Georgetown University Health Policy Institute
Center for Children and Families
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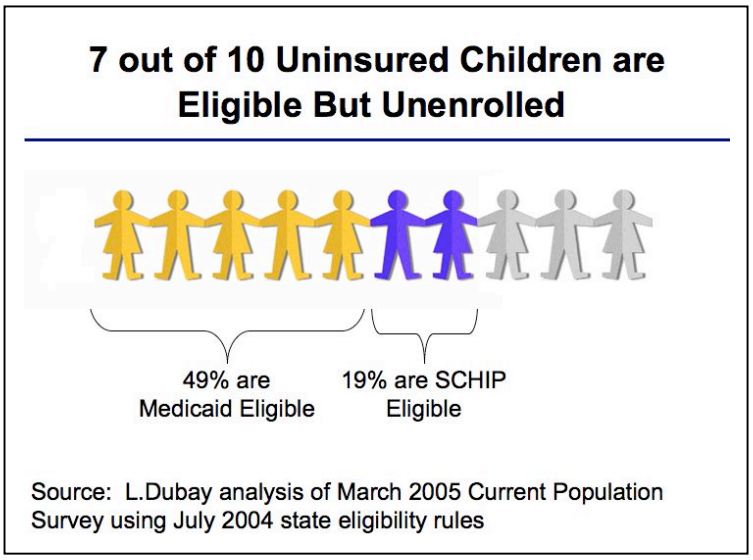
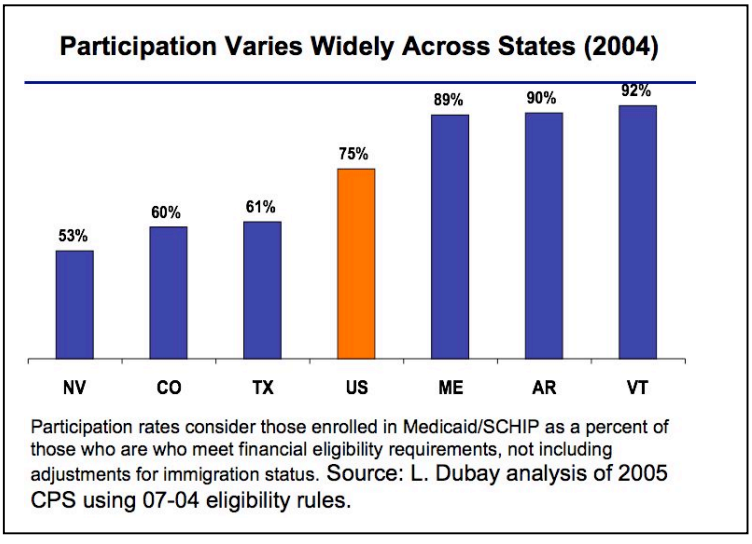
Reaching Eligible but Uninsured Children in Medicaid and CHIP

Summary

One of the most important steps a state can take to provide health coverage to its children is to reach uninsured children who already qualify for Medicaid or the State Children's Health Insurance Program (CHIP). Nationally, some six million children who are uninsured qualify for the two programs, representing close to seven in ten of all uninsured children.[1] The vast majority of these children are low-income, have a parent who is employed and come from families that are eager to enroll their children in coverage.[2]



Although the country has made steady progress in reaching these children, much more can be done. In particular, there are still strategies a state can take to increase their Medicaid and CHIP participation rates, and thus reach more "eligible but uninsured" children. These strategies include adopting and improving the operation of core policies, implementing enhanced enrollment and retention procedures, and conducting targeted outreach. If successful, states could assure that millions of uninsured children gain the coverage they need and for which they already qualify.



Where States Stand

As a result of CHIP's creation in 1997, states across the country moved to take advantage of the opportunity to cover more uninsured children. Every state expanded eligibility levels, but equally important, to reach more eligible children, they conducted outreach and

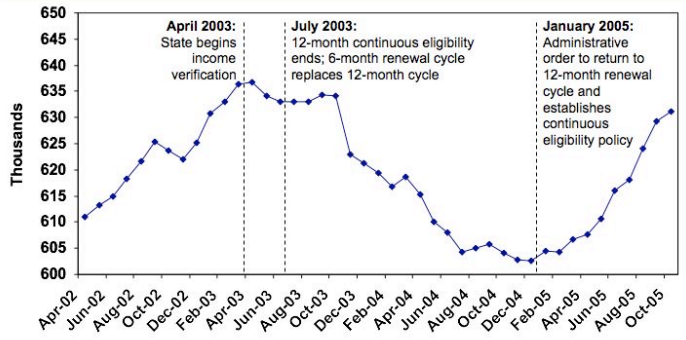
made their enrollment and renewal procedures for CHIP and Medicaid more family-friendly.

