared to 8 percent in Alabama. There were differences across states in the percentage of enrollees with certain risk factors for poor health, including unhealthy weight and exposure to smoke in the household. Of the 10 states in this study, Alabama and Virginia had the highest rates of children who were overweight or obese (43 percent), whereas Utah had the lowest (26 percent). More than one in 10 CHIP enrollees were exposed to smoking in the household in Louisiana and Ohio (11 percent and 16 percent, respectively), compared to 1 percent in California and Utah.

⁴⁹ A child was identified as having a special health care need if his or her parent reported an ongoing health condition for which the child experienced one or more of the following: (1) need or use of prescription medications, (2) more than routine use of services, (3) need or use of specialized therapies or services, (4) need or use of mental health counseling, or (5) a functional limitation.

VIII. HOW WELL MEDICAID AND CHIP MEET THE HEALTH CARE NEEDS OF LOW-INCOME CHILDREN AND FAMILIES

KEY FINDINGS

- Children in Medicaid and CHIP experienced better access to care, fewer unmet needs, and greater financial protection than children who were uninsured. Similarly positive results were found when comparing the health care experiences of Medicaid enrollees to those of uninsured children.⁵⁰
- Compared to children with private insurance, CHIP enrollees were more likely to have access to dental benefits and much less likely to report financial burdens and stress in meeting their child's health care needs. However, they were less likely than children with private insurance to have either a regular source of medical care or nighttime or weekend access to a provider at that source of care.
- The care experiences of Medicaid enrollees were similar to those of privately insured children who later enroll in Medicaid. One exception is that Medicaid enrollees were less likely to have a preventive care visit.
- Nearly all parents of CHIP enrollees (96 percent) reported feeling confident that their child will be able to get needed health care and a large share of children enrolled in CHIP (86 percent) had seen a doctor or health professional in the last year.
- Despite relatively high rates of contact with providers in outpatient settings, nearly one in four CHIP enrollees had an unmet need for health care, and many children were not receiving recommended preventive care.
- Medicaid enrollees had similar access and use experiences as CHIP enrollees, but had higher rates of emergency department visits, hospitalization, and unmet need.

Having CHIP or Medicaid coverage eases entry into the health care system and is an important part of reducing health care barriers and achieving good health outcomes. However, coverage alone does not guarantee that a child will get the care they need and that the content of care received aligns with recommended standards. Other important factors include the family's ability to find and obtain appointments with health care providers when services are needed, financial burden associated with accessing care, and care experiences with providers. When services are not available, affordable, and/or acceptable to the patient or family, unmet health care needs and delays in the diagnosis and treatment of health care problems can arise.

In the first section of the chapter we present findings on a wide range of health care access and use measures among CHIP and Medicaid enrollees, including access to a regular source of care or provider; type of usual source of care; receipt of primary medical and oral health care,

⁵⁰ Throughout this chapter, CHIP includes both Medicaid expansion and separate CHIP components.

specialist and mental health care, and other services; oral health care access and use; patient-centeredness of care received; unmet needs; and parental perceptions of coverage and financial burden of their child's health care. We then describe how access and use varied across enrollee subpopulations defined by demographic and health characteristics of the child or their family and across states. The final section of the chapter presents findings from the impacts analysis, examining how access to care and care experiences under CHIP and Medicaid compare to private coverage and being uninsured.

Access, Service Use and Care Experiences of CHIP and Medicaid Enrollees⁵¹

CHIP provided high levels of access to care, but areas for program improvement remain.

Overall, CHIP programs were meeting the health care needs of most of the children who enroll. CHIP enrollees had high levels of access to providers; almost all children enrolled in CHIP had seen a medical and dental provider in the past year and the vast majority of parents of CHIP enrollees reported feeling very confident their child will be able to get needed health care. However, despite high rates of overall service use in outpatient settings, one in four CHIP enrollees had an unmet health care need and many children enrolled in CHIP were not receiving recommended preventive care (Table VIII.1).

- **Health care access and use.** Most CHIP enrollees had access to a regular source of care or provider and had little trouble finding or obtaining appointments with providers.⁵² More than 85 percent of children enrolled in CHIP had seen a doctor or health care professional in the past 12 months, and 80 percent had received a well-child visit. However, only 28 percent of CHIP enrollees had a usual source of care (USC) that offered appointments at night or on the weekend, and only 37 percent had after-hours access to a provider at their usual source of care. This may contribute to greater use of the emergency department, and nearly one-quarter of CHIP enrollees had an emergency department (ED) visit in the past year.
- **Content of preventive care received.** Although most enrollees received annual well-child checkups, including having their height and weight measured, many children covered by CHIP were not receiving recommended health screenings and anticipatory guidance on a regular basis. For example, 60 percent had their vision screened in the past year, but slightly less than half received a flu vaccination and only about one-third received anticipatory guidance on all four key health topics examined, or a developmental screening (among children under age 6).⁵³

⁵¹ For further details on findings reported in this section, see Smith and Dye (2013), contained in Harrington and Kenney et al. (2014).

⁵² Access to a regular source of care or provider is a composite measure that incorporates (1) presence of a usual source of care and (2) having a personal doctor or nurse, and we use it to assess whether a child had a continuous source of care during the previous 12 months. More information on the construction and individual components of this measure can be found in Smith and Dye (2013), contained in Harrington and Kenney et al. (2014).

⁵³ Anticipatory guidance topics examined include: (1) how to avoid injury, (2) child's eating habits, (3) child's exercise habits, and (4) risks of secondary smoke.

Table VIII.1. Access, Use, and Care Experiences In the Past 12 Months Among Established CHIP Enrollees, Based on Parent Reports

Reports for the Past 12 Months	Percent
Access to Care Based on Parent Reports	
Had USC or personal doctor or nurse during past 12 months	88
USC Type: Private doctor's office or group practice/HMO	49
USC has night or weekend office hours	28
Could reach doctor at USC after hours	37
Provider Accessibility Based on Parent Reports	
No trouble finding a general doctor	97
No trouble finding a specialist	94
Usually/always easy to get appointments with medical provider	83
Service Use Based on Parent Reports	
Any doctor/other health professional visit	86
Any preventive care or checkup visit	80
Any specialist visit	21
Any mental health visit	7
Any emergency department (ED) visit	23
Any hospital stays	4
Content of Preventive Care Received Based on Parent Reports	
Height and weight measurement	92
Vision screening	60
Flu vaccination	48
Anticipatory guidance on four key health topics	30
Developmental screening (among children under age 6)	30
Access to and Use of Oral Health Care Based on Parent Reports	
Has dental benefits or coverage for dental services	92
Had USC for dental care	87
USC for dental care has night or weekend hours	38
No trouble finding a dentist	89
Usually/always easy to get appointments with dental provider	72
Any dental visit for checkup or cleaning	84
Dentist recommended additional or follow-up treatment	37
Had dental procedure, such as having a cavity treated or tooth pulled	68
Dental sealants (if age > 6 years)	54
Patient Centeredness of Health Care Based on Parent Reports	
Obtained referrals when needed	74
Received effective care coordination	68
Received family-centered care	47
Unmet Needs Based on Parent Reports	
Doctor/health professional care	5
Prescription drugs	6
Specialists	5
Hospital care	3
Mental health care	3
Dental care	12
Any unmet need	24

Table VIII.1 (Continued)

Reports for the Past 12 Months	Percent
Parental Perceptions of Coverage and Financial Burden of Child's Health Care	
Very or somewhat confident could get needed health care for child	96
Never or not very often stressed about meeting child's health care needs	84
No problem paying child's medical bills for care (or no out-of-pocket costs)	92
Out of pocket costs: Greater than \$0 up to \$250	3
Out of pocket costs: Between \$250 and \$2,000	4
Out of pocket costs: Greater than \$2,000	1

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

Notes: Anticipatory guidance topics examined include: (1) how to avoid injury, (2) child's eating habits, (3) child's exercise habits, and (4) risks of secondary smoke. Receipt of effective care coordination is a composite measure that incorporates assessments of (1) communication between doctors when needed, (2) communication between doctors and schools when needed, and (3) getting help coordinating care when needed. Receipt of family-centered care is a composite measure based on parent reports of whether (1) the child's provider usually spends enough time with the child, (2) always listens carefully, (3) is sensitive to family values/customs, (4) gives needed information, (5) makes the family feel like a partner, and (6) getting non-family member to interpret conversations with doctors or other health care providers. "No out-of-pocket costs" includes those who indicated out-of-pocket costs but then said they had no problem paying, or later indicated they paid \$0 in out-of-pocket costs.

- **Oral health care access and use.** The vast majority of CHIP enrollees' parents accurately reported that their child's insurance covers dental benefits, and most (89 percent) reported they did not have trouble finding a dentist who would see their child. Nine in 10 CHIP enrollees had a USC for dental care, but less than 40 percent of them had access to a dental provider at the USC on nights or weekends. More than 80 percent of CHIP enrollees received a dental cleaning or checkup in the past year, and 54 percent of children over age 6 had dental sealants placed on their back teeth—a rate exceeding targets established in "Healthy People 2020" (U.S. DHHS). A significant share (32 percent) of CHIP enrollees did not get dental treatment when follow-up dental treatment was recommended by a dentist, and parents of over half of children enrolled in CHIP reported that their child's teeth were in less than excellent or very good condition (data not shown).
- **Patient-centeredness of care received.** Parents of CHIP enrollees reported positive care experiences with their child's providers at high rates on most aspects of patient-centered care. Most parents reported they had no problem getting referrals when needed (74 percent) and received effective care coordination across a number of care coordination elements (68 percent).⁵⁴ A relatively high proportion of CHIP enrollees' parents also reported having family-centered care interactions with their child's provider across the six dimensions of this care component. Specifically, about 65 to 80 percent reported that the provider usually spends enough time with the child, always listens carefully, is sensitive to family values/customs, gives needed information, makes the family feel like a partner, and receives interpreter services

⁵⁴ Receipt of effective care coordination is a composite measure that incorporates assessments of (1) communication between doctors when needed, (2) communication between doctors and schools when needed, and (3) getting help coordinating care when needed.

when needed. However, only 47 percent of CHIP enrollees' parents reported positive care experiences on all six of these dimensions of family-centered care.

- **Unmet need.** Almost one in 4 CHIP enrollees had an unmet need for any type of care. Unmet need was highest for dental care (12 percent of enrollees). About one in 20 CHIP enrollees had an unmet need for physician services, prescription drugs, or specialty care. Unmet need was lowest for hospital care and mental health service (about 3 percent).
- **Parental perceptions of coverage and financial burden of child's health care.** Most parents of CHIP enrollees (96 percent) were confident that they could get health care to meet their child's needs, with more than 8 in 10 parents reporting never or not often feeling stressed about meeting these needs. In addition, only 8 percent of parents reported that they had any problem paying their child's medical care bills in the past year—3 percent reported having out-of-pocket costs between \$0 and \$250, 4 percent reported out-of-pocket costs between \$250 and \$2,000, and less than one percent reported out-of-pocket costs greater than \$2,000.

Medicaid enrollees had similar access and use experiences as CHIP enrollees.

Levels of primary care access and use were generally similar among CHIP and Medicaid enrollees in three selected states (California, Florida, and Texas), and consistent with the 10-state CHIP results presented above (Medicaid findings are presented in Appendix Table B.4). Similar to CHIP enrollees, most Medicaid enrollees had a regular source of care or provider, received a preventive medical and a dental care visit in the past year, and generally had little trouble finding a provider or obtaining appointments when needed.

Medicaid enrollees were less likely than CHIP enrollees to have a private provider as their USC, and they had similarly low access to their USC at nighttime and on weekends. For most of the services examined, levels of service use were similar between CHIP and Medicaid enrollees. One notable exception was the rate of hospitalization, which was twice as high for Medicaid enrollees (8 percent versus 4 percent). Despite similar rates of service use between children enrolled in Medicaid and CHIP, parents of Medicaid enrollees reported higher rates of unmet need. Almost one in three children enrolled in Medicaid in the three states had some type of unmet need in the past year (versus one in four CHIP children).

Access to care under CHIP varied with respect to the child's race/ethnicity and primary language, age, parents' educational attainment, and health care needs.

While CHIP provided high levels of access to care for most children, some groups of children appear to be faring better than others in CHIP. Table VIII.2 shows differences in selected access and use measures across subgroups.

Table VIII.2. Variation in Selected Access and Use Measures Under CHIP, by Child and Parent Characteristics

	Percent of Parent's Reporting for Past 12 Months							
	Child Had A Regular Source of Care or Provider	USC is a Private Doctor's Office, Group Practice, or HMO	Child Had Preventive Care or Check-up Visit	Child Had Specialist Visit	Child Received Patient-Centered Care (Composite)	Child Had an Unmet Need for Care	Parent Confident Could Get Needed Health Care	Parent(s) Had No Problem Paying Child's Medical Bills
All CHIP Enrollees	88	49	80	21	47	24	96	92
Race/Ethnicity and Primary Language (PL)								
Hispanic								
PL: English	88	49**	78	20**	49**	24	97	90
PL: Spanish	88	40**	78	15**	37**	26	94	95**
Non-Hispanic								
White	91	67	82	29	62	23	97	90
Black	86**	47**	83	22**	51**	21	96	94**
Age of Child								
1 to 5 years	88	48	87**	16	49	21	96	96
6 to 12 years	88	49	80	19	48	23	97	93**
13 to 18 years	88	49	77**	25**	45	27*	94	90**
Highest Education Level of Parents								
Less Than High School	86	32	74	15	30	26	67	94
High School	85	45**	78	21**	47**	23	73	92
More Than High School	91**	59**	83**	23**	55**	24	80	91**
Health Status of Child								
Without Special Health Care Needs	86	46	78	37	45	20	96	94
With Special Health Care Needs	93**	56**	83**	15**	52**	38**	95	87**

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

Notes: Tests of significance compare children with this characteristic to the reference category (in italics). Primary language is based on interview language. Receipt of family-centered care is a composite measure based on parent reports of whether (1) the child's provider usually spends enough time with the child, (2) always listens carefully, (3) is sensitive to family values/customs, (4) gives needed information, (5) makes the family feel like a partner, and (6) getting non-family member to interpret conversations with doctors or other health care providers.

**p-value (of difference) < 0.01; * p-value (of difference) < 0.05 level.

- **Race/ethnicity and language.** Relative to non-Hispanic white enrollees, Hispanic and non-Hispanic black enrollees were less likely to have a regular source of care or provider, a private doctor's office for their USC, and access to a provider at their USC at nighttime and on weekends. They were also less likely to have seen a doctor or health professional or to have received care from a specialist in the past 12 months. There were no significant differences across racial and ethnic subgroups in the ease of finding and making appointments with providers or in receipt of most of the preventive care services examined. However, parents of Hispanic and Non-Hispanic black enrollees were less likely to report patient-centered care experiences than white enrollees. Where there were differences in access to care between Non-Hispanic white enrollees and Hispanics or non-Hispanic black enrollees, the differences tended to be largest for Hispanics whose primary language is Spanish.

