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CHIP Outreach Funds Are Available to Prevent Children from Becoming Uninsured: Few States Report Using Them

by Tricia Brooks and Margaux Johnson-Green

Introduction

Since the beginning of the COVID-19 public health emergency (PHE) in March 2020, states have been required to keep children, low-income families, and adults continuously covered in Medicaid. Recognizing the dual public health and economic crises, Congress established the Medicaid continuous coverage protection in the Families First Coronavirus Response Act (FFCRA) as part of a fiscal relief package that boosted the Federal Medical Assistance Percentage (FMAP) for Medicaid expenditures by 6.2 percentage points during the PHE. A recent analysis by the Kaiser Family Foundation illustrated that the bump in federal funding has accomplished what was intended: protect coverage for low-income children and families and provide appropriate fiscal relief to the states during an unprecedented public health emergency.[1]

Between February 2020 and January 2022, child enrollment in Medicaid and the Children's Health Insurance Program (CHIP) grew by 14.4 percent (over 5.2 million children) as a result of the pandemic's impact on employment and private coverage coupled with the continuous coverage provision and the countercyclical nature of Medicaid.[2] And there are positive signs that the child uninsured rate decreased during this time, illustrating the correlation between stable coverage and uninsured rates. According the Centers for Disease Control and Prevention's National Health Interview Survey (NHIS) Early Release, the uninsurance rate for children under age 18 fell from 5.1 to 4.1 percent between 2020 and 2021.[3]

What lies ahead when the public health emergency ends and the continuous coverage protection is lifted? When states begin to renew eligibility for all Medicaid enrollees, 6.7 million children or more could be at risk for a disruption in coverage.[4] Those who follow Medicaid policy recognize the enormity of the task ahead and the threat it poses to health insurance for low-income children and families. To minimize the potential for significant coverage losses, it is critical to apply the lessons learned from decades of efforts to reduce the rate of uninsurance among children, which include policy simplification, outreach, consumer assistance, and coordination across public coverage programs.

This analysis is intended to highlight the requirements for, and opportunities to, boost outreach, consumer assistance, and coordination of coverage for children covered in Medicaid and CHIP using CHIP administrative funds that qualify for an enhanced federal match.

In preparing this brief, we examined the CHIP Annual Financial Management Reports (FMR) for 2018 through 2020. The FMRs are compiled by the Centers for Medicare & Medicaid Services (CMS) from each state's quarterly reporting of CHIP expenditures and posted on Medicaid.gov.[5]

Summary of Key Findings

- **Almost all states can boost outreach and consumer assistance without hitting the 10 percent cap on overall CHIP administrative expenses.**
- **States are required by law to conduct outreach to families of children likely to be eligible for CHIP, Medicaid, or other public coverage but few states consistently report outreach expenditures.**
- **States should focus more funding and resources on children of color and households with limited English proficiency who historically have higher uninsured rates.**

Key Findings

- **Almost all states can boost outreach and consumer assistance without hitting the 10 percent cap on overall CHIP administrative expenses.**[6] The majority of states have ample room to significantly increase outreach and consumer assistance. In fact, in 2020, 40 states had administrative expenses that were 5 percent or less of total CHIP expenditures (see Figure 1 and Appendix table 1). This means that states can leverage additional federal funding to cover between 69 percent and 85 percent of costs associated with public education, outreach and community-based assistance to help with Medicaid renewals and transitions between Medicaid and separate CHIP programs.
- **Although all states are required by law to conduct outreach to families of children likely to be eligible for CHIP or Medicaid and assist them in enrolling their children, less than one-third of states (13) reported direct expenditures for outreach in the 2020 CHIP Annual Financial Management Report (FMR).** Only 11 of those states (AL, CO, IN, IA, MD, NY, OR, PA, VA, VT and WY) consistently reported outreach expenditures in each of the three years included in the analysis—2018 to 2020 (see Appendix table 2). While it may be that other states include outreach expenses in their general administrative costs, without transparency in these data, it is unclear if or to what extent states are conducting outreach and meeting their statutory obligation.
- **States should focus more funding and resources on children of color and households with limited English proficiency who historically have higher uninsured rates.**