As a result, the rate at which eligible but uninsured children participate in Medicaid is far above the pre-CHIP levels and participation rates in CHIP have been rising steadily as well. In 1999 the Medicaid participation rate was 73 percent compared to 82 percent in 2002. CHIP's rate of 48 percent in 1999 jumped to 68 percent by 2002.[3]

The extent in which states are covering eligible but uninsured children varies by state, with participation rates ranging from 53 percent in Nevada to 92 percent in Vermont.[4] Particularly telling is that if all states brought the participation rates up to the levels already achieved in some states (e.g., 90-92 percent), the number of uninsured children in America could be cut by about half (4.1-4.6 million).[5]

The experiences to date in states show that "if you build it right" states can make a significant impact on enrollment. This is exemplified by Washington State's experiences with 12-month continuous eligibility and other simplifications for its Medicaid program. In 2003, Washington moved from 12-months of continuous eligibility to a 6-month renewal period. As a result the state witnessed a large drop in children enrolled in the program. On the reverse, when Washington reinstated the policy in 2005 and once again made the program easier for children to remain enrolled, the enrollment numbers rose.[6] Other states have had success in keeping children enrolled in their programs through retention strategies. For example, after implementing a number of retention strategies, including *ex parte* renewal (described later), Louisiana's procedural closures at renewal dropped to less than one percent.[7]

Children's Enrollment in Washington's Public Insurance Programs, April 2002-October 2005



Source: Washington State Department of Social and Health Services, 2005, updated 2006.

Unfortunately, some notable federal barriers also remain for states in increasing enrollment for uninsured but eligible children. These include federal policies that make it harder for states to reach these lower income eligible children or concerns on coverage costs. For example, over the past year, states must meet a federal mandate to document citizenship status in Medicaid and CHIP.[8] Thousands of eligible children have lost or experienced delayed coverage as a result.[9]

The CHIP law enacted in 2009 has created additional opportunities for states to reach eligible but uninsured children. Measures include streamlining the citizenship

documentation requirement and allowing states to use other public program findings to enroll children in Medicaid and CHIP. These new tools are accompanied by a performance bonus system that provides states with additional federal financial help when they significantly increase their enrollment of already-eligible uninsured children in Medicaid and adopt measures to streamline enrollment and renewal in both Medicaid and CHIP.[10]

About Eligible but Uninsured Children

Despite the marked progress in states, almost 70 percent of all uninsured children (some six million) are eligible but not enrolled in Medicaid and CHIP. This is due to many factors including complicated enrollment and retention procedures that make it hard for families to enroll, or once enrolled, to keep their coverage. In addition, families still may not know about the coverage available for their children.

The characteristics of these eligible but uninsured children are:

- The vast majority (93 percent) is "low-income" which is defined as having family income below 200 percent of the federal poverty level. [11]
- In fact, nationwide the majority of already-eligible uninsured children qualify for Medicaid, rather than CHIP. Of the 6.1 million uninsured children eligible for coverage, 4.4 million are eligible for Medicaid and 1.7 million for CHIP. These proportions will vary markedly by state.[12]
- Most (70 percent) have parents who are employed, many in small firms, or are self-employed. [13]
- The families of these children are eager to enroll their children in public programs when told about them and given the opportunity to do so.[14]

Strategies States Can Take

The following are strategies states can take to reach more eligible but uninsured children. They provide a general starting place and a way to think about developing a plan for increasing enrollment. However, every state is different and any efforts to increase coverage among eligible but uninsured children should start with a state review. Data is critical to this effort in order to diagnose where a state can be more effective. For example, data on how many children are losing coverage at renewal, and for what reasons, is critical to understanding the best strategy to put into place to ensure that children are not unnecessarily losing coverage.