- **Age.** Service use patterns tended to vary with the age of the child in ways that reflect the changing types of care children need and receive as they grow and develop. For example, the recommended rate at which children should receive well-child checkups varies by age, with more frequent visits recommended for younger children than adolescents. Consistent with this, we find a higher rate of well-child checkups for younger children. No age differences were found in access to a regular source of care or provider, provider accessibility, or the patient centeredness of care received. However, unmet need was higher among adolescents than younger children—roughly one-third of children ages 13 to 18 had an unmet need for any care versus one-fifth of children ages 1 to 5.
- **Parent’s education.** CHIP enrollees whose parents had more education tended to have higher rates of access to care and outpatient service use, and lower hospitalization rates. Parents with more education also tended to report higher levels of confidence in their ability to meet their child’s health care needs. Differences were more pronounced and more likely to be significant when comparing enrollees whose parents have less than a high school education to enrollees whose parents have some college education. For example, CHIP enrollees whose parents had some college education were 10 percentage points more likely to have a preventive care visit than enrollees whose parents had less than a high school education.
- **Health status.** Not surprisingly, CHIP enrollees with at least one special health care need (SHCN) were more likely to have a regular source of care or provider, a private doctor’s office as a USC, and a USC with night or weekend hours. Children with an SHCN were also more likely to have seen a general doctor or specialist in the past year, to have received a well-child visit, and to have patient-centered interactions with providers. However, children with an SHCN had roughly two- to three-times greater rates of unmet need for every type of health service examined compared to children without an SHCN. Unmet needs for children with an SHCN were especially high for prescription drugs (25 percent) and specialist care (10 percent).

Access to care was high but variable across states, with no apparent pattern to the variability.

Although CHIP enrollees tended to experience high levels of access to primary care in each of the 10 study states, several key access and use measures varied considerably across states, with few consistent patterns indicating persistently high- or low-performing states. Cross-state variation for selected primary care measures is shown in Table VIII.3.

- **Health care access.** CHIP enrollees’ access to general doctors and specialists did not vary extensively across states, with the exception of USC characteristics. For example, the percentage of CHIP enrollees who had access to a regular source of care or provider ranged narrowly from 87 percent in Texas to 94 percent in Utah. However, there was considerable variation across states in the type of provider as the USC, and in access to USC providers during nighttime and weekends. For example, CHIP enrollees in Michigan were 30 percentage points more likely than enrollees in California to have a private doctor’s office or group practice as their USC, and the share of enrollees with a USC that has night or weekend office hours ranged from 20 percent in Louisiana to 44 percent in Utah (data not shown).

- **Service Use.** Overall service use was consistently high across the study states, but rates of receipt of different types of care varied considerably. For example, the share of enrollees who received a well-child check-up in the last 12 months ranged from 66 percent in Utah to 88 percent in New York. There was also a two-fold difference in service use rates for specialist visits, mental health care, and prescription medicine between the lowest state and the highest state. Despite this variation in service use across states, unmet need for care did not vary extensively across states.
- **Patient-centeredness of care received.** There were considerable differences across states in the patient-centeredness of care received. For example, the percentage of parents reporting that their child received family-centered care ranged from 40 percent in California to 67 percent in Michigan. There was also a 20 percentage point difference between the highest and lowest states in the share of parents of CHIP enrollees reporting that their child received referrals when needed and effective care coordination (not shown). Finally, in all 10 states, most parents of CHIP enrollees felt very confident in their ability to meet their child’s health care needs (ranging from 94 percent in Virginia to 99 percent in Alabama) and never or rarely had problems paying for their child’s medical bills (ranging from 85 percent in Utah to 97 percent in Louisiana).

Table VIII.3. Variation in Selected Access, Use, and Financial Burden Measures Under CHIP, by State

	Percent of Parent’s Reporting for Past 12 Months							
	Child Had A Regular Source of Care or Provider	USC is a Private Doctor’s Office, Group Practice, or HMO	Child Had Preventive Care or Check-up Visit	Child Had Specialist Visit	Child Received Family-Centered Care (Composite) ^a	Child Had an Unmet Need for Care	Parent Confident Could Get Needed Health Care	Parent(s) Had No Problem Paying Child’s Medical Bills
Alabama	92*	65**	73*	35**	62**	14**	99**	90
California	86*	39**	76**	14**	40**	26	95	94**
Florida	88	60**	85**	25**	50	27	95	89*
Louisiana	87	52	78	28*	52	19*	97	97**
Michigan	92*	69**	81	33**	67**	18*	98**	91
New York	91**	57**	88**	30**	52**	23	96	93*
Ohio	91	60**	82	28**	61**	20	96	93
Texas	87	48	80	22	45	26	96	88**
Utah	94**	56*	66**	19	61**	20	97	85**
Virginia	90	62**	80	20	47	25	94	92
Pooled 10-state	88	49	80	21	47	24	96	92

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

**Difference between the state outcome and the mean outcome of the nine other states collectively is statistically significant at p-value<0.01; * significant at p-value<.05.

^a This is a composite measure of family-centered care based on parent reports of whether the child’s provider usually spends enough time with the child, always listens carefully, is sensitive to family values/customs, gives needed information, and makes the family feel like a partner.

Impacts of CHIP and Medicaid on Access, Use, Content of Care and Family Well-Being⁵⁵

Ultimately, the impact of CHIP and Medicaid on the lives of children and their families depends on the extent to which the program improves access to care, receipt of services, and satisfaction with care, and reduces the financial burden of care for the children who enroll. To measure the impact of CHIP on the health and well-being of children and their families, evaluation of these intermediate outcomes is critical. These factors may also influence whether parents want their children to remain in the program and the extent to which they are willing to pay premiums and cost sharing.

CHIP and Medicaid are expected to lower the financial and nonfinancial barriers associated with obtaining care for the children who enroll and increasing enrollees' access to health care, particularly relative to being uninsured.⁵⁶ The expected effects of CHIP and Medicaid coverage compared to private insurance are uncertain. On one hand, children enrolled in CHIP and Medicaid generally have a broader benefits package with lower cost sharing than those with private insurance, thereby reducing financial barriers to care relative to those with private insurance.⁵⁷ On the other hand, physician payments tend to be lower in CHIP and Medicaid, and physicians are more likely to accept privately insured children as new patients compared to children enrolled in CHIP and Medicaid, increasing nonfinancial barriers to care relative to those with private insurance (Zuckerman et al. 2009; Government Accountability Office 2011).

This section presents an assessment of CHIP impacts in the 10 study states and Medicaid impacts in 3 of these states. The estimates contrast the experiences of established enrollees who had been in CHIP ("CHIP enrollees") or Medicaid ("Medicaid enrollees") for at least 12 months to the pre-CHIP or pre-Medicaid experiences of comparison samples of recent enrollees. For the CHIP and Medicaid samples, the comparison groups of recent enrollees were classified into two groups: those who were uninsured for at least 5 of the 12 months before they enrolled in the relevant program ("uninsured"), and those who had 12 months of private coverage in the 12 months before they enrolled in the relevant program ("privately insured"). Estimates were computed for each group, controlling for observed differences between the groups. Percentage point differences in mean outcomes for CHIP enrollees and Medicaid enrollees are shown relative to both the uninsured and privately insured comparison groups.⁵⁸ Analogous analyses for Medicaid were conducted for 3 states, with a generally similar pattern of results.

⁵⁵ For further details on findings reported in this section of the chapter, see Clemans-Cope et al. (2013a) and Clemans-Cope et al. (2013b), contained in Harrington and Kenney et al. (2014).

⁵⁶ However, a priori, the expected effects of CHIP and Medicaid enrollment on visits to the ED and hospital stays are not clear.

⁵⁷ For a comparison of benefits and cost sharing in Medicaid and private plans, see Baumrucker and Fernandez (2013).

⁵⁸ The main CHIP findings reported are from models that combined all 10 states, but separate models estimated for each state produced generally similar patterns, as did separate models for different subgroups of enrollees.

Children enrolled in CHIP have substantially better access to care compared to uninsured children.

The parents of children enrolled in CHIP reported substantially more confidence in their ability to get needed health care for their children, their children were more likely to have received a range of health services, and they reported fewer financial burdens associated with the child's health care compared to parental reports of children who lacked coverage (Table VIII.4).⁵⁹ Estimates in the table show, for example, that the percent with a usual source of care or a private doctor or nurse in the past 12 months was 10 percentage points higher for CHIP enrollees than for children who were uninsured. A parallel study of the health care experiences of children enrolled in Medicaid relative to uninsured children found similar results to those found for CHIP (Appendix Table B.5).

- **Health Care Access.** Compared to being uninsured, children enrolled in CHIP had significantly better access to primary care. A total of 88 percent of CHIP enrollees had a regular source of care or provider compared to an estimated 78 percent of uninsured children. Compared to the parents of children who lack coverage, the parents of CHIP enrollees had less trouble finding a variety of providers to see their child. They were between 9 and 11 percentage points less likely to have trouble finding a general doctor or specialist to see their child. Parents of CHIP enrollees were also more likely to report having an easy time making appointments with medical providers.
- **Service Use.** Enrollment in CHIP was also associated with increased health care use. Compared to uninsured children, CHIP enrollees were 25 percentage points more likely to have an annual well-child checkup visit: 80 percent of CHIP enrollees received a well-child checkup in the past year versus an estimated 55 percent of uninsured children. Children enrolled in CHIP were also more likely to receive a range of health services, including mental health visits, specialty care, and prescription drugs. However, the rates of use for ED visits and hospital stays were comparable among children enrolled in CHIP and uninsured children.
- **Content of preventive care received.** CHIP enrollees were more likely than uninsured children to receive all of the preventive care measures examined except a developmental screening for children under age 6. CHIP enrollees were 12 percentage points more likely to have had a flu vaccination, 9 percentage points more likely to have had a vision screening, and 18 percentage points more likely to have had their height and weight measured during the year. Moreover, parents of CHIP enrollees were 12 percentage points more likely than parents of uninsured children to have received anticipatory guidance on key health topics.⁶⁰

⁵⁹ As described above, these findings control for observed differences between the two groups.

⁶⁰ Parents of CHIP enrollees are between 15 and 19 percentage points more likely to report having discussions with the child's provider about how to avoid child injuries, the child's eating and exercise habits, and the risks of secondary smoke, than parents of uninsured children.

Table VIII.4. Access, Use, and Care Experiences of Children in CHIP Compared to the Uninsured and those with Private Insurance

	Percentage of CHIP Enrollees in 10 States ^a	Percentage Point Difference Between CHIP Enrollees and Children Who Were Uninsured ^b	Percentage Point Difference Between CHIP Enrollees and Children Who Were Privately Insured ^c
Access to Care Based on Parent Reports			
Had USC or private doctor or nurse during past 12 months	88	10**	-7**
USC type: private doctor's office or group practice/HMO	49	9**	-22**
USC has night or weekend office hours	28	2	-13**
Could reach doctor at USC after hours	37	3	-23**
Provider Accessibility Based on Parent Reports			
No trouble finding a general doctor	97	11**	-1
No trouble finding a specialist	94	9**	-1
Usually/always easy to get appointments with medical provider	83	18**	2
Service Use Based on Parent Reports			
Any doctor/other health professional visit	86	19**	0
Any preventive care or checkup visit	80	25**	1
Any specialist visit	21	12**	3
Any mental health visit	7	6**	2
Any emergency department visit	23	-3	-5*
Any hospital stays	4	0	-6**
Content of Preventive Care Received Based on Parent Reports			
Flu vaccination	48	12**	-9**
Height and weight measurement	92	18**	-2
Vision screening	60	9**	2
Developmental screening (combined measure)	30	2	4
Anticipatory guidance (combined measure)	30	12**	-3
Patient-Centeredness of Health Care Based on Parent Reports			
Obtained referrals when needed	74	38**	0
Received effective care coordination	69	23**	9**
Received family-centered care	47	12**	-5
Access to and Use of Oral Health Care Based on Parent Reports			
Had dental benefits or coverage for dental services	92	67**	15**
Had USC for dental care	87	38**	7**
USC for dental care has night or weekend hours	38	3	8*
No trouble finding a dentist	86	8**	-5**
Usually/always easy to get appointments with a dental provider	72	18**	-3
Any dental visit for checkup or cleaning	84	39**	5*
Dentist recommended additional or follow-up treatment	37	2	5
Had dental procedure, such as cavity treated or tooth pulled	68	-4	-1
Dental sealants (if age > 6 years)	54	13**	2
Unmet Needs Based on Parent Reports			
Doctor/health professional care	5	-7**	2
Prescription drugs	6	-7**	-2
Specialists	5	-6**	-3
Hospital care	3	-7**	0
Mental health care	3	-3*	-1
Dental care	12	-12**	0
Any unmet need	24	-12**	3
Parental Perceptions of Coverage and Financial Burden of Child's Health Care			
Very or somewhat confident could get needed health care for child	96	27**	5**
Never or not very often stressed about meeting child's health care needs	84	37**	12**
No problem paying child's medical bills (or no out-of-pocket costs)	92	28**	23**
Out-of-pocket costs: greater than \$0 up to \$250	3	-4**	-1
Out-of-pocket costs: between \$250 and \$2,000	4	-21**	-14**

Table VIII.4 (Continued)

	Percentage of CHIP Enrollees in 10 States ^a	Percentage Point Difference Between CHIP Enrollees and Children Who Were Uninsured ^b	Percentage Point Difference Between CHIP Enrollees and Children Who Were Privately Insured ^c
Out-of-pocket costs: greater than \$2,000	1	-1*	-6**

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

Notes: The regression-adjusted differences derived from multivariate regression models control for age, sex; race/ethnicity and language groups, more than three children in the household, highest education of any parent, parents' employment status, parent citizenship, and local area or county. Sample sizes differ across outcome indicators due to differences in response rates and survey skip patterns. "No out-of-pocket costs" includes those who indicated out-of-pocket costs but then said they had no problem paying, or later indicated they paid \$0 in out-of-pocket costs. USC = usual source of care

^a CHIP enrollees are those enrolled in CHIP for at least 12 months at time of sampling.

^b Uninsured children had 5 or more months without any coverage in the past 12 months.

^c Privately insured children had 12 months of private coverage in the past 12 months.

*/** Indicates that the values are statistically different from CHIP enrollees at the 0.05/ 0.01 level.