  Only one state (OR) reported outreach expenditures focused on American Indian and Alaska Native children (AI/AN), even though these expenditures do not count toward the 10 percent CHIP administrative cap. Native American children are nearly 2.5 times more likely to be uninsured compared to the national uninsured rate for all children (13.8 percent compared to 5.7 percent in 2019). Yet, none of the 10 states with the highest number of AI/AN children (AK, AZ, CA, MT, NM, NC, OK, SD, TX, and WA) reported direct outreach expenditures focused on Native children.[7]

  Additionally, only 1 in 4 states report expenditures for interpretation and translation, which are essential for families with limited English proficiency (see Appendix table 3). A lack of access to language supports and culturally-competent consumer assistance, in addition to the effects of anti-immigration policy, are primary reasons Latino children are more than twice as likely to be uninsured compared to non-Latino kids (9.3 percent compared to 4.4 percent in 2019).[8]

As noted above, it may be that states report such expenditures as general administrative expenses but without accurate reporting, it is difficult to assess where and how well states are investing in outreach and supporting the needs of diverse families. These data, along with a scan of reporting on outreach in CHIP state plans and annual reports, suggest that much more attention needs to be focused on ensuring that states maximize opportunities to educate and assist families in enrolling and retaining Medicaid and CHIP, particularly for children of color.

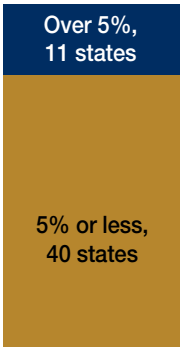

Figure 1.
Number of States with Share of CHIP Administrative Expenses Above and Below 5 Percent of Total CHIP Expenditures

CHIP administrative expenses are capped at 10 percent of total CHIP expenditures.

Source: CCF analysis of 2020 CHIP Financial Management Reports, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Background

When CHIP was enacted in 1997, 5 million uninsured children were eligible but not enrolled in Medicaid, despite the previous decade's Medicaid eligibility expansions for children. CHIP's high profile and bipartisan popularity ushered in a new urgency to reducing the number of uninsured children, spurring states to build consumer awareness by branding their programs, conduct marketing and outreach, build community partnerships, and test procedural simplifications that improve administrative efficiency while boosting enrollment and retention. Importantly, CHIP was required to coordinate with Medicaid, resulting in a decisive "welcome mat" effect—meaning uninsured children eligible for Medicaid were connected to coverage.

By law, states are required to conduct outreach to families of uninsured children and assist them with any public or private coverage option. Outreach expenditures combined with CHIP administrative costs and Health Services Initiatives cannot exceed 10 percent of total CHIP expenditures. Outreach activities qualify for the enhanced federal CHIP match, which ranges from 65 – 85 percent by state. During the PHE, states also receive an extra 4.34 percentage points in CHIP match up to the statutory cap of 85 percent, although the FFCRA continuous coverage protection does not apply to children or pregnant women covered in CHIP.

States are also expected to report and assess outreach activities as follows:

- **State CHIP Plan:** In order to be eligible for federal CHIP funding, each state must submit a Title XXI plan for approval by the Secretary that details how the state intends to use the funds and fulfill other requirements under the law and regulations. Congress conveyed the importance of outreach by explicitly requiring each state to articulate and assess its outreach strategies in the state's CHIP Plan (see text box).[9]
- **CHIP Annual Report:** States must assess the operation of their separate CHIP and Medicaid expansion programs and the progress made to reduce the number of uncovered, low-income children.[10] The annual report collects information about programmatic changes (including outreach), performance goals, operations, financing, challenges and accomplishments.
- **CMS-21 Quarterly Expenditures Report:** States submit an accounting of actual recorded expenditures on this form, include an itemization of costs for outreach, as well as language translation and interpretation services.[11]

CHIP Statutory and Regulatory Requirements on Outreach and Coordination

Social Security Administration Title 2102(c)

Outreach and Coordination – A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) Outreach – Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

(2) Coordination with other health insurance programs – Coordination of the administration of the State program under this title with other public and private health insurance programs.

42 Code of the Federal Register Section 457.90

Outreach.

(a) Procedures required. A State plan must include a description of procedures used to inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs of the availability of the programs, and to assist them in enrolling their children in one of the programs.