While these strategies are focused on state activities, it is also important to note where federal law changes could help alleviate barriers to reaching eligible but uninsured children. These include providing extra federal assistance for coverage costs in states that are making significant progress in reaching eligible but unenrolled children, and eliminating or streamlining the new citizenship documentation requirement.

Strategy 1: Establish a Core Set of Enrollment and Renewal Standards

While some states have steadily made progress in implementing enrollment and renewal policy simplifications, like eliminating face-to-face interviews, others have not. In addition, even if a state has moved forward on this front, it may not have gone as far as it can. Because of the remarkable impact policy simplifications have on enrollment, the most important strategy a state can take to reach eligible but uninsured children is establishing and implementing a set of core enrollment and renewal policy simplifications.

Some of these policies are required by federal regulations, and some are not required but are still critical to creating effective enrollment and retention procedures. Together they make up a set of core enrollment and renewal standards that every state should meet.

1. **Meet federal requirements.** There are a number of important enrollment and retention policies that are required under federal law. The following policies are critical to helping ensure that children obtain the coverage they are eligible for and retain it once enrolled.

    - **Screen and Enroll**. For children who apply for coverage under a separate CHIP program, federal law requires that states first screen children for Medicaid eligibility and enroll eligible children. States must also assist families in applying for CHIP if their child applies for Medicaid and is not eligible. The requirement helps boost enrollment by assuring that families are able to enroll their children, even if they applied to the wrong program.[15]

    - **Coordination.** Federal law requires states with separate CHIP-funded programs to coordinate their enrollment and renewal procedures with Medicaid. This coordination helps prevent children from "falling through the cracks" in states with two child health coverage programs.[16]

    - **Ex Parte.** When conducting a Medicaid renewal process, federal law requires states to base their review "to the maximum extent possible" on information already known to the Medicaid agency. This means that a state should use information it has collected from other programs, such as food stamps, to assess ongoing Medicaid eligibility to limit the amount of information a family has to submit, increasing the ease of renewal.[17]

    - **Delinking**. The federal welfare law enacted in 1996 eliminated the AFDC cash assistance program and created the TANF block grant. In order to assure that welfare changes did not cause children and their parents to lose coverage under Medicaid, the welfare law "delinked" Medicaid eligibility from eligibility for cash assistance and established a new family coverage category under section 1931 of the federal Medicaid law (Title XIX). Eligibility is based on family income, not receipt of welfare. Delinking means that families who do not apply for welfare, or who become ineligible for welfare, should always be separately evaluated for Medicaid eligibility. Medicaid regulations[18] also require states to provide families the opportunity to apply for Medicaid without delay. As a result, a state should

implement outreach and enrollment strategies to ensure that eligible families not receiving, or leaving, cash assistance receive Medicaid coverage.[19]

2. **Establish a basic level of simplification**. Most states have implemented a set of basic simplification measures. Before getting started states should ensure the very basic level of measures, as follows, are implemented and are functioning properly.

   - **No procedural differences between Medicaid and CHIP policies**. States with a separate CHIP program should not have separate policies for Medicaid and CHIP. Abolishing procedural and policy differences between Medicaid and CHIP makes the process for obtaining children's health coverage less confusing for families and facilitates a smooth transfer of children from one program to another, preventing lost applications and gaps in coverage. This includes ensuring Medicaid and CHIP have the same application, renewal form, eligibility rules, and verification processes.

   - **No assets test for children**. States can establish asset (resource) requirements, but they need not do so. Most states, but not all, currently have no asset limit for their children's coverage in either Medicaid or, if applicable, in their separate CHIP programs. Few low- and moderate-income families have any assets of note. Eliminating the test ensures that families (who have little or no flexibility to leave work for an interview) are not unnecessarily burdened by the intensive paperwork requirements associated with documenting assets during the enrollment or renewal process.

   - **No face-to-face interviews**. Requiring families to come into an office to enroll or renew coverage creates an unnecessary burden on families and increases the likelihood of parents not seeking out and retaining coverage. A family still has the option of coming to the office to seek assistance but eliminating the interview requirement significantly simplifies the application and renewal processes for families.

   - **Coordinated Medicaid and CHIP enrollment and renewal processes**. States should ensure that their Medicaid and CHIP programs are relatively seamless for families. This includes having joint applications and renewal forms and automatic bridges between programs to ensure children only have to apply through one-door and remain enrolled even if their circumstances change.