- **Oral health care access and use.** Children covered by CHIP were much more likely to have had a usual source of dental care compared to uninsured children, an estimated difference of 38 percentage points. The parents of children covered by CHIP were also less likely to have had trouble finding a dentist to see their child compared to uninsured children. Children covered by CHIP were much more likely to have had a dental checkup in the past year and more likely to have received dental sealants, compared to uninsured children. However, among children whose dentist recommended dental follow-up care, children with CHIP were not more likely than uninsured children to have had a dental procedure.
- **Patient-centeredness of care received.** Compared to uninsured children, CHIP enrollees were more likely to have had care experiences that meet criteria for having a patient-centered medical home, including receipt of needed referrals, care coordination, and family-centered care. For example, 74 percent of parents of established enrollees reported they were able to obtain referrals for their child when needed, versus an estimated 36 percent of parents of uninsured children, a 38 percentage point difference. Compared to uninsured children, established CHIP enrollees were also 23 percentage points more likely to have received effective care-coordination services and 12 percent more likely to have had care experiences that meet the criteria for being family-centered.
- **Unmet needs.** Children with CHIP coverage were less likely than uninsured children to have any unmet health needs. Although nearly one in four (24 percent) CHIP enrollees had an unmet health care need, more than one in three (36 percent) uninsured children were estimated to have an unmet need, a difference of 12 percentage points. Children enrolled in CHIP were between 3 and 7 percentage points less likely to have an unmet need for care from a doctor or health professional, prescription drugs, specialist care, hospital care, and mental health care compared to uninsured children, and are 12 percentage points less likely to have an unmet need for dental care.

- **Parental perceptions of coverage and financial burden of child’s health care.** Compared to parental reports for uninsured children, the parents of children enrolled in CHIP were 28 percentage points less likely to report having trouble paying their child’s medical bills and they reported substantially more confidence in their ability to get needed health care for their child. While nearly all (94 percent) parents of CHIP enrollees reported being confident that they can meet their child’s health care needs, two-thirds (67 percent) of the parents of uninsured children reported this level of confidence. In addition, the parents of children who lack coverage were 37 percentage points more likely than the parents of CHIP enrollees to report being stressed about meeting their child’s health care needs.

Medicaid also improved access to care for children who enrolled.

A parallel study of Medicaid impacts on access to care in three states (California, Florida, and Texas) relative to uninsured children found similar results to those found for CHIP, with higher levels of access and use relative to the uninsured, and parents more confident that they can meet their child’s health care needs (Appendix Table B.5). However, compared to CHIP, Medicaid appears to have had less of an impact on reducing the unmet need for dental care. Parents of children enrolled in Medicaid reported financial burdens that are as low as or even lower than those in CHIP, with parents of Medicaid children 30 percentage points more likely to have reported no problems paying for children’s health care relative to uninsured children.

Compared with private coverage, access and service use for CHIP enrollees was comparable for many measures but not as good for some. Financial burdens were substantially lower and dental access was better in CHIP.

Findings from the impact analysis suggest that children enrolled in CHIP and those with private insurance had largely similar health care access and service use, dental service use, levels of unmet need, and patient-centeredness of care, but CHIP enrollees were somewhat less likely to have a regular source of care and nighttime and weekend access to that source of care, and they were somewhat more likely to have a regular source of dental care (Table VIII.4). The parents of children enrolled in CHIP reported having had substantially less trouble paying their child’s medical bills, and were more likely to report that their child had “adequate” health insurance coverage (described below)—as well as more confidence and less stress associated with getting health care for their children.⁶¹

- **Health care access and use.** Relative to privately insured children, CHIP enrollees were less likely to have a regular source of care or provider and nighttime and weekend access to a USC. Both groups of children experienced a similar level of problem finding a general doctor or specialist, and a similar level of ease in getting appointments with medical providers. Children with CHIP coverage used a similar level of preventive care and other health care services compared to children with

⁶¹ As described above, these findings control for observed differences between the two groups.

private insurance, except CHIP enrollees had higher usage of prescription medicines and lower levels of ED visits and hospital stays.

- **Content of preventive care received.** Children enrolled in CHIP had generally similar experiences to children with private insurance in terms of the content of preventive care received. Both groups had similar rates of health and development screenings and anticipatory guidance. The only significant difference was for receipt of a flu vaccination—CHIP enrollees were 9 percentage points less likely than privately insured children to receive a flu vaccination, 48 percent versus 39 percent, respectively.
- **Oral health care access and use.** Overall, children covered by CHIP appear to have somewhat greater access to dental care compared to children with private coverage. While the vast majority (92 percent) of the parents of CHIP enrollees reported that their children had dental benefits, only about three-quarters (77 percent) of the parents of privately insured children reported having access to these benefits, a difference of 15 percentage points. Children covered by CHIP were more likely to have a usual source of dental care, and to have access to this usual source of dental care at night or on weekends. Their parents were also more likely to report that it was easy to get an appointment with a dentist. Compared to children with private coverage, children covered by CHIP were more likely to have had a dental checkup or cleaning and equally likely to have received dental sealants. Parents of CHIP enrollees were more likely to report problems with the condition of their child’s teeth, although these problems could have pre-dated their CHIP enrollment (data not shown).
- **Patient-centeredness of care received.** CHIP enrollees were 10 percentage points more likely to have received comprehensive and effective care coordination services than privately insured children, 69 percent versus 59 percent, respectively. Nevertheless, CHIP enrollees were less likely than privately insured children to have had care experiences that met the criteria for having a patient-centered medical home. Roughly one-quarter of CHIP enrollees meet the criteria for having a medical home compared to one-third of privately insured children. This result is driven largely by the higher likelihood of having a regular source of care or provider among privately insured children. There are no significant differences between privately insured and CHIP children on the other three medical home components examined.
- **Unmet needs.** Children with CHIP coverage have similar levels of unmet health need compared to children with private insurance.
- **Parental perceptions of coverage and financial protection of child’s health insurance.** The parents of children enrolled in CHIP reported substantially less trouble paying their child’s medical bills compared to those with private coverage and had much lower out-of-pocket spending levels. Compared to parental reports for privately insured children, the parents of children enrolled in CHIP were 23 percentage points less likely to report having trouble paying their child’s medical bills. Parents of CHIP enrollees were more likely to report feeling very confident in their ability to meet their child’s health care needs and more likely to report that meeting their child’s health care needs did not often cause stress.

- Children enrolled in CHIP were also more likely to be considered “adequately” insured across three domains— adequacy of benefits, adequacy of access to providers, and financial protection —particularly when taking into account coverage for dental benefits (data not shown).⁶²

Children enrolled in Medicaid generally had similar experiences to privately insured children who later enroll in Medicaid, but Medicaid enrollment was associated with much higher levels of affordability.

A parallel study of Medicaid impacts on access to care in three states (California, Florida, and Texas) relative to privately insured children who later enroll in Medicaid found similar results to those found for CHIP, indicating that experiences were generally similar between the two groups (Appendix Table B.5). One exception is that children enrolled in Medicaid were less likely to have a preventive care visit than privately insured children; this difference was not observed in the analysis of CHIP enrollees. Similar to CHIP, Medicaid enrollment was associated with much higher levels of affordability compared to the comparison group of privately insured children. Nearly all (95 percent) of parents of children enrolled in Medicaid did not have trouble paying their child’s medical bills, whereas that share was only 70 percent among children in private coverage.

⁶² The composite measure of insurance adequacy used in this analysis combines parental responses to questions about the following: whether the child’s health insurance offered benefits or covered services that met the child’s needs; adequacy of access to various providers through child’s health insurance, and whether the parent was told by a provider that they do not accept child’s health coverage; and whether the parent reported having trouble paying child’s medical bills, if any were reported.

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IX. FAMILIES' PERCEPTIONS, KNOWLEDGE, AND EXPERIENCES WITH THE CHIP/MEDICAID APPLICATION AND RENEWAL PROCESS

KEY FINDINGS:

- While most lower-income families with uninsured children expressed interest in enrolling their children in CHIP or Medicaid, roughly half did not believe they were eligible and one-third did not know where to get more information about these programs and how to enroll in them.
- Most new enrollees said that they had applied for CHIP coverage either because of its affordability (35 percent), a specific health care need for their child (33 percent), or to keep their child healthy (26 percent).
- More than one-third of new CHIP enrollees applied for coverage online, and this was the most popular application option for new CHIP enrollees in half the study states. Online approaches were less common at renewal.
- Among those who had newly enrolled in Medicaid or CHIP, 46 percent said the application process was very easy and 43 percent said it was somewhat easy. Roughly one-third of these families obtained assistance completing their application, and those receiving assistance reported overwhelmingly that it was helpful. However, these results contrast with the perception of families with uninsured children who may be eligible for these programs, only 43 percent of whom thought the application process would be easy.

In this chapter, we present findings on how low-income families perceive and experience the application and renewal processes for CHIP and Medicaid. The chapter begins with findings from an analysis of the 2011/2102 National Survey of Children's Health (NSCH) focused on a subsample of families below 200 percent of the FPL with an uninsured child, most of whom are likely eligible for one of these two coverage programs.⁶³ The findings presented in this chapter focus on families' knowledge of the programs, interest in enrolling, beliefs about their child's eligibility, and perceptions of the enrollment/re-enrollment processes. The chapter then presents findings from the CHIP 10-state survey on both the experiences of new enrollee families as they applied for CHIP (or Medicaid) coverage and the experiences of more established enrollee or recent disenrollee families with the renewal process for these programs.⁶⁴

⁶³ For further details on relevant findings from the analysis of data from the 2011/2012 National Survey of Children's Health, see Haley et al. (2013), Kenney et al. (2013a), and Kenney et al. (2013b).

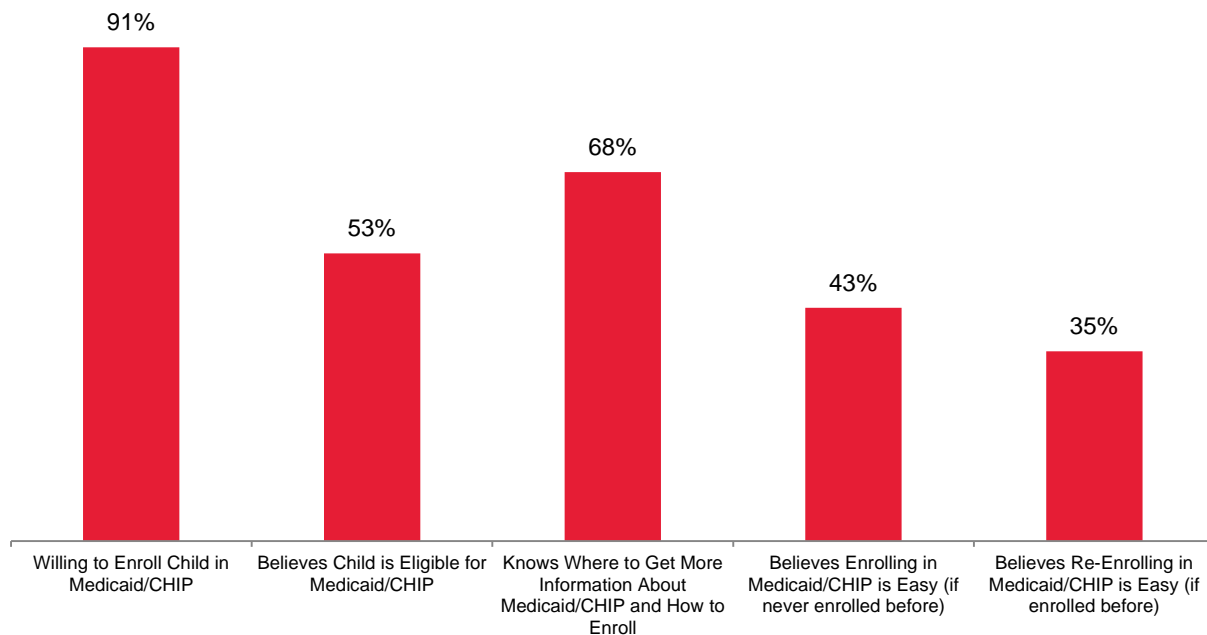
⁶⁴ For further details on relevant findings from the analysis of data from the 2012 congressionally mandated survey of CHIP and Medicaid enrollees and disenrollees, see Trenholm et al. (2013), contained in Harrington and Kenney et al. (2014).

Nearly all low-income families with an uninsured child were familiar with Medicaid/CHIP and said they would like to enroll their child, but several barriers to enrollment remain.

On the 2011/2012 NSCH, nearly all families below 200 percent of the FPL with an uninsured child (95 percent) said that they had heard of CHIP or Medicaid; awareness of CHIP was lower than awareness of Medicaid (74 and 94 percent, respectively). Many low-income uninsured children had prior experience with the programs: 59 percent had been covered by at least one of these programs in the past, many within the past year.

Of those who had heard of Medicaid or CHIP, 91 percent said that they would enroll if told that their child was eligible (Figure IX.1). This includes 88 percent of those who had not been enrolled in one of these programs in the past and 94 percent of those with prior enrollment (data not shown). Interest in enrolling was high across a variety of subgroups, including different racial/ethnic and age groups. For example, among parents of black and Hispanic children, 96 percent said that they would be interested in enrolling in Medicaid or CHIP; and among parents of white children, 81 percent expressed similar interest.

Figure IX.1. Perceptions of Medicaid/CHIP Among Parents of Low-Income Uninsured Children, 2011–2012



Source: 2011/2012 National Survey of Children's Health.

Note: Excludes those who have not heard of Medicaid or CHIP. Low income is below 200 percent of the FPL.

While most low-income parents with uninsured children were familiar with Medicaid and CHIP and said they want to enroll their child, barriers to enrollment remain.

Parents identified several reasons for their children remaining uninsured, including confusion about eligibility, lack of information, and negative perceptions of the enrollment/renewal processes. For example, the parents of just over half (53 percent) of low-income uninsured children believe their child is eligible (Figure IX.1); the remaining 47 percent reported either that they did not think their child was eligible or that they were uncertain whether their child was

eligible. Since the vast majority of low-income uninsured children qualify for one of the programs, this indicates that some of these families may be confused about the eligibility requirements. Moreover, a third of these uninsured children have parents who either did not know where to get more information about Medicaid/CHIP coverage or did not know how to enroll their child (Figure IX.1).