(b) Examples. Outreach strategies may include but are not limited to the following:

(1) Education and awareness campaigns, including targeted mailings and information distribution through various organizations.

(2) Enrollment simplification, such as simplified or joint application forms.

(3) Application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

- **CHIP Financial Management Report:** CMS aggregates quarterly CMS-21 data and reports annual expenditures separately for these categories: CHIP-funded Medicaid expansion (M-CHIP), separate CHIP, and CHIP adjustments for the 11 qualifying states that expanded Medicaid to 185 percent FPL prior to CHIP enactment.[12]

A scan of these documents suggests that, in many states, the content is incomplete or outdated. For example, a number of states omit responses to the five questions in the outreach section of their CHIP annual reports. This illustrates the need for both state and federal officials to take steps to ensure that state plans and the annual reporting accurately reflect current state outreach strategies and practices.

There is no doubt that the nation's success in insuring children can be directly attributed to efforts to enroll and retain eligible children and low-income families in Medicaid and CHIP. While there are many factors that impact enrollment, outreach and consumer assistance are essential elements of the nation's success in insuring children as many studies have shown.[13] Between 2008 and 2016, the rate of uninsurance among children declined by more than half from 9.7 to 4.7 percent,[14] while the participation rate in Medicaid and CHIP increased from 81.2 to 93.4 percent.[15]

History also illustrates the reverse. The Trump administration dramatically cut marketing, outreach, and consumer assistance grants from $163 million in 2016 to $20 million in 2018.[16] During that time, states were encouraged by CMS to implement policies known to suppress enrollment and increase churn in Medicaid including work reporting requirements and periodic data checks.[17] Moreover, Trump's public charge policies had a chilling effect on enrollment of eligible immigrant children. Between 2016 and 2019, the child uninsured rate increased from 4.7 to 5.7 percent,[18] while the participation rate in Medicaid and CHIP declined from 93.4 to 91.9 percent.[19]

Conclusion

The unwinding of the continuous coverage protection is expected to be the largest single public coverage enrollment event in history affecting children and their families. Half of the nation's children access health care through Medicaid and CHIP, and as many as 1 in 5 could be at risk for a gap or loss of coverage at the end of the PHE. While the continuous coverage protection does not apply to children enrolled in separate CHIP programs (34 states), the statute and regulations are clear that CHIP funding can be used to connect children with any public or private insurance option. If states act now, there is time to secure the additional FFCRA federal funding (see Appendix table 4) to develop materials, commence marketing and outreach campaigns, boost funding for navigators and assisters, and provide grants to community-based organizations that serve at-risk populations, including rural communities and families of color.

With the end of the public health emergency protections looming, it is urgent for states to immediately re-examine their current strategies and make plans to keep eligible children enrolled in public coverage by boosting outreach and consumer assistance. As states prepare to return to routine eligibility and enrollment operations, all available resources must be deployed to preserve the gains in coverage for children and low-income families.

The pandemic and economic turmoil have taken a big toll on children and families and the impact will linger long after the PHE is lifted. States can cushion the blow by leveraging CHIP outreach funding to ensure no child eligible for public coverage falls through the cracks and becomes uninsured.

Acknowledgments

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Appendix Table 1. Administrative Expenses as a Share of Total CHIP Expenditures by State, FY2018-2020