3. **Implement time-tested participation boosters**. There are a few enrollment and retention strategies that have proven to increase participation rates to a significant degree. States wishing to make an even larger impact on their enrollment should finish their core set of enrollment and renewal standards with the following strategies.

   - **12-months "continuous eligibility"**. To promote continuity of coverage and care, states have the option under Medicaid and CHIP to enroll children for periods of up to 12 months. The continuous eligibility period allows a child to remain

enrolled regardless of changes in income, which tend to be relatively inconsequential. Most importantly, it ensures a family need not submit unnecessary paperwork to retain coverage and guarantees a set period of coverage. This in turn ensures continuity of care and that children do not lose coverage due to small fluctuations in income. Continuous eligibility also limits costly "churning" and makes it easier to attract managed care plans to participate. If continuous eligibility is not possible in a state, another option is implementing a 12-month renewal period–in which a family renews yearly but if their income or circumstances change they must report that to the state.

- **No unnecessary documentation requirements**. Families usually have to submit numerous pieces of documentation, such a payroll statements, at enrollment and renewal. States can, however, rely solely on electronic databases and audits and they can require families to provide documentation of income or other eligibility requirements only if the state cannot verify the information through other means (e.g., checking existing state databases). The only components of their eligibility that families must document under federal law are citizenship and immigration status. The other components also must be verified, but verification can be done by a state agency.

Strategy 2. Enhance and Modernize Enrollment and Renewal Procedures

Beyond the core strategies, there are a number of policies that can be put into place to make enrollment and renewal procedures work more effectively, especially by relying on interconnections between different programs and technology. Some ideas include:

- **Use presumptive eligibility as an enrollment and outreach tool.** Presumptive eligibility is an option in federal law that allows states to screen a child eligible for Medicaid and CHIP and enroll them in coverage immediately, while a full determination is being made. This ensures children can get medical care right away and provides the family with more of an incentive to stick with the enrollment process. States can implement presumptive eligibility in different ways, including, finding new children who have not applied previously because of complicated applications or to make sure children who submit a full application are enrolled immediately.

- **Address Medicaid citizenship requirements to help easy the burden on states and families.** The federal Medicaid citizenship requirement took effect in July 2006 and requires that most U.S. citizens applying for Medicaid or renewing their coverage prove their citizenship and identity by presenting documentation. This requirement has added an extra burden on states and families applying for coverage, and resulted in a negative impact on enrollment and increased administrative costs. States can implement strategies to ease this burden such as outreach and training, using presumptive eligibility to ensure children receive coverage while following up on the citizenship requirement, linking to vital records to match citizenship data and accepting affidavits for children's identification.

In addition, the CHIP law enacted in 2009 applies the citizenship requirement to CHIP, but also includes a new electronic option for documenting citizenship status in both Medicaid and CHIP to address red tape barriers that were keeping low-income citizen children from enrolling in coverage.[20]

- **Utilize technology to automate enrollment and renewal.** This includes online enrollment and allowing better connections between agencies so data can be shared more readily. The more enrollment and renewal procedures can be automated the less need there is for manual data entry and paper transfers which can mean lost paperwork and more complicated enrollment processes for families.

- **Coordinate Medicaid/CHIP with other public programs, like school lunch or food stamps.** Over 70 percent of uninsured low-income children already participate in other public programs. States can implement referral processes between the programs to identify eligible but uninsured children, combine enrollment procedures, or use information from the other programs to automatically renew Medicaid or CHIP coverage for children already enrolled in coverage.

  The CHIP law enacted in 2009 provides states with new tools and flexibility for reaching and enrolling these children. This includes allowing states to use relevant finding form other public program when determining children's eligibility for CHIP and Medicaid at enrollment and renewal.[21]

Strategy 3. Conduct Community Outreach Efforts

There are a number of outreach activities a state can undertake to reach eligible but uninsured children. These include media campaigns, establishing toll-free numbers for families to call to request information, and working with community-based organizations to get the word out. While data are limited on what is the most effective type of outreach activity, state experiences show that a successful model includes one-on-one contact or assistance with families. States have implemented such measures through grants provided to community-based organizations or payments to application "assistors". This is a particularly critical avenue for reaching those harder-to-reach families who may speak a foreign language or have limited literacy.