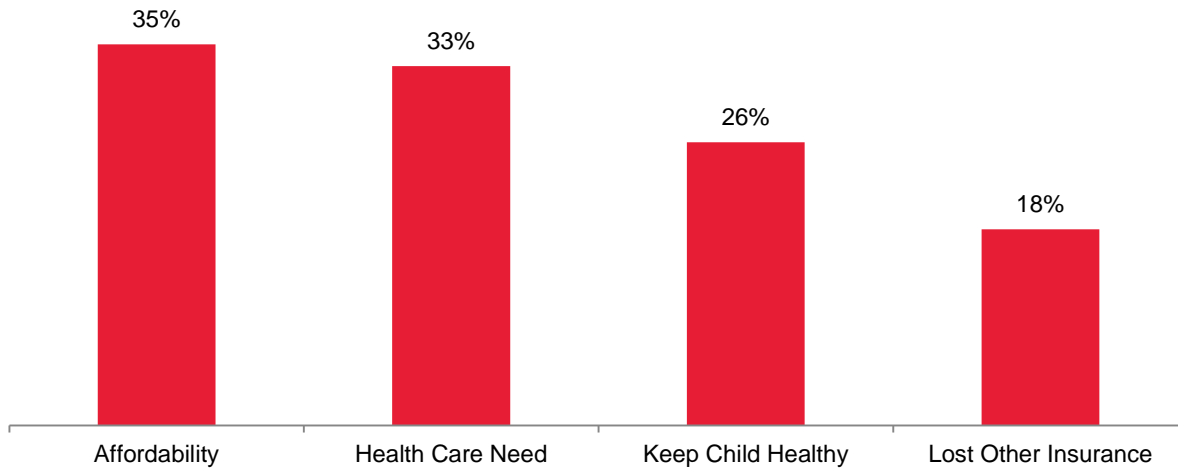
Some parents of uninsured children had negative perceptions of the application and re-enrollment processes (Figure IX.1). Among those whose children have never been enrolled in Medicaid or CHIP, 43 percent believed applying for Medicaid/CHIP is easy. The rate was lower among those whose children had been enrolled before; only 35 percent of these parents believed enrolling is easy. In addition, the survey indicates differential patterns of awareness, knowledge, and perceptions across many demographic, socioeconomic, and geographic subgroups. Most notably, non-English-speaking Hispanic families—who have high levels of uninsurance—had less experience with and lower awareness of the programs, more confusion about the eligibility requirements, and less knowledge about how and where to enroll.

New CHIP enrollees learned about the program from numerous sources and usually applied because of affordability or a medical need.

When asked what source of information was most important in applying for coverage, new CHIP enrollees mentioned numerous different sources with some frequency (not shown). Close to a third (29 percent) answered that it was a friend or family member, making it the most common response. This was followed by a hospital or other health care provider (19 percent), a government agency (18 percent), various forms of media (10 percent), school (9 percent), and other types of programs, such as SNAP (9 percent). This distribution held fairly stable across the 10 states and demographic subgroups.

When asked why they applied for CHIP coverage for their child, roughly two-thirds of parents of new enrollees cited affordability (35 percent) and/or an immediate health care need (33 percent) as a main reason (Figure IX.2). Among the health needs most often cited by parents were a prescription (23 percent), a dental need (16 percent), or an urgent medical need (15 percent) (data not shown). Other common reasons parents applied for CHIP coverage were to keep their child healthy or a loss of other coverage. Parents with a new Medicaid enrollee cited similar reasons for applying for coverage, though a higher proportion cited health care needs (49 percent) and a smaller proportion cited loss of other coverage (13 percent).

Figure IX.2. Most Common Reasons for Enrolling in CHIP, New CHIP Enrollees



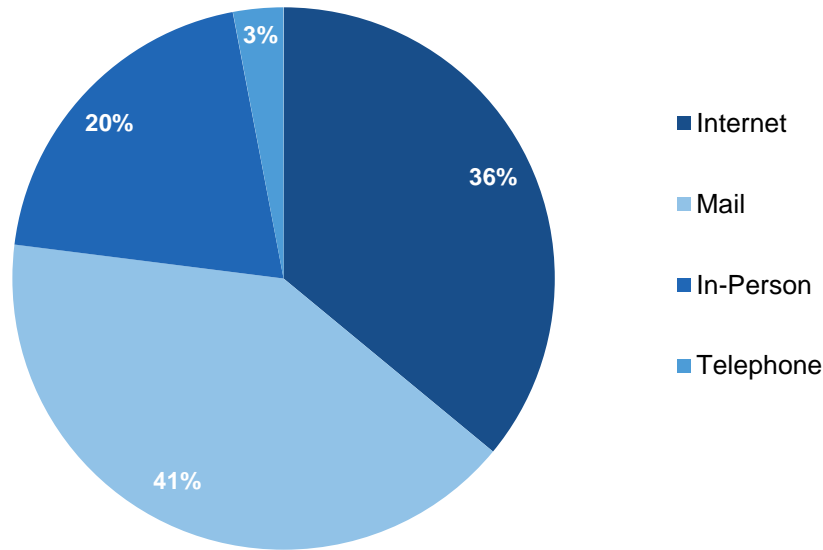
Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; new enrollee sample (N = 4,140).

Note: Reasons related to health care need were largely given in response to three direct questions that asked whether the child had enrolled due to an urgent medical need (such as an illness), a dental need, or a need to fill a prescription. All other reasons were given in response to an open-ended question and, with the exception of those shown above, offered with low prevalence (6 percent or less of respondents).

More than one-third of new CHIP enrollees applied for coverage online, and this was the most popular application option for new CHIP enrollees in half the study states. Online approaches were less common at renewal.

As seen in Figure IX.3, the largest proportion of new CHIP enrollees still applied for coverage through the mail (41 percent), but the share using the internet was nearly as large (36 percent). In 5 of the 10 study states, a majority of the new CHIP enrollees applied for coverage through an online tool—Florida (77 percent), Michigan (67 percent), Utah (66 percent), Alabama (64 percent), and Louisiana (63 percent) (data not shown). The share using the internet is likely to grow, as it was still a relatively new option in most states at the time of the survey, and it is a required pathway under the Affordable Care Act in 2014.

Figure IX.3. Mode of Application, New CHIP Enrollees



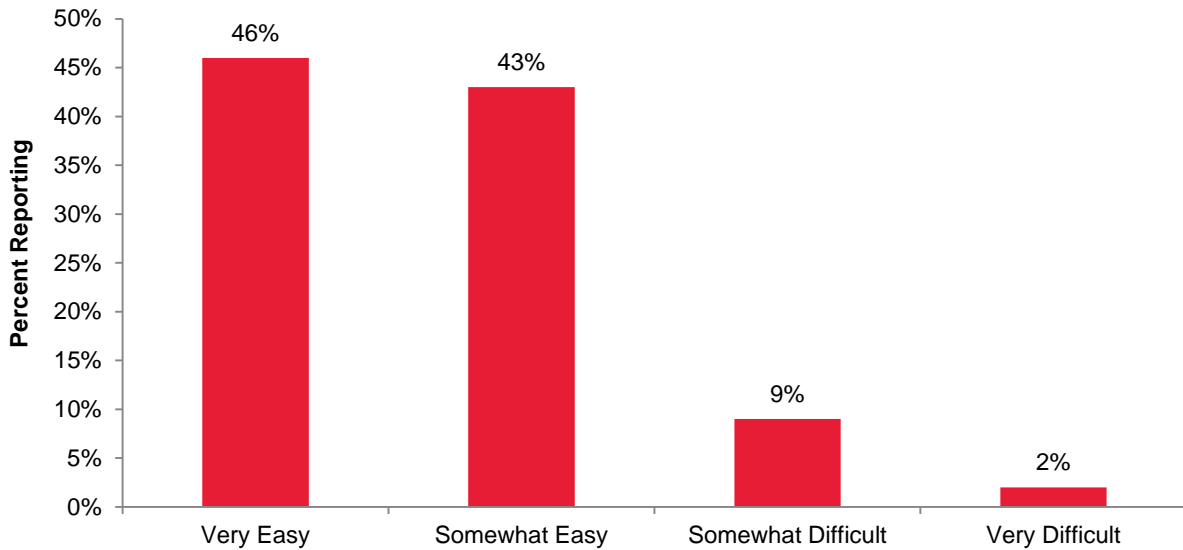
Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; new enrollee sample (N = 4,140).

Most families that recently enrolled in CHIP found the application process at least somewhat easy.

The vast majority of the parents of recent CHIP enrollees surveyed reported little difficulty completing the application process. When asked about their overall experience with this process, 46 percent reported that it was very easy, and an additional 43 percent reported that it was somewhat easy (Figure IX.4). Just 11 percent reported that it was somewhat difficult. These findings were generally consistent across the 10 states and also among different demographic groups; they were also consistent with those for new Medicaid enrollees in three states (not shown).

Findings for CHIP enrollees contrast with the less-positive perceptions held by families with eligible-but-uninsured children reported above, including those who reported being covered by these programs in the past. This difference could arise for numerous reasons, making it difficult to interpret. For example, it could arise purely as a matter of perception, as those families who just successfully enrolled their children into CHIP or Medicaid might offer more favorable impressions of the application process than those whose children had enrolled in these programs in the past but were now without coverage. Conversely, it may reflect real differences in the experience of families, especially because the enrollment experiences of the uninsured population reported on the NSCH predated the experiences of families interviewed for this evaluation. Families of children newly enrolling in CHIP or Medicaid in 2012 may have encountered a different, likely easier, application process than families who applied earlier.

Figure IX.4. Ease/Difficulty of the Application Process, New CHIP Enrollees



Source: 2012 Congressionally Mandated Survey of CHIP and Medicaid Enrollees and Disenrollees; new enrollee sample (N = 4,140).

About a quarter (26 percent) of new CHIP enrollees received assistance completing the application form, including 12 percent who received help with translation. Most (71 percent) received this assistance from a government agency, though some cited either a health care provider (13 percent) or a friend/family member (10 percent) as their source of assistance. When asked if this assistance was helpful, 90 percent reported that it was very helpful. Across states, assistance was most common for new CHIP enrollees in New York (48 percent) and California (34 percent), both states that have been relatively proactive in connecting families to assistance. Findings were similar across demographic groups and for new Medicaid enrollees in the three states surveyed.

New CHIP enrollees often waited weeks for coverage, and few understood the renewal requirement.

When asked for the length of time between submitting the application and receiving a notification of enrollment, 15 percent of new CHIP enrollees reported that it was less than two weeks, whereas 42 percent reported it was four weeks or more. This distribution was generally consistent across states. The only exception is Michigan, which had by far the shortest wait times; 38 percent of families reported waiting less than two weeks, while 24 percent waited four weeks or more. This result is likely due in part to Michigan's online application process, which notifies families immediately of their eligibility status upon completion of their application. Consistent with this policy measure, 44 percent of new CHIP enrollees who applied online in Michigan reported enrolling within two weeks, far more than those applying through any mode in any other state.

When asked if they had heard of a renewal requirement for CHIP, 65 percent of new CHIP enrollees reported that they had heard of this requirement; of this group, 79 percent reported the correct time frame for the renewal. Taken together, this means that about half of new CHIP enrollees understood the renewal requirement for the program, a factor that could ultimately

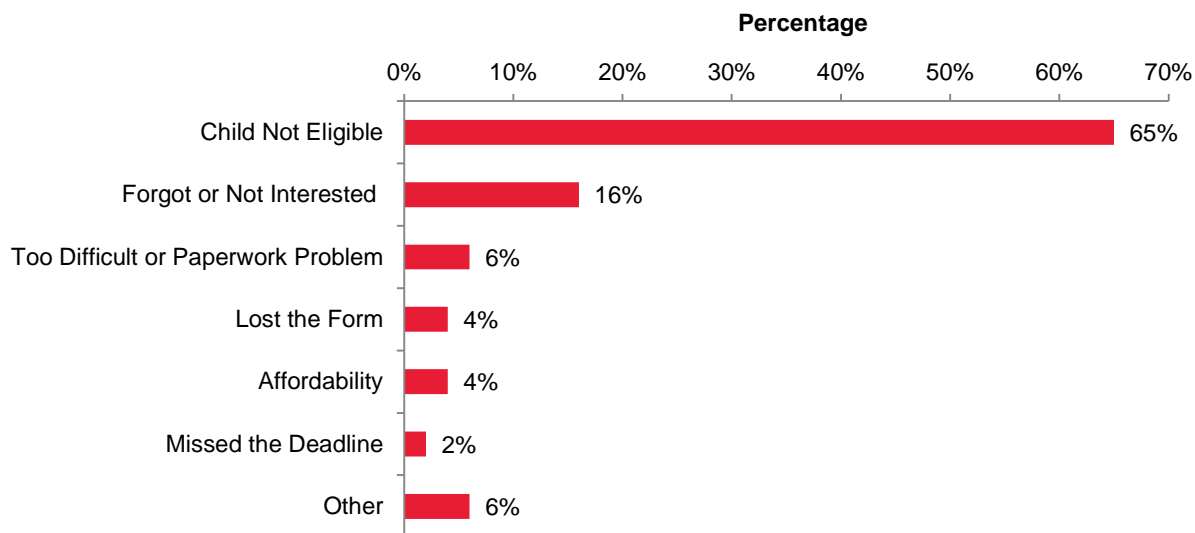
contribute to some eligible children eventually losing coverage. Findings were similar among new Medicaid enrollees and also largely consistent across different demographic groups.

Nearly all CHIP enrollees who tried to renew coverage found the process at least somewhat easy, even if they subsequently left the program.

Among families who had successfully renewed coverage for their child and remained enrolled, most (79 percent) said that they received a renewal form by mail and returned it for processing. Relatively few of these families reported receiving assistance in returning the form (18 percent), and nearly all found the process of doing so at least somewhat easy -- 52 percent reported it to be very easy and an additional 40 percent reported it to be somewhat easy. Among families whose child had been recently disenrolled, a smaller fraction (48 percent) reported receiving and returning a renewal form by mail. However, even among these families, nearly all found the process of returning the renewal form to be at least somewhat easy (92 percent) and only a small share reported receiving assistance (13 percent).

As seen in Figure IX.5, among CHIP disenrollees who did not return a renewal form, two-thirds (65 percent) said they believed their child was no longer eligible. When asked for the reason, more than half said that that they had obtained other insurance and about a quarter said that their family’s income had changed (see note to Figure IX.5). Another 16 percent showed a lack of interest by not returning the form, as indicated by reasons like forgetting, not needing the insurance, and not being interested in renewing. Just 6 percent of disenrollees cited difficulties with paperwork as a reason for not returning the form and only 4 percent cited affordability issues. Taken together, these findings suggest that barriers to completing the renewal process (such as paperwork burden and affordability) are a much less common reason for leaving CHIP coverage than changes in eligibility.

Figure IX.5. Reasons for Not Returning a Renewal Form, CHIP Disenrollees



Source: Congressionally Mandated Survey of CHIP Enrollees and Disenrollees, disenrollee sample (N = 469).

Notes: The category "Child not eligible" includes one or more of the following: gained other insurance (35 percent), income too high or low (13 percent), child is too old (9 percent), moved out of states (3 percent), and other eligibility-related reasons (7 percent).