State	2018	2019	2020
Alabama	4.01%	2.91%	2.67%
Alaska	10.00%	10.00%	9.98%
Arizona	4.30%	4.83%	4.72%
Arkansas	0.29%	0.83%	0.64%
California	1.68%	1.37%	1.51%
Colorado	2.54%	3.12%	2.65%
Connecticut	10.00%	10.00%	10.00%
Delaware	3.29%	2.82%	2.69%
District of Columbia	3.97%	3.21%	1.74%
Florida	5.65%	4.64%	4.23%
Georgia	5.88%	4.72%	4.28%
Hawaii	4.40%	5.84%	5.36%
Idaho	5.16%	2.94%	3.78%
Illinois	7.08%	5.18%	4.20%
Indiana	2.74%	4.52%	3.25%
Iowa	8.15%	6.72%	2.54%
Kansas	7.89%	7.19%	7.39%
Kentucky	1.77%	1.65%	1.61%
Louisiana	3.93%	3.86%	3.91%
Maine	3.78%	5.13%	4.47%
Maryland	4.11%	5.47%	5.13%
Massachusetts	2.55%	3.71%	3.25%
Michigan	2.99%	1.96%	1.15%
Minnesota	8.94%	8.87%	3.00%
Mississippi	1.26%	1.34%	1.60%
Missouri	2.11%	1.88%	1.80%
Montana	4.96%	4.43%	6.70%
Nebraska	2.50%	2.53%	2.79%
Nevada	3.34%	5.30%	3.80%
New Hampshire	0.05%	0.04%	0.01%
New Jersey	2.96%	2.88%	3.29%
New Mexico	1.79%	2.14%	2.40%
New York	2.46%	2.49%	1.96%
North Carolina	2.65%	2.80%	3.24%
North Dakota	8.46%	7.22%	8.62%
Ohio	6.31%	6.59%	5.50%
Oklahoma	3.45%	3.45%	3.47%
Oregon	2.78%	3.30%	3.58%
Pennsylvania	1.50%	2.00%	1.65%
Rhode Island	2.67%	4.41%	4.83%
South Carolina	6.79%	7.06%	4.30%
South Dakota	1.67%	1.45%	1.60%
Tennessee	4.35%	6.18%	3.03%
Texas	4.80%	4.75%	3.71%
Utah	4.69%	5.33%	4.95%
Vermont	8.68%	8.08%	7.98%
Virginia	7.05%	5.01%	6.18%
Washington	1.24%	2.13%	0.85%
West Virginia	5.54%	5.08%	7.36%
Wisconsin	6.24%	5.68%	5.00%
Wyoming	1.92%	3.19%	2.55%

Source: CCF Analysis of CHIP Annual Financial Management Reports, FY2018-2020, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Appendix Table 2.1. States with Outreach Expenditures Reported, FY2018-2020

State	2018	2019	2020
Alabama	$190,131	$257,633	$201,055
Colorado	$552,544	$535,406	$558,921
District of Columbia	$0	$0	$363,259
Indiana	$3,739,161	$2,437,777	$5,109,486
Iowa	$663,405	$599,881	$589,648
Maryland	$3,402,749	$2,943,583	$3,755,678
New York	$1,729,625	$1,868,682	$1,700,927
Oregon	$400,247	$436,168	$475,708
Pennsylvania	$2,643,631	$3,159,466	$1,009,664
Vermont	$167,068	$265,828	$274,473
Virginia	$766,851	$931,192	$1,111,356
Washington	-$5,087	$0	$745,303
Wyoming	$65,179	$44,494	$13,765

Appendix Table 2.2. States with No or Negative Outreach Expenditures Reported, FY2018-2020

State	2018	2019	2020
Alaska	$0	$0	$0
Arizona	$0	$0	$0
Arkansas	$0	$0	$0
California	$0	$0	$0
Connecticut	$0	$0	$0
Delaware	$0	-$43,211	$43,211
Florida	$0	$0	$0
Georgia	$0	$0	$0
Hawaii	$0	$0	$0
Idaho	$0	$0	$0
Illinois	$0	$0	$0
Kansas	$0	$0	$0
Kentucky	$0	$0	$0
Louisiana	$0	$0	$0
Maine	$0	$0	$0
Massachusetts	$11,482	-$11,482	$0
Michigan	-$2	$0	$0
Minnesota	$0	$0	$0
Mississippi	$0	$0	$0
Missouri	$0	$0	$0
Montana	$0	$0	$0
Nebraska	$0	$0	$0
Nevada	$0	-$609,280	$0
New Hampshire	$0	$0	-$20
New Jersey	$0	$0	$0
New Mexico	$0	$0	$0
North Carolina	$0	$0	$0
North Dakota	$0	$0	$0
Ohio	$0	$0	$0
Oklahoma	$0	$0	$0
Rhode Island	$0	$0	$0
South Carolina	$0	$0	$0
South Dakota	$0	$0	$0
Tennessee	$0	$0	$0
Texas	$0	$0	$0
Utah	$0	$0	$0
West Virginia	$0	$0	$0
Wisconsin	$0	$0	$0

Source: CCF Analysis of CHIP Annual Financial Management Reports, FY2018-2020, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Note: We assume the negative expenditures offset a prior reporting error and do not include states with offsetting negative and positive expenditures among states reporting outreach activities.