The CHIP law enacted in 2009 provides increased outreach funding to enroll eligible but uninsured children. The funding will be available to state and local governments and community-based organizations.[22]

Resources

CCF Website

- **Strategy Center**: information on enrollment and retention strategies, mentioned in this report that can be implemented to increase coverage to uninsured children.

http://ccf.georgetown.edu/index/strategy-center

- **CHIP Law:** post-CHIP reauthorization resources on new opportunities for covering children under Medicaid and CHIP. http://ccf.georgetown.edu/index/chip-law

- **Facts and Statistics:** data on uninsured children and families and their access to state health coverage programs, in addition on enrollment and renewal procedures by state. http://ccf.georgetown.edu/index/facts-statistics

Research

About Eligible but Uninsured Children

Children's Eligibility and Coverage: Recent Trends and a Look Ahead
Julie Hudson and Thomas Selden, Health Affairs, September 2007
This article examines changes in children's eligibility for Medicaid and CHIP and their effect on coverage. Between 1996 and 2001, the number of children eligible for public insurance programs nearly doubled, and the number of children enrolled in public coverage grew during the post-expansionary period (2001-2005), even as eligibility levels remained steady. The authors also simulate the effects of a uniform expansion of eligibility to 300% of the federal poverty level (FPL), which would make an additional 9.1 million children eligible for CHIP or Medicaid, and the effects of a uniform contraction of eligibility to 200% of the FPL, which would result in the loss of public insurance coverage for an estimated 500,000 children.

Making Sense of Recent Estimates of Eligible but Uninsured Children
Lisa Dubay, Kaiser Commission on Medicaid and the Uninsured, August 2007
This report reviews discussion during the 2007 CHIP reauthorization debate on the number of children who are uninsured but eligible for Medicaid or CHIP. It shows that the Congressional Budget Office concluded that there are between 5 and 6 million children who are uninsured and eligible for Medicaid and CHIP, which is in sharp contrast to estimates recently by the Bush Administration indicating there were only 1.1 million eligible but uninsured children. This brief describes the methodologies underlying the two sets of estimates that have been at the center of the controversy.

Coverage Patterns Among SCHIP-Eligible Children and Their Parents
Genevieve Kenney and Allison Cook, Urban Institute, February 2007
This brief addresses coverage patterns among CHIP-eligible children and their policy implications. Using data from the 2005 Current Population Survey, the findings estimate that close to 2 million children who are eligible for CHIP remain uninsured. Most CHIP enrollees do not have access to employer-sponsored health insurance, and about four in ten CHIP enrollees live with a parent who is uninsured. The study concludes that if CHIP is not adequately funded, millions of eligible children will remain uninsured and that other children who lose CHIP coverage will likely become uninsured.

Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage
John Holahan, Allison Cook, and Lisa Dubay, Kaiser Commission on Medicaid and the Uninsured, February 2007
In an analysis based on the 2005 Current Population Survey, the authors estimate that approximately 80 percent of the uninsured are currently eligible for public health insurance coverage or live in families with income below 300% of the federal poverty level. The report states that policy options to reduce the number of uninsured will vary depending on if the population is eligible for public coverage or if financial assistance is needed to obtain coverage.

Outreach/Enrollment Strategies

Challenges of Providing Health Coverage for Children and Parents in a Recession
Donna Cohen Ross and Caryn Marks, Kaiser Commission on Medicaid and the Uninsured, January 2009
Overall, more than one-third of the states (19 states) took steps last year to increase access to health coverage for low-income children, pregnant women, and parents —- including 15 states that authorized or implemented coverage expansions. At the same time, 10 states enacted at least one measure to restrict access.

Emerging Health Information Technology for Children in Medicaid and SCHIP Programs
Beth Morrow, The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured, November 2008
This report highlights states' innovative use of health information technology in their Medicaid and CHIP programs to improve their ability to reach and enroll eligible children, improve the quality of care for children, increase communications with families, and continue to modernize their programs. Although many of these efforts are still in their early stages, findings to date indicate improvements in access to care, care coordination, case management, and administrative efficiency.

Covering All Children: Issues and Experiences in State Policy Development
National Academy for State Health Policy, April 2008
This report briefly describes some of the most common strategies states are using to achieve universal children's coverage, including expanding public programs and creating other opportunities for families with uninsured children.