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X. IMPLICATIONS OF HEALTH REFORM FOR CHIP PROGRAMS AND FAMILIES

KEY FINDINGS

- CHIP is currently funded through September 2015 and authorized through September 2019; current law prohibits states from lowering eligibility thresholds for children in Medicaid and CHIP below March 2010 levels throughout the authorization period.
- Given the uncertainty about continued federal funding for CHIP after 2015, CHIP administrators expressed concern for CHIP’s future, but most had not made contingency plans as of early 2013.

After the Affordable Care Act became law in March 2010, the contextual environment for state CHIP programs changed substantially and the evaluation sought to understand the implications of this major legislation for state CHIP programs and for children’s health coverage overall. In addition to broader system-wide reforms, the Affordable Care Act includes several elements specific to CHIP. It authorized CHIP through September 2019, extended funding for the program through September 2015, and required states to maintain at March 2010 levels the minimum income eligibility thresholds for children in Medicaid and CHIP throughout this period (Table X.1). Although funding for CHIP after September 2015 is not assured, the Affordable Care Act specifies an increase of 23 percentage points in federal financial participation for CHIP from FFY 2016 through FFY 2019.

Table X.1. Key Affordable Care Act Provisions Affecting CHIP^a

Requires states to develop automated and streamlined eligibility systems that integrate eligibility determinations for Medicaid, CHIP, and health insurance Marketplace plans.
Requires that CHIP enrollees in families with income below 133 percent of FPL be transitioned to Medicaid, and establishes a new Medicaid eligibility option for adults with income below the same level. ^b
Allows states to cover children of public employees in CHIP if states can demonstrate minimum state agency contributions or hardship.
Creates a new definition of income—modified adjusted gross income (MAGI)—that states must use to determine eligibility for non-elderly Medicaid and CHIP beneficiaries except the blind and disabled and for government subsidies provided to qualified individuals for the purchase of coverage through the Marketplace beginning in 2014. Also changes household composition rules used for determining income eligibility. These changes may lead to some children now in Medicaid moving to CHIP and some now in CHIP moving to Medicaid.
Requires states to eliminate any remaining asset tests for the populations subject to MAGI eligibility determinations (essentially, those who are not age 65 or older, blind, or disabled), and replace any previously existing income disregards used in computing income eligibility for that population with a standard 5 percent income disregard in cases where income would otherwise exceed the eligibility threshold.
Increases the federal match rate for CHIP during the period of funding uncertainty—when MOE requirements are still in effect (FFY 2016–2019)—to an average amount of 93 percent in each state.
Requires children to have coverage in order for their parents to be eligible for coverage under the new adult expansion group, which may increase children’s enrollment in Medicaid and CHIP, and expands coverage options for parents, which may have similar effects on children’s coverage.
Requires that the Secretary of the U.S. Department of Health and Human Services certify Qualified Health Plans comparable to CHIP.

^a Many other Affordable Care Act provisions related to Medicaid will directly influence states with Medicaid expansion CHIP programs and indirectly influence separate CHIP programs. These provisions include requirements to cover new benefits (such as tobacco cessation services for pregnant women) or providers (such as freestanding birth centers), a temporary increase in Medicaid reimbursement rates for primary care services in 2013–2014; and

Table X.1 (Continued)

enhanced federal funding for providing health home services (such as comprehensive care management) to beneficiaries with chronic diseases.

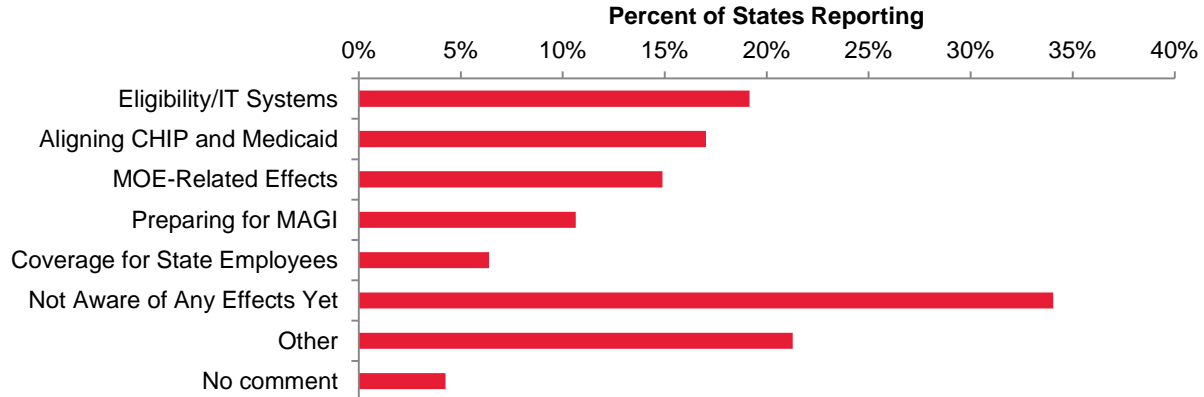
^b The Affordable Care Act legislation also specifies that a 5 percentage point income disregard be applied in computing MAGI-based income for those who would not meet the income threshold without this disregard, so the effective income threshold in these cases is actually 138 percent of the FPL. More than half of states already covered all children below this income threshold in Medicaid.

How the Affordable Care Act Had Influenced CHIP Programs as of Early 2013

The Affordable Care Act had already affected CHIP operations in early 2013 and was expected to have an even larger influence on future CHIP operations and enrollment.

In early 2013, administrators in 29 states reported that the Affordable Care Act had already affected CHIP in some way, particularly with respect to the time that program staff had spent preparing for eligibility and enrollment changes (Figure X.1). For example, state staff had devoted time to ensuring the alignment and compatibility of CHIP and Medicaid eligibility and enrollment policies, systems, and processes and to preparing for the implementation of new MAGI rules. Administrators in 7 states cited the Affordable Care Act’s MOE rules as significantly affecting their CHIP programs while administrators in 3 states cited CHIP’s expansion to dependents of state employees as an important effect of the act. In 10 states, administrators pointed to other changes, such as CHIP’s increased attention to care delivery approaches.

Figure X.1. Effects of the Affordable Care Act on CHIP Reported by States as of Early 2013 (N=47)



Source: Survey of State CHIP Program Administrators Conducted by Mathematica Policy Research in 2013.

Note: CHIP = Children’s Health Insurance Program; IT = Information Technology; MAGI = Modified Adjusted Gross Income.

When asked how the Affordable Care Act might affect CHIP in the future, the majority of administrators focused on potential operational and enrollment effects. For example, administrators in 10 states cited the switch to MAGI rules for income eligibility determination as an important influence of the Affordable Care Act on CHIP, along with the resulting movement of children from CHIP to Medicaid because of the new income eligibility rules. Administrators from 6 states talked about the streamlining of CHIP eligibility and enrollment processes to coordinate with the Marketplace as an important future effect on CHIP. Administrators in several states expressed concern about the way the new rules and regulations are making CHIP programs

more like Medicaid, placing at risk some of the unique features of CHIP that contributed to the program's success.

Given the uncertainty about continued federal funding for CHIP after 2015, CHIP administrators expressed concern for CHIP's future, but most had not made contingency plans as of early 2013.

The 2013 survey of program administrators found widespread uncertainty about how CHIP would fit into states' post-reform environments: administrators in more than three-quarters of states that participated in the survey were unsure about CHIP's future. The relatively unprecedented nature of the pending expansions and programmatic changes made it difficult for states to forecast and plan. Further, the vast majority of state legislatures and state-based advocates had yet to initiate discussions about CHIP's future. Most CHIP administrators were overwhelmed with the many tasks and efforts involved in understanding and preparing for compliance with the Affordable Care Act's rules and timelines; they had been too busy to focus on contingency planning in the event that CHIP funding is not reauthorized in 2015. The states that had engaged in some contingency planning generally expected that, if CHIP were to expire, children would move to Medicaid or the Marketplace. However, families with access to affordable ESI coverage for the employee are not eligible for subsidies for dependent coverage in the Marketplace.

Most CHIP administrators expected there would be good continuity of care for families as they move from one program to another: overlap among Medicaid and CHIP plans and providers was generally high, and administrators expected that most Marketplace plans and providers will also overlap with Medicaid and CHIP.

Even though CHIP administrators expressed concern regarding coordination between plans and programs after the full implementation of the Affordable Care Act, the majority of states with separate CHIP programs noted that their CHIP and Medicaid plans currently overlap completely. As a result, only 2 states expected little overlap, and only one state expected no overlap among health plans that participate in Medicaid, CHIP, and the Marketplace. Likewise, many CHIP administrators reported that current provider networks between Medicaid and separate CHIP programs in their states are similar; in only 4 states do Medicaid and CHIP networks differ more than minimally. When asked about provider overlap once the Marketplaces are in place, administrators in 21 of 44 responding states said that they expect a high degree of overlap; in 10 states, administrators said that they expect some overlap. Administrators in 2 states expect complete overlap among providers participating in Medicaid, CHIP, and the Marketplace.

Some states are taking (or considering) steps to minimize coverage disruptions. For example, administrators in 9 states said that their states were encouraging plans to participate in Medicaid, CHIP, and the Marketplace; seven states were implementing enrollment and renewal simplification strategies that will help families remain enrolled in whatever programs they qualify for; and six states were using outreach efforts to encourage providers to participate in all three options.

Although details on benefits and costs in the Marketplace options were not known when we interviewed them, many administrators expected the benefits or costs between Medicaid, CHIP, and the Marketplace plans to differ.

Where differences in cost sharing arrangements were expected, cost sharing in Marketplace plans was expected to be higher than in Medicaid and CHIP, primarily because cost sharing in Medicaid and CHIP is kept to a minimum by federal rules. Most states were unsure about how Marketplace benefit packages would compare with Medicaid and CHIP but administrators in 5 states expected benefits in Marketplace plans to be less generous than in Medicaid and CHIP. Administrators from 6 states expected there would be some similarities between benefits or cost-sharing arrangements among the three programs. When asked about what Medicaid services might be excluded from Marketplace plans, administrators identified such services as non-emergency transportation; early and periodic screening, diagnostic and treatment (EPSDT) services; and long-term care, among others.

Most states are concerned that provider capacity may not be adequate for some services or geographic areas.

Administrators in 7 states (of 43 responding) expected their state's health care system to be able to handle the additional volume of newly insured individuals because the state either already covered newly eligible people in some way or had added capacity in preparation for the increase. Administrators in 28 states said that the capacity of their health care system would be inadequate to deal with the influx; administrators in 8 states did not know if their state could handle the newly insured. With respect to provider capacity, respondents in 32 states (of 47 responding) expressed concern about the availability of at least one type of provider (22 expressed concern about two or more types of providers); the concern applied especially to dental and mental health providers but also to primary care and pediatric providers. CHIP administrators in 3 states were concerned about all types of providers in their states. Of those noting concerns, administrators in 16 states said that they were considering steps to mitigate potential problems, including, for example, the possibility of adopting alternative delivery mechanisms (such as providing more care in schools to relieve some demand on the system, or permitting nurses to take on an expanded role in primary care) and reforms as well as increases in provider rates.

Administrators in 30 of 35 responding states expressed concern about capacity in specific geographic areas. In 18 states, administrators mentioned rural areas; in 6 rural states (labeled as "rural states" by the CHIP administrators in those states), administrators were concerned about capacity statewide. Administrators in 7 other states mentioned specific regions of their states (for example, "the northern part of the state"), and one mentioned concern about capacity in inner-city areas. In 5 states, administrators noted that their states were looking into ways to address the shortages in the areas mentioned by, for example, increasing provider rates, implementing statewide managed care, and conducting outreach to providers.

XI. CONCLUSIONS AND POLICY IMPLICATIONS

This evaluation demonstrated that CHIP has succeeded in expanding health insurance coverage for children, increasing their access to needed health care, and reducing the financial burdens and stress on families associated with meeting children's health care needs. These positive impacts were found for children and families in states with different CHIP program designs and features, across demographic and socioeconomic groups, and for children with different health care needs. The findings from this evaluation affirm and build on those in the prior congressionally mandated evaluation of CHIP that was released in 2005 (Wooldridge et al. 2005). As a result of CHIP, since 1997, millions of low- and moderate-income children have secured health insurance coverage and needed care and their families have received significant fiscal relief from the costs associated with addressing their children's health care needs. This chapter summarizes the main evaluation findings and then closes with a discussion of policy implications, highlighting issues affecting the future of CHIP in the context of policies implemented under the Affordable Care Act.

SUMMARY OF MAJOR FINDINGS

Together, CHIP and Medicaid have contributed to declines in uninsurance among children.

From 1997, when CHIP was enacted, to 2012, the uninsured rate among all children declined by six percentage points and by even more (12 percentage points) among children with incomes below 200 percent of the FPL--the target population for Medicaid and CHIP. Racial and ethnic differences in uninsured rates for children also narrowed. In contrast, uninsured rates did not decline for low-income adults and increased for some groups, including low-income parents. Underlying the reductions in uninsurance among children were increases in Medicaid and CHIP coverage. Private coverage decreased among children since 1997, but the increases in public coverage more than offset those declines.

Participation in Medicaid and CHIP among eligible children increased under CHIPRA.

CHIP programs continued to evolve and innovate under CHIPRA, leading to streamlined enrollment and renewal procedures, expanded eligibility and outreach efforts, and new investments in quality measurement and care improvements for children. Despite declines in employer-sponsored insurance among children and adults during the most recent recession, rates of children's health insurance coverage continued to increase since 2008, and the number of uninsured children who are eligible for Medicaid or CHIP but not enrolled fell from 4.9 to 3.7 million. Participation in Medicaid and CHIP increased nationwide from 82 to 88 percent between 2008 and 2012, and 21 states had participation rates at or above 90 percent in 2012. These states draw from all four census regions and vary in their racial and ethnic composition and other factors such as the degree of urbanicity, indicating it is possible to achieve high participation rates in Medicaid and CHIP under different local circumstances. The parents of over 80 percent of new CHIP enrollees reported that the application process was easy or very easy, and a third said they had received assistance with their application.

CHIP and Medicaid improved children’s access to needed care and reduced financial burdens and stress on their families.

Overall, CHIP programs were meeting the health care needs of most of the children who enroll based on information provided by parents surveyed in the 10 study states. Fully 96 percent of the parents of CHIP enrollees reported feeling confident that their children will be able to get the health care they need and 86 percent of children enrolled in CHIP had seen a doctor or other health provider in the past year. Moreover, enrollment in CHIP and Medicaid had clear benefits for children, particularly relative to going without coverage. For nearly every health care access, use, care, and cost measure examined, CHIP enrollees fared better than uninsured children--their parents reported less stress and substantially more confidence in their ability to get needed health care for their children, less trouble paying medical bills and substantially lower out of pocket spending on health care for their child, greater access to health and dental providers, fewer unmet health needs, and greater receipt of screenings, anticipatory guidance, and health care. Similar patterns were found for Medicaid enrollees in the three study states.