Making Real Gains for Children: Strategies for Reaching the More Than Six Million Uninsured Children Eligible for Medicaid/SCHIP
Center for Children and Families, June 2007
CHIP reauthorization in 2007 provided an opportunity for Congress to adopt policies that help children gain the coverage they need and for which they already qualify. This issue brief describes the barriers to covering additional uninsured but eligible children, as well as the options for addressing them.

Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices
Beth Morrow and Dawn Horner, The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, May 2007
Children fail to enroll and/or lose coverage primarily due to misinformation, difficult enrollment and renewal procedures, and inefficient administrative practices. This report explores how technological innovations can be applied to remove these impediments for Medicaid and CHIP enrollment and retention, while at the same time making the programs more efficient.

Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health
Covering Kids and Families National Program Office and the Southern Institute on Children and Families, April 2007
This report illustrates the many creative and collaborative ways the Covering Kids & Families coalitions worked to break down barriers to public health coverage for low-income children and adults. From 1997-2002, these coalitions encouraged the adoption of outreach, simplification, and coordination strategies across the states.

Reaching Out: Enrolling and Keeping Kids in the SCHIP Program
Alliance for Health Reform, February 2007
As Congress began to debate CHIP reauthorization in 2007, policymakers examined what prevents eligible children from enrolling in either CHIP or Medicaid. In February 2007, the Alliance for Health Reform held a briefing to discuss the success of state outreach, enrollment, and retention efforts, as well as the role of community and private sector partners.

Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance
Dawn Horner and Beth Morrow, Kaiser Commission on Medicaid and the Uninsured and The Children's Partnership, April 2006
By focusing efforts on those children that are eligible for public coverage, up to 95% of the uninsured children can be covered. This report details a 10-step plan for opening doorways to Medicaid and CHIP coverage for all of these eligible children.

Endnotes

[1] Analysis of March 2005 Current Population Survey using July 2004 state eligibility rules by L. Dubay, Urban Institute.
[2] M. Perry and J. Paradise, “Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents,” Kaiser Commission on Medicaid and the Uninsured (May 2007); and G. Kenney, J. Haley, & A. Tebay, "Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children Is High," Urban Institute, Snapshots of America’s Families III, no. 2 (July 2003).
[3] 1997, 1999, 2002 National Survey America’s Families by L. Dubay, Urban Institute.
[4] *op. cit.* (1).

[5] Calculations by the Center for Children and Families based on 2005 CPS using July 2004 eligibility rules.
[6] Washington State Department of Social and Health Services, 2005, updated 2006.
[7] Conversation with Ruth Kennedy, Medicaid Deputy Director/LaCHIP Director Louisiana Department of Health & Hospitals.
[8] See A. Grady, "Medicaid Citizenship Documentation," Congressional Research Services (May 16, 2007); P. Shin, B. Finnegan, L. Hughes, & S. Rosenbaum, "An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients," The George Washington University School of Public Health (May 7, 2007); and National Academy for State Health Policy, "Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors," (April 2007).
[9] See D. Cohen Ross, "New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up," Center on Budget and Policy Priorities (March 13, 2007); and Virginia Health Care Foundation, "Unintended Consequences: The Impact of New Medicaid Citizenship Documentation Requirements on Virginia's Children," (May 24, 2007).
[10] D. Horner, J. Guyer, C. Mann & J. Alker, "The Children's Health Insurance Program Reauthorization Act of 2009 Overview and Summary," Georgetown University Center for Children and Families (February 2009).
[11] J. Holahan, A. Cook, & L. Dubay, "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?," Kaiser Commission on Medicaid and the Uninsured (February 2007).
[12] *op. cit.* (2).
[13] *op. cit.* (9).
[14] *op. cit.* (2).
[15] 42 CFR 457.350
[16] 42 CFR 457.80
[17] Letter from Health Care Financing Administration to State Medicaid Directors, April 7, 2000.
[18] 42 CFR 435.906
[19] "Supporting Families in Transition, A Guide to Expanding Health Coverage in the Post-Welfare Reform World," Health Care Financing Administration, n.d.
[20] *op. cit.* (10).
[21] *ibid.*
[22] *ibid.*

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