Access to care was similar for children with public and private coverage for most measures, but financial burdens were substantially lower under public coverage, and access to weekend and nighttime care was not as good.

Overall, children with Medicaid and CHIP coverage have similar service-use patterns and unmet needs relative to comparable children with private health insurance coverage, but on a few measures, Medicaid and CHIP differ from private insurance. CHIP and Medicaid enrollees are more likely to have access to dental benefits and much more likely to be protected from financial burdens associated with meeting their children’s health care needs, as reflected in lower out-of-pocket spending levels and fewer problems paying medical bills as reported by their families. The greater financial protection provided by Medicaid and CHIP coverage compared with private insurance likely also contributes to findings that parents reported being more confident that they will be able to meet their children’s health care needs and feeling less stress about doing so with Medicaid and CHIP coverage as opposed to private insurance. Relative to privately insured children, however, CHIP enrollees were less likely to have a regular source of medical care or a regular provider, and nighttime or weekend access at their usual source of care.

Relatively few low-income children with CHIP coverage have access to private insurance coverage, and the direct substitution of private for public coverage at the time of enrollment was estimated to be as low as 4 percent.

Just 13 percent of children enrolling in CHIP had private coverage in the prior 12-month period, according to their parents, and only 4 percent were estimated to have dropped private coverage in order to enroll in CHIP. Reported access to dependent coverage was limited among CHIP enrollees and even more so among Medicaid enrollees and the remaining low-income uninsured children—reportedly just 20 percent of CHIP enrollees, 16 percent of low-income uninsured children, and 5 percent of Medicaid enrollees could be covered on a parent’s ESI policy. Although some of the reduction in private coverage among children that has occurred since the inception of CHIP has been found to be the result of the expansions in Medicaid and CHIP coverage, many different studies have found that the majority appears to be the result of secular declines in ESI that also led to reductions in private coverage and rising rates of uninsurance among adults (Howell and Kenney 2012). An estimated 57 percent of CHIP enrollees in the ten study states had a parent who was uninsured; similarly, approximately 54 percent of children

enrolled in Medicaid in the three study states of California, Florida, and Texas had an uninsured parent.

Despite progress, 3.7 million children who are eligible for Medicaid or CHIP remain uninsured. Variable retention across the study states suggests that efforts to streamline the renewal process through such things as automatic renewals and less frequent redeterminations have been more successful in some states.

Despite increasing Medicaid and CHIP participation rates and declining numbers of uninsured children in recent years, approximately four million children who are eligible for public coverage remain uninsured. Overall, 68 percent of all uninsured children are eligible for Medicaid/CHIP coverage but not enrolled. While over 90 percent of parents said they would enroll their uninsured child in public coverage if told their child was eligible, many did not believe that their child was eligible or know how to enroll them or where to go for more information. Moreover, 59 percent of low-income uninsured children had been enrolled in Medicaid or CHIP at some point in the past, many within the prior year. As a consequence, retention of eligible children who are enrolled in Medicaid and CHIP is critical to achieving further reductions in uninsurance among eligible children.

Some children cycled in and out of Medicaid and CHIP and had gaps in coverage in between.

Between 10 and 20 percent of the children who disenrolled from Medicaid and CHIP in the study states returned to the same program within seven months, experiencing periods of uninsurance in between. Transitions between Medicaid and CHIP were also common as income and other family circumstances changed, and while transitions between Medicaid and Medicaid expansion CHIP programs was nearly always seamless, children were more likely to experience temporary gaps in coverage of between two and six months when moving between Medicaid and separate CHIP programs. In terms of the median percentage across states, 40 percent of transitions from Medicaid to separate CHIP programs and 33 percent of those from Medicaid expansion to separate CHIP programs resulted in such a coverage gap; gaps were less common for transitions in the other direction, occurring for 16 and 11 percent of transitions from separate CHIP to Medicaid or Medicaid expansion programs, respectively. These findings suggest that coordination of movement from Medicaid to separate CHIP programs remains an issue and continued efforts to improve transitions between programs and the adoption of policies that simplify these transitions are needed. It remains to be seen whether the Affordable Care Act will reduce the gaps in coverage that result when children experience transitions in eligibility for different types of coverage.

There is some room for improvement in care provided to children.

While CHIP is providing dental and well-child checkups to four in five enrollees, there is room for improvement in care provided to some enrollees. In particular, one in four children enrolled in CHIP had some type of unmet need as reported by parents, with the most frequent unmet need being for dental services, reported for 12 percent. Although most CHIP enrollees received annual well-child checkups, many did not receive key preventive services such as immunizations and health screenings during those visits. And while 84 percent CHIP enrollees received annual dental checkups, a significant share was not getting recommended follow-up dental treatment and many had oral health problems, according to their parents. Gaps in care were also found among children with private coverage and were not unique to Medicaid and CHIP coverage.

POLICY IMPLICATIONS

Changes in children’s coverage in the coming years under the Affordable Care Act.

Additional take up and retention in existing Medicaid and CHIP programs, as they are currently structured, are key to driving further increases in children’s health insurance coverage. Implementation of the major coverage provisions of the Affordable Care Act in 2014 holds promise for further reducing the number of uninsured children in the coming years due to a combination of policy changes, including “no wrong door” provisions for applications, new data-driven enrollment and retention processes, the expansion of coverage to parents and other adults, and the requirement on individuals to have health insurance coverage, which will lead to penalties beginning in 2015 for uninsured children and adults who are not exempt from the mandate. Under current Medicaid and CHIP programs for children, almost 7 in 10 (68 percent) uninsured children are eligible for Medicaid and CHIP and very few are eligible for employer-sponsored insurance.

The Affordable Care Act has changed the context for CHIP and children’s coverage, introducing a number of new issues for states.

Flexibility has been a hallmark of the CHIP program, key to state ownership and commitment to the program and reflected in the considerable variation across state CHIP programs in their eligibility levels, cost sharing, and other program features. Under the Affordable Care Act, states must now cover all children with family incomes below 133 percent of FPL in Medicaid rather than separate CHIP programs and, unless they run out of federal CHIP funding, states cannot roll back eligibility levels before 2019. States are also precluded from instituting enrollment freezes, increasing premiums beyond the cost of living, or imposing waiting periods of more than three months in length; they also have less latitude in use of income disregards and defining household composition when computing CHIP eligibility. These policy changes are designed to reduce coverage gaps and increase Medicaid and CHIP coverage among children.

The changing policy environment under the Affordable Care Act presents new options for families with children who are enrolled in CHIP.

Many parents will be newly eligible for Medicaid or will qualify for subsidized coverage through the Marketplace, which is expected to lower their uninsured rates. In addition, the Marketplace subsidies, which target those with incomes below 400 percent of the FPL, have the potential to offer new affordable coverage options to uninsured children who are not eligible for Medicaid or CHIP. The reforms introduced as part of the coverage available through the new Marketplaces include guaranteed issue and bans on lifetime and annual limits that should improve the coverage options available to children, particularly to those who have preexisting health conditions. Moreover, CHIP offers an affordable way for many families to insure their children and satisfy the Affordable Care Act’s coverage requirement.

While the new coverage options under the Affordable Care Act have the potential to reduce uninsured rates among children, some families may still experience financial burdens, and risks of coverage gaps and discontinuities in care exist for children who experience transitions between Medicaid, CHIP, and the new Marketplace plans.

As currently structured, some families with CHIP-eligible children face both Marketplace and CHIP premiums, and Marketplace subsidies are not adjusted for CHIP premiums (a situation

sometimes referred to as “premium stacking”). Families could also face challenges maintaining coverage for their children in states that have waiting periods and lock out periods for premium non-payment in their CHIP programs due to administrative challenges associated with implementing these policies. In addition, some uninsured children with access to employer-sponsored coverage will not be able to receive the new Marketplace subsidies due to the so-called “firewall,” which is designed to prevent crowd-out of employer coverage. Access to affordable ESI coverage is currently defined by the cost of employee-only coverage. Other members of the family are precluded from receiving Marketplace subsidies for their coverage if employee-only coverage is affordable, even when their ESI coverage for dependents is very costly.

The coming years offer the potential to build upon the coverage and access gains and financial protections for children and their families that resulted from CHIP, but uncertainties remain about how children’s coverage will be affected.

Since 1997, CHIP has focused federal and state policy attention on improving health insurance coverage and health care for low- and moderate-income children, with resulting gains in coverage and access to care for children and lowered financial burdens and stress for their families. But it is unclear at this time how implementation of the Affordable Care Act will affect CHIP’s target population of low-income children and their families.

The prospects of positive changes for children result primarily from the expected gains in health insurance coverage for their parents. The Affordable Care Act coverage expansions are expected to improve the health and wellbeing of parents and other low-income adults, particularly in states that choose to expand Medicaid under the Affordable Care Act. Further reductions in uninsurance among children are also possible given the availability of Marketplace subsidies and health insurance reforms, the individual mandate, and the new outreach, enrollment, and renewal processes that are being implemented.

The Affordable Care Act extended federal CHIP funding through September 2015, and funding for CHIP beyond that date will require legislative action. This study, like the prior Congressionally-mandated evaluation in ten states, has demonstrated the successful role that CHIP has played in meeting children’s health care needs in very different contexts and with very different program structures, adapted to states’ unique circumstances. The central question for policy makers is how to build upon CHIP’s accomplishments to achieve additional coverage, access, and quality gains for children.

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APPENDIX A

ENABLING LEGISLATION FOR THE CHIPRA AND BBRA EVALUATIONS

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SEC. 603. UPDATED FEDERAL EVALUATION OF CHIP

Section 2108(c) (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

“(5) **SUBSEQUENT EVALUATION USING UPDATED INFORMATION.**—

“(A) **IN GENERAL.**—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

“(B) **SELECTION OF STATES AND MATTERS INCLUDED.**—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

“(C) **SUBMISSION TO CONGRESS.**—Not later than December 31, 2011, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

“(D) **FUNDING.**—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated \$10,000,000 for fiscal year 2010 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2012.”

P.L. 106-113

H.R.3426

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999

TITLE VII--STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

SEC. 703. IMPROVED DATA COLLECTION AND EVALUATIONS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) **FUNDING FOR RELIABLE ANNUAL STATE-BY-STATE ESTIMATES ON THE NUMBER OF CHILDREN WHO DO NOT HAVE HEALTH INSURANCE COVERAGE-** Section 2109 (42 U.S.C. 1397ii) is amended by adding at the end the following:

(b) **ADJUSTMENT TO CURRENT POPULATION SURVEY TO INCLUDE STATE-BY-STATE DATA RELATING TO CHILDREN WITHOUT HEALTH INSURANCE COVERAGE-**

(1) **IN GENERAL-** The Secretary of Commerce shall make appropriate adjustments to the annual Current Population Survey conducted by the Bureau of the Census in order to produce statistically reliable annual State data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected. The Current Population Survey should produce data under this subsection that categorizes such children by family income, age, and race or ethnicity. The adjustments made to produce such data shall include, where appropriate, expanding the sample size used in the State sampling units, expanding the number of sampling units in a State, and an appropriate verification element.

(2) **APPROPRIATION-** Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated \$10,000,000 for fiscal year 2000 and each fiscal year thereafter for the purpose of carrying out this subsection'.

(b) **FEDERAL EVALUATION OF STATE CHILDREN'S HEALTH INSURANCE PROGRAMS-** Section 2108 (42 U.S.C. 1397hh) is amended by adding at the end the following:

(c) **FEDERAL EVALUATION-**

(1) **IN GENERAL-** The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

(2) **SELECTION OF STATES-** In selecting States for the evaluation conducted under this subsection, the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic areas (including a mix of rural and urban areas), and contain a significant portion of uncovered children.

(3) **MATTERS INCLUDED-** In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this title).

(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the medicaid program under title XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been enrolled previously in the medicaid program under that title.

(C) Evaluation of the extent to which State medicaid eligibility practices and procedures under the medicaid program under title XIX are a barrier to the enrollment of children under that program, and the extent to which coordination (or lack of coordination) between that program and the program under this title affects the enrollment of children under both programs.

(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

(4) SUBMISSION TO CONGRESS- Not later than December 31, 2001, the Secretary shall submit to Congress the results of the evaluation conducted under this subsection.

(5) FUNDING- Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated \$10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002'.

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APPENDIX B

SUPPLEMENTAL TABLES AND EXHIBIT

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Table B.1. Characteristics of the 10 States Selected for the CHIPRA Evaluation of CHIP

Primary Selection Criteria (status in late 2010)	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 with 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;

Table B.2. Number of Children Enrolled in CHIP from FFY 1998 Through FFY 2012, by State (Alphabetically Listed)

State	Type of CHIP Program (2012)	Number of Children Ever Enrolled in CHIP Programs											Change From 2006 to 2012	
		1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	Number of Children	Percentage
Total		660,351	3,358,417	5,336,508	6,111,038	6,755,199	7,105,986	7,355,746	7,695,264	7,705,723	7,977,203	8,148,397	1,393,198	20.6
Number of States Reporting		28	51	51	50	50	51	51	51	51	51	51		
Alabama	Separate	8,492 ^a	37,587 ^b	66,027 ^c	79,407	84,257	106,691	110,821	110,158	137,545	109,255	112,972	28,715	34.1
Alaska	Medicaid exp.	--	13,413	22,306	21,966	20,432	17,558	18,707	11,655	12,473	14,278	13,499	-6,933	-33.9
Arizona	Separate	--	59,601 ^b	92,673	87,681	96,669	104,209	112,072	66,275	39,589	20,043	35,679	-60,990	-63.1
Arkansas	Combo	--	1,892	1,912	799 ^b	89,238	89,642	93,446	101,312	100,770	103,693	114,056	24,818	27.8
California	Combo	18,713 ^{a,b}	484,359	861,445	1,035,752	1,391,405	1,538,416	1,692,087	1,748,135	1,731,605	1,765,893	1,784,032	392,627	28.2
Colorado	Separate	14,847 ^b	34,889	51,826	57,244	69,997	84,649	99,555	102,395	106,643	105,255	126,169	56,172	80.2
Connecticut	Separate	6,649 ^{a,b}	19,925	20,500	21,438 ^c	23,301	23,632	22,320	21,874	21,033	20,072	19,986	-3,315	-14.2
Delaware	Combo	--	4,474 ^b	9,719 ^a	10,250	10,751	11,143	11,192	12,599	12,852	15,443	12,850	2,099	19.5
District of Columbia	Medicaid exp.	--	2,264 ^a	5,060	6,093	6,332	6,566	8,746	9,260	8,100	8,675	7,293	961	15.2
Florida	Combo	27,435 ^{a,b}	227,463	368,180	419,707	303,595	323,529	354,385	417,414	403,349	431,717	415,027	111,432	36.7
Georgia	Separate	--	120,626 ^b	221,005	280,083	343,690	356,285	311,243	254,365	248,268	248,536	258,425	-85,265	-24.8
Hawaii	Medicaid exp.	--	341 ^a	8,474	19,237	22,031	23,958	28,803	24,691	27,256	30,584	33,764	11,733	53.3
Idaho	Combo	--	12,449 ^a	16,895	19,054 ^b	24,727	33,060	43,526	44,319	42,208	42,604	45,932	21,205	85.8
Illinois	Combo	27,780 ^a	62,507 ^b	68,032	234,027	316,781	345,576	356,460	376,618	329,104	336,885	347,904	31,123	9.8
Indiana	Combo	21,172 ^a	44,373 ^b	66,225	80,698	133,696	130,368	124,954	142,665	141,497	158,138	154,262	20,566	15.4
Iowa	Combo	4,798 ^a	19,958 ^b	34,506	41,636	49,575	50,238	50,390	52,608	63,985	75,133	80,454	30,879	62.3
Kansas	Separate	--	26,306 ^b	40,838	44,350	48,934	49,536	51,173	48,090	56,384	60,431	64,229	15,295	31.3
Kentucky	Combo	3 ^a	55,593 ^b	94,608	94,500	65,290	70,197	72,360	73,143	79,380	85,554	85,331	20,041	30.7
Louisiana	Combo	--	49,995 ^a	74,654	105,580	142,389	154,286 ^b	164,998	170,082	157,012	152,404	150,672	8,283	5.8
Maine	Combo	3,204 ^{a,b}	22,742	22,586	29,171	31,114	31,037	30,947	31,349	32,994	35,986	36,324	5,210	16.7
Maryland	Medicaid exp.	27,880 ^a	93,081	125,180 ^b	111,488	136,034	132,887 ^d	132,864	124,622	118,944	119,906	131,898	-4,136	-3.0
Massachusetts	Combo	17,528 ^{a,b}	113,034	119,732	166,508	201,037	184,483	200,950	143,044	142,279	144,767	145,203	-55,834	-27.8
Michigan	Combo	6,226 ^{a,b}	55,375	71,882	87,563	118,501	64,771	67,763	72,035	69,796	83,004	81,429	-37,072	-31.3
Minnesota	Combo	--	24 ^a	49	4,784 ^b	5,343	5,408	5,621	5,470	5,164	4,461	4,104	-1,239	-23.2
Mississippi	Separate	5,477 ^a	12,156 ^b	64,805	82,900 ^c	83,359	81,565	84,370	86,839	95,556	91,470	93,257	9,898	11.9
Missouri	Combo	10,809 ^a	73,825	150,533	176,014	106,577	81,764 ^b	88,911	103,709	86,261	93,734	92,795	-13,782	-12.9
Montana	Combo	--	8,317 ^b	13,875	15,281	17,304	20,115	22,679	25,749	25,231 ^a	24,365	28570	11,266	65.1
Nebraska	Combo ^g	2,119 ^a	11,400	16,227	44,646	44,981	46,199	49,185	48,139	47,922	52,852	56,266	11,285	25.1
Nevada	Combo ^g	--	15,946 ^b	37,878	38,519	39,317	41,862	38,592	33,981	31,554	29,760	29,854	-9,463	-24.1
New Hampshire	Medicaid exp. ^g	--	4,272 ^{a,b}	8,138	10,969	12,393	12,088	12,236	13,197	10,630	10,801	11,437	-956	-7.7
New Jersey	Combo	16,810 ^{a,b}	89,034	117,053	127,244	142,805	150,277	151,805	167,009	187,211	198,283	201,417	58,612	41.0
New Mexico	Medicaid exp.	--	7,971 ^a	19,940	20,804	25,155	16,525	14,944	11,169	9,654	9,635	9,582	-15,573	-61.9
New York	Combo ^g	279,917 ^b	769,457 ^a	807,145 ^e	765,030	688,362 ^c	651,853	517,256	532,635	539,614	552,068	547,671	-140,691	-20.4
North Carolina	Combo	--	103,567 ^b	120,378	174,434	248,366 ^a	240,152	253,112	259,652	253,892	254,460	259,978	11,612	4.7
North Dakota	Combo	--	2,573 ^b	4,463	5,137	6,318	5,469	7,617	6,983	7,192	7,115	7,792	1,474	23.3

Table B.2 (Continued)

State	Type of CHIP Program (2012)	Number of Children Ever Enrolled in CHIP Programs											Change From 2006 to 2012	
		1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	Number of Children	Percentage
Ohio	Medicaid exp.	49,565 ^a	118,290	183,034	220,190	221,643	231,538	251,278	265,680	253,711	280,650	284,774	63,131	28.5
Oklahoma	Combo	17,538 ^a	57,719	84,490	100,761	116,012	117,084	117,507 ^b	123,681	122,874	120,501	125,889	9,877	8.5
Oregon	Separate	6,488 ^b	37,092	42,976	46,720	59,039	63,090	73,686	51,835	64,727	112,165	121,962	62,923	106.6
Pennsylvania	Separate	--	119,710 ^b	148,689	177,415	188,765	227,367	256,627	264,847	273,221	272,492	271,642	82,877	43.9
Rhode Island	Combo	2,030 ^a	11,539	19,515	25,573 ^b	25,492	26,067	26,031	19,596	23,253	24,815	26,968	1,476	5.8
South Carolina	Medicaid exp.	43,074 ^a	60,415	66,591	75,597	68,870	59,920	73,620 ^b	85,046	73,438 ^d	72,084	75,281	6,411	9.3
South Dakota	Combo	1,047 ^a	5,888 ^b	11,233	13,397	14,584	14,982	15,277	15,249	15,872	16,623	17,428	2,844	19.5
Tennessee	Combo	12,662 ^a	14,861	10,216 ^c	--	--	41,363 ^{a,b}	63,619	83,333	81,341	96,028	101,543	60,180 ^f	145.5
Texas	Separate	25,176 ^a	131,096 ^b	727,459 ^e	650,856	585,461	710,690	731,916	869,867	928,483	972,715	999,838	414,377	70.8
Utah	Separate	2,752 ^b	25,294	33,808	38,693	51,967	44,785	51,092	59,806	62,071	59,698	65,983	14,016	27.0
Vermont	Separate	--	4,081 ^b	6,162	6,693	6,519	6,132	6,496	7,092	7,026	7,054	7,570	1,051	16.1
Virginia	Combo	--	37,681 ^b	67,974 ^a	99,569	137,182	144,163	155,289	167,589	173,515	182,128	189,961	52,779	38.5
Washington	Separate	--	2,616 ^b	8,754	25,256	25,005	23,136	27,657	27,415	35,894	44,322	43,584	18,579	74.3
West Virginia	Separate	160 ^g	21,659 ^b	35,949 ^c	36,906	39,855	38,582	37,645	38,200	37,539	37,631	37,807	-2,048	-5.1
Wisconsin	Combo	--	47,140 ^{a,b}	59,850	67,893	57,034	62,523 ^b	52,940	153,917	161,469	172,451	169,339	112,305	196.9
Wyoming	Separate	--	2,547 ^b	5,059	5,525	7,715	8,570	8,976	8,871	8,342	8,586	8,715	1,000	13.0

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. The enrollment data shown for FFYs 2011 and 2012 are publicly available (Centers for Medicare & Medicaid Services 2013). 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; CMS = Centers for Medicare & Medicaid Services; 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 in this year or prior federal fiscal year.

^b State implemented a separate CHIP program in this year or prior federal fiscal year.

^c State eliminated its Medicaid-expansion CHIP program in this year or prior federal fiscal year.

^d State eliminated its separate CHIP program in this year or prior federal fiscal year.

^e 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.

^f Tennessee has no recorded enrollees for 2006. The absolute and percentage difference in enrollment reported is for 2007 to 2012.

^g This state switched its CHIP program type between FFY 2010 and FFY 2012 (program type as of FFY 2012 is displayed).

Table B.3. Number of Children Enrolled in CHIP from FFY 1998 Through FFY 2012, by State and Program Type

State	Number of Children Ever Enrolled in CHIP Programs											Change From 2006 to 2012	
	1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	Number of Children	Percentage
Total	660,351	3,358,417	5,336,508	6,111,038	6,755,199	7,105,986	7,355,746	7,695,264	7,705,723	7,977,203	8,148,397	1,393,198	20.6
Number of States Reporting	28	51	51	50	50	51	51	51	51	51	51		
Medicaid-Expansion CHIP States													
Alaska	--	13,413	22,306	21,966	20,432	17,558	18,707	11,655	12,473	14,278	13,499	-6,933	-33.9
District of Columbia	--	2,264	5,060	6,093	6,332	6,566	8,746	9,260	8,100	8,675	7,293	961	15.2
Hawaii	--	341a	8,474	19,237	22,031	23,958	28,803	24,691	27,256	30,584	33,764	11,733	53.3
Maryland	27,880 ^a	93,081	125,180 ^b	111,488	136,034	132,887 ^d	132,864	124,622	118,944	119,906	131,898	-4,136	-3.0
New Hampshire	--	4,272	8,138	10,969	12,393	12,088	12,236	13,197	10,630	10,801	11,437	-956	-7.7
New Mexico	--	7,971	19,940	20,804	25,155	16,525	14,944	11,169	9,654	9,635	9,582	-15,573	-61.9
Ohio	49,565 ^a	118,290	183,034	220,190	221,643	231,538	251,278	265,680	253,711	280,650	284,774	63,131	28.5
South Carolina	43,074 ^a	60,415	66,591	75,597	68,870	59,920	73,620 ^b	85,046	73,438 ^d	72,084	75,281	6,411	9.3
Separate CHIP States													
Alabama	8,492 ^a	37,587 ^b	66,027 ^c	79,407	84,257	106,691	110,821	110,158	137,545	109,255	112,972	28,715	34.1
Arizona	--	59,601	92,673	87,681	96,669	104,209	112,072	66,275	39,589	20,043	35,679	-60,990	-63.1
Colorado	14,847 ^b	34,889	51,826	57,244	69,997	84,649	99,555	102,395	106,643	105,255	126,169	56,172	80.2
Connecticut	6,649 ^{a,b}	19,925	20,500	21,438 ^c	23,301	23,632	22,320	21,874	21,033	20,072	19,986	-3,315	-14.2
Georgia	--	120,626 ^b	221,005	280,083	343,690	356,285	311,243	254,365	248,268	248,536	258,425	-85,265	-24.8
Kansas	--	26,306	40,838	44,350	48,934	49,536	51,173	48,090	56,384	60,431	64,229	15,295	31.3
Mississippi	5,477 ^a	12,156 ^b	64,805	82,900 ^c	83,359	81,565	84,370	86,839	95,556	91,470	93,257	9,898	11.9
Oregon	6,488 ^b	37,092	42,976	46,720	59,039	63,090	73,686	51,835	64,727	112,165	121,962	62,923	106.6
Pennsylvania	--	119,710	148,689	177,415	188,765	227,367	256,627	264,847	273,221	272,492	271,642	82,877	43.9
Texas	25,176 ^a	131,096 ^b	727,459 ^e	650,856	585,461	710,690	731,916	869,867	928,483	972,715	999,838	414,377	70.8
Utah	2,752 ^b	25,294	33,808	38,693	51,967	44,785	51,092	59,806	62,071	59,698	65,983	14,016	27.0
Vermont	--	4,081 ^b	6,162	6,693	6,519	6,132	6,496	7,092	7,026	7,054	7,570	1,051	16.1
Washington	--	2,616 ^b	8,754	25,256	25,005	23,136	27,657	27,415	35,894	44,322	43,584	18,579	74.3
West Virginia	160 ^a	21,659 ^b	35,949 ^c	36,906	39,855	38,582	37,645	38,200	37,539	37,631	37,807	-2,048	-5.1
Wyoming	--	2,547 ^b	5,059	5,525	7,715	8,570	8,976	8,871	8,342	8,586	8,715	1,000	13.0
Combination Program States													
Arkansas	--	1,892	1,912	799 ^b	89,238	89,642	93,446	101,312	100,770	103,693	114,056	24,818	27.8
California	18,713 ^{a,b}	484,359	861,445	1,035,752	1,391,405	1,538,416	1,692,087	1,748,135	1,731,605	1,765,893	1,784,032	392,627	28.2
Delaware	--	4,474 ^b	9,719 ^a	10,250	10,751	11,143	11,192	12,599	12,852	15,443	12,850	2,099	19.5
Florida	27,435 ^{a,b}	227,463	368,180	419,707	303,595	323,529	354,385	417,414	403,349	431,717	415,027	111,432	36.7
Idaho	--	12,449 ^a	16,895	19,054 ^b	24,727	33,060	43,526	44,319	42,208	42,604	45,932	21,205	85.8
Illinois	27,780 ^a	62,507 ^b	68,032	234,027	316,781	345,576	356,460	376,618	329,104	336,885	347,904	31,123	9.8
Indiana	21,172 ^a	44,373 ^b	66,225	80,698	133,696	130,368	124,954	142,665	141,497	158,138	154,262	20,566	15.4

Table B.3 (Continued)

State	Number of Children Ever Enrolled in CHIP Programs											Change From 2006 to 2012	
	1998	2000	2002	2004	2006	2007	2008	2009	2010	2011	2012	Number of Children	Percentage
Iowa	4,798 ^a	19,958 ^b	34,506	41,636	49,575	50,238	50,390	52,608	63,985	75,133	80,454	30,879	62.3
Kentucky	3 ^a	55,593 ^b	94,608	94,500	65,290	70,197	72,360	73,143	79,380	85,554	85,331	20,041	30.7
Louisiana	--	49,995 ^a	74,654	105,580	142,389	154,286 ^b	164,998	170,082	157,012	152,404	150,672	8,283	5.8
Maine	3,204 ^{a,b}	22,742	22,586	29,171	31,114	31,037	30,947	31,349	32,994	35,986	36,324	5,210	16.7
Massachusetts	17,528 ^{a,b}	113,034	119,732	166,508	201,037	184,483	200,950	143,044	142,279	144,767	145,203	-55,834	-27.8
Michigan	6,226 ^{a,b}	55,375	71,882	87,563	118,501	64,771	67,763	72,035	69,796	83,004	81,429	-37,072	-31.3
Minnesota	--	24 ^a	49	4,784 ^b	5,343	5,408	5,621	5,470	5,164	4,461	4,104	-1,239	-23.2
Missouri	10,809 ^a	73,825	150,533	176,014	106,577	81,764 ^b	88,911	103,709	86,261	93,734	92,795	-13,782	-12.9
Montana	--	8,317 ^b	13,875	15,281	17,304	20,115	22,679	25,749	25,231 ^a	24,365	28,570	11,266	65.1
Nebraska	2,119 ^a	11,400	16,227	44,646	44,981	46,199	49,185	48,139	47,922	52,852	56,266	11,285	25.1
Nevada	--	15,946 ^b	37,878	38,519	39,317	41,862	38,592	33,981	31,554	29,760	29,854	-9,463	-24.1
New Jersey	16,810 ^{a,b}	89,034	117,053	127,244	142,805	150,277	151,805	167,009	187,211	198,283	201,417	58,612	41.0
New York	279,917 ^b	769,457 ^a	807,145 ^e	765,030	688,362 ^c	651,853	517,256	532,635	539,614	552,068	547,671	-140,691	-20.4
North Carolina	--	103,567 ^b	120,378	174,434	248,366 ^a	240,152	253,112	259,652	253,892	254,460	259,978	11,612	4.7
North Dakota	--	2,573 ^b	4,463	5,137	6,318	5,469	7,617	6,983	7,192	7,115	7,792	1,474	23.3
Oklahoma	17,538 ^a	57,719	84,490	100,761	116,012	117,084	117,507 ^b	123,681	122,874	120,501	125,889	9,877	8.5
Rhode Island	2,030 ^a	11,539	19,515	25,573 ^b	25,492	26,067	26,031	19,596	23,253	24,815	26,968	1,476	5.8
South Dakota	1,047 ^a	5,888 ^b	11,233	13,397	14,584	14,982	15,277	15,249	15,872	16,623	17,428	2,844	19.5
Tennessee	12,662 ^a	14,861	10,216 ^c	--	--	41,363 ^{a,b}	63,619	83,333	81,341	96,028	101,543	60,180 ^f	145.5
Virginia	--	37,681 ^b	67,974 ^a	99,569	137,182	144,163	155,289	167,589	173,515	182,128	189,961	52,779	38.5
Wisconsin	--	47,140 ^{a,b}	59,850	67,893	57,034	62,523 ^b	52,940	153,917	161,469	172,451	169,339	112,305	196.9

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. The enrollment data shown for FFYs 2011 and 2012 are publicly available (Centers for Medicare & Medicaid Services 2013). 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; CMS = Centers for Medicare & Medicaid Services; "--" denotes that the State did not report enrollment in SEDS for that fiscal year.

^a State implemented a Medicaid-expansion CHIP program in this year or prior federal fiscal year.

^b State implemented a separate CHIP program in this year or prior federal fiscal year.

^c State eliminated its Medicaid-expansion CHIP program in this year or prior federal fiscal year.

^d State eliminated its separate CHIP program in this year or prior federal fiscal year.

^e 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.

^f Tennessee has no recorded enrollees for 2006. The absolute and percentage difference in enrollment reported is for 2007 to 2012.

Table B.4. Access and Use Among CHIP and Medicaid Enrollees in Three States (California, Florida, and Texas), 2012

Reports for the Past 12 months	CHIP Enrollees	Medicaid Enrollees
Access to Care Based on Parent Reports		
Had USC or Private Doctor or Nurse During Past 12 Months	87	85
USC Type: Private Doctor's Office or Group Practice/HMO	44	35**
USC has Night or Weekend Office Hours	25	25
Could Reach Doctor at USC After Hours	34	33
Provider Accessibility Based on Parent Reports		
No Trouble Finding a General Doctor	97	97
No Trouble Finding a Specialist	94	94
Usually/Always Easy to Get Appointments with Medical Provider	82	80
Service Use Based on Parent Reports		
Any Doctor/Other Health Professional Visit	84	85
Any Preventive Care or Check-up Visit	78	81
Any Specialist Visit	17	16
Any Mental Health Visit	6	8
Any Emergency Department Visit	21	36**
Any Hospital Stays	4	8**
Content of Preventive Care Received Based on Parent Reports		
Health and weight measurement	91	92
Vision screening	60	53**
Flu vaccination	49	55**
Anticipatory Guidance On Key Health Topics	33	36
Developmental screening (among children under six)	31	31
Access to and Use of Oral Health Care Based on Parent Reports		
Has dental benefits or coverage for dental services	92	88**
Had USC for Dental Care	86	79**
USC for Dental Care has night or weekend hours	39	39
No Trouble Finding a Dentist	88	84**
Usually/Always Easy to Get Appointments with Dental Provider	73	70
Any Dental Visit for Check-up or Cleaning	82	77**
Dentist recommended additional or follow up treatment	36	34
Had dental procedure, such as having a cavity treated or tooth pulled	68	70
Dental sealants (if age > 6 years)	56	53
Patient Centeredness of Health Care Based on Parent Reports		
Obtained referrals when needed	71	68
Received effective care coordination	65	64
Received family-centered care	43	39
Unmet Needs Based on Parent Reports		
Doctor/health professional care	6	8*
Prescription drugs	7	9*
Specialists	6	7
Hospital care	3	4
Mental Health Care	3	5
Dental Care	13	16**
Any Unmet Need	26	31**
Parental Perceptions of Coverage and Financial Burden of Child's Health Care		
Very or somewhat confident could get needed health care for child	95	95
Never or not very often stressed about meeting child's health care needs	82	83
No problem paying child's medical bills for care (or no out-of-pocket costs)	92	95
Out of pocket costs: Greater than \$0 up to \$250	3	3
Out of pocket costs: Between \$250 and \$2,000	4	1**
Out of pocket costs: Greater than \$2,000	1	0

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

Notes: Anticipatory guidance topics examined include: (1) how to avoid injury, (2) child's eating habits, (3) child's exercise habits, and (4) risks of secondary smoke. Receipt of effective care coordination is a

Table B.4 (Continued)

composite measure that incorporates assessments of (1) communication between doctors when needed, (2) communication between doctors and schools when needed, and (3) getting help coordinating care when needed. Receipt of family-centered care is a composite measure based on parent reports of whether (1) the child's provider usually spends enough time with the child, (2) always listens carefully, (3) is sensitive to family values/customs, (4) gives needed information, (5) makes the family feel like a partner, and (6) getting non-family member to interpret conversations with doctors or other health care providers. "No out-of-pocket costs" includes those who indicated out-of-pocket costs but then said they had no problem paying, or later indicated they paid \$0 in out-of-pocket costs.

**p-value (of difference) < 0.01; * p-value (of difference) < 0.05 level

Table B.5. Parents' Reported Access, Use, and Care Experiences of Children in Medicaid Compared to the Uninsured and those with Private Insurance

	Percentage of Medicaid Enrollees, Pooled 3-State ^a	Percentage Point Difference Between Medicaid Enrollees and Children Who Were Uninsured ^b	Percentage Point Difference Between Medicaid Enrollees and Children Who Were Privately Insured ^c
Access to Care Based on Parent's Reports			
Had USC or private doctor or nurse during past 12 months	85	18**	-9**
USC type: private doctor's office or group practice/ HMO	35	11**	-26**
USC has night or weekend office hours	25	-7	-9
Could reach doctor at USC after hours	33	2	-21**
Had USC for Dental Care	79	44**	16**
USC for Dental Care has or night or weekend hours	39	-1	2
Provider Accessibility			
No trouble finding a general doctor	97	13**	1
No trouble finding a specialist	94	17**	1
No trouble finding a dentist	84	11**	-5
Usually/always easy to get appointments with medical provider	80	21**	5
Usually/always easy to get appointments with dental provider	70	27**	3
Service Use Based on Parent's Reports			
Any doctor/other health professional visit	85	21**	-2
Any preventive care or checkup visit	81	28**	-10**
Any specialist visit	16	13**	4
Any mental health visit	8	6**	3
Any emergency department visit	36	3	7
Any hospital stays	8	0	4
Any dental visit for checkup or cleaning	77	45**	11*
Dentist recommend additional or follow-up treatment	34	-4	6
Dental procedure, such as having a cavity treated or a tooth pulled	70	-2	-9
Content of Preventive Care Received Based on Parent's Reports			
Flu vaccination	55	16**	-8
Height and weight measurement	92	22**	-3
Vision screening	53	10*	4
Developmental screening (combined measure)	32	20**	-8
Anticipatory guidance (combined measure)	36	12**	-3
Access to and Use of Oral Health Care Based on Parent Reports			
Has dental benefits or coverage for dental services	92	66**	10*
Had USC for Dental Care	79	44**	16**
USC for Dental Care has night or weekend hours	39	-1	2
No Trouble Finding a Dentist	84	11**	-5
Usually/Always Easy to Get Appointments with Dental Provider	70	27**	3
Any Dental Visit for Check-up or Cleaning	77	45**	11*
Dentist recommended additional or follow up treatment	34	-4	6
Had dental procedure, such as having a cavity treated or tooth pulled	70	-2	-9
Dental sealants (if age > 6 years)	56	13*	14*
Patient-Centeredness of Health Care Based on Parent's Reports			
Obtained referrals when needed	68	34**	3
Received effective care coordination	64	11	3
Received family-centered care	39	10*	5

Table B.5 (Continued)

	Percentage of Medicaid Enrollees, Pooled 3-State ^a	Percentage Point Difference Between Medicaid Enrollees and Children Who Were Uninsured ^b	Percentage Point Difference Between Medicaid Enrollees and Children Who Were Privately Insured ^c
Unmet Needs Based on Parent's Reports			
Doctor/health professional care	8	-7*	1
Prescription drugs	9	-8*	-3
Specialists	7	-3	-1
Hospital care	4	-5**	1
Mental health care	5	1	6
Dental care	16	-1	6
Any unmet need	31	-4	9*
Parental Perceptions of Coverage and Financial Burden of Child's Health Care			
Very or somewhat confident could get needed health care for child	95	25**	3
Never or not very often stressed about meeting child's health care needs	83	27**	5
No problem paying child's medical bills for care (or no out-of-pocket costs)	95	30**	24**
Out of Pocket Costs: Greater than \$0 up to \$250	3	-8**	-4
Out of Pocket Costs: Between \$250 and \$2,000	1	-18**	-14**
Out of Pocket Costs: : Greater than \$2,000	<1	-2	-5**

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

Notes: The regression-adjusted differences derived from multivariate regression models control for age, sex, race/ethnicity and language groups, more than three children in the household, highest education of any parent, parents' employment status, parent citizenship, and, local area or county. Sample sizes are different across outcome indicators due to differences in response rates and survey skip patterns. "No out-of-pocket costs" includes those who indicated out-of-pocket costs but then said they had no problem paying, or later indicated they paid \$0 in out-of-pocket costs.

^a CHIP enrollees are those enrolled in CHIP for at least 12 months at time of sampling.

^b Uninsured children had 5 or more months without any coverage in the past 12 months.

^c Privately insured children had 12 months of private coverage in the past 12 months.

*/** Indicates that the values are statistically different from Medicaid enrollees at the 0.05/ 0.01 level.

Exhibit B.1. Publications Produced in the CHIPRA Mandated Evaluation of CHIP

"Findings From the 2012 Congressionally Mandated CHIP and Medicaid Survey." Series of memos submitted to ASPE. Mathematica Policy Research and the Urban Institute, December 2013.

- "Prior Coverage Patterns for New CHIP Enrollees." Stacey McMorro, Genevieve Kenney, Timothy Waidmann, and Nathaniel Anderson, Urban Institute.
- "Sociodemographic and Health Characteristics of CHIP Enrollees." Joseph Zickafoose, Kimberly Smith, and Claire Dye, Mathematica Policy Research.
- "Families' Application and Renewal Experiences." Christopher Trenholm, Claire Dye, and Connie Qian, Mathematica Policy Research.
- "Access to Employer-Sponsored Insurance Among Children with Public Coverage." Stacey McMorro, Genevieve Kenney, Timothy Waidmann, and Nathaniel Anderson, Urban Institute.
- "Access and Use for Primary and Preventive Medical Care under CHIP and Medicaid." Kimberly Smith and Claire Dye, Mathematica Policy Research.
- "How Well CHIP and Medicaid Are Addressing Health Care Access and Affordability for Children." Lisa Clemans-Cope, Genevieve Kenney, Timothy Waidmann, Michael Huntress, and Nathaniel Anderson, Urban Institute.
- "How Well CHIP and Medicaid Are Addressing Oral Health Care Access and Adequacy of Insurance for Children." Lisa Clemans-Cope, Genevieve Kenney, Timothy Waidmann, Michael Huntress, and Nathaniel Anderson, Urban Institute.
- "Characteristics and Experiences of Disenrollees." Mary Harrington, Tyler Fisher, and Andrew McQuirk.

"Enrollment and Retention of CHIP and Medicaid Enrollees." Sean Orzol, Lauren Hula, Adam Swinburn and Mary Harrington. Memorandum submitted to ASPE, December 2013.

"Cross-Cutting Report on Findings from Ten State Case Studies." Ian Hill, Sarah Benatar, Embry Howell, Bridget Courtot, and Margaret Wilkinson, with Sheila Hoag, Cara Orfield, and Victoria Peebles. Final report submitted to ASPE. Mathematica Policy Research and the Urban Institute, May 2013.

- Alabama Case Study. Sarah Benatar, Margaret Wilkinson, and Ian Hill, Urban Institute.
- California Case Study. Ian Hill, Sarah Benatar, and Juliana Macri, Urban Institute.
- Florida Case Study. Sheila Hoag and Victoria Peebles, Mathematica.
- Louisiana Case Study. Fiona Adams, Embry Howell, and Bridget Courtot, Urban Institute.
- Michigan Case Study. Sheila Hoag and Cara Orfield, Mathematica.
- New York Case Study. Ian Hill and Sarah Benatar, Urban Institute.
- Ohio Case Study. Jung Kim and Victoria Peebles, Mathematica.
- Texas Case Study. Cara Orfield and Jung Kim, Mathematica.
- Utah Case Study. Ian Hill, Bridget Courtot, and Margaret Wilkinson, Urban Institute.
- Virginia Case Study. Sarah Benatar, Margaret Wilkinson, and Ian Hill, Urban Institute.

"Findings from a Survey of State CHIP Program Administrators." Sheila Hoag, Michael Barna, Cara Orfield, Mary Harrington, and Vivian Byrd. Final report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation Ann Arbor, MI: Mathematica Policy Research, November 2013.

"Children's Health Insurance Program: An Evaluation (1997 – 2010)." Sheila Hoag, Mary Harrington, Cara Orfield, Victoria Peebles, Kimberly Smith, Adam Swinburn, Matthew Hodges, Kenneth Finegold, Sean Orzol, and Wilma Robinson. Interim Report to Congress submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Mathematica Policy Research, December 2011.

"Findings from the Analysis of the 2011 – 2012 National Survey of Children's Health." Series of issue briefs submitted to ASPE. Urban Institute, July 2013.

- Haley, J., G. Kenney, and N. Anderson. "Uninsurance Among Children: Changes Over Time and Current Patterns."
- "What Prevents Eligible but Uninsured Children From Enrolling in Medicaid and CHIP?"
- "How Do Barriers to Medicaid and CHIP Enrollment Vary Among Uninsured Children?"

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