Appendix Table 3.1. States with Translation & Interpretation Expenditures Reported, FY2018-2020

State	2018	2019	2020
Illinois	$813.397	$308,453	$141,473
Louisiana	$39,962	$43,485	$78,457
Maine	$17,507	$18,516	$10,151
Michigan	$0	$869,292	$75,809
Minnesota	$88,262	$69,552	$91,018
Nevada	$54,428	$68,393	$100,553
New Hampshire	$19	$21	$0
New Jersey	$1,660,770	$2,646,135	$3,230,097
Oregon	$18,091	$3,705	$9,639
Pennsylvania	$3,607	$4,864	$5,406
Texas	$220,828	$0	$177,420
Virginia	$579	$0	$0
Washington	$1,210,280	$1,495,683	$1,228,915
Wyoming	$81	$0	$0

Appendix Table 3.2. States with No Translation & Interpretation Expenditures Reported, FY2018-2020

State	2018	2019	2020
Alabama	$0	$0	$0
Alaska	$0	$0	$0
Arizona	$0	$0	$0
Arkansas	$0	$0	$0
California	$0	$0	$0
Colorada	$0	$0	$0
Connecticut	$0	$0	$0
Delaware	$0	$0	$0
District of Columbia	$0	$0	$0
Florida	$0	$0	$0
Georgia	$0	$0	$0
Hawaii	$0	$0	$0
Idaho	$0	$0	$0
Indiana	$0	$0	$0
Iowa	$0	$0	$0
Kansas	$0	$0	$0
Kentucky	$0	$0	$0
Louisiana	$0	$0	$0
Maryland	$0	$0	$0
Massachusetts	$0	$0	$0
Michigan	$0	$0	$0
Mississippi	$0	$0	$0
Missouri	$0	$0	$0
Montana	$0	$0	$0
Nebraska	$0	$0	$0
New Mexico	$0	$0	$0
North Carolina	$0	$0	$0
North Dakota	$0	$0	$0
Ohio	$0	$0	$0
Oklahoma	$0	$0	$0
Rhode Island	$0	$0	$0
South Carolina	$0	$0	$0
South Dakota	$0	$0	$0
Tennessee	$0	$0	$0
Utah	$0	$0	$0
Vermont	$0	$0	$0
West Virginia	$0	$0	$0
Wisconsin	$0	$0	$0

Source: CCF Analysis of CHIP Annual Financial Management Reports, FY2018-2020, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Appendix Table 4. CHIP Enhanced Federal Medical Assistance Percentage (eFMAP)

State	FY 2022 (Oct 1, 2022 – Sept 30, 2023)	FY 2023 (Oct 1, 2023 – September 30, 2024)	
	eFMAP with FFCRA 4.34 percentage point bump through the quarter in which PHE ends	CHIP Enhanced Federal Medical Assistance Percentage (eFMAP)	eFMAP with FFCRA 4.34 percentage point bump through the quarter in which PHE ends*
United States	69.3%	65.0%	69.3%
Alabama*	85.0%	80.7%	85.0%
Alaska	69.3%	65.0%	69.3%
Arizona	83.4%	78.7%	83.0%
Arkansas	84.5%	79.9%	84.3%
California	69.3%	65.0%	69.3%
Colorado	69.3%	65.0%	69.3%
Connecticut	69.3%	65.0%	69.3%
Delaware	74.7%	70.9%	75.3%
District of Columbia	83.3%	79.0%	83.3%
Florida	77.1%	72.0%	76.4%
Georgia	81.1%	76.2%	80.6%
Hawaii	71.9%	69.2%	73.6%
Idaho	83.5%	79.1%	83.4%
Illinois	70.1%	65.0%	69.3%
Indiana	80.8%	76.0%	80.3%
Iowa	77.8%	74.2%	78.5%
Kansas	76.5%	71.8%	76.2%
Kentucky*	85.0%	80.5%	84.9%
Louisiana	82.0%	77.1%	81.4%
Maine	79.1%	74.3%	78.6%
Maryland	69.3%	65.0%	69.3%
Massachusetts	69.3%	65.0%	69.3%
Michigan	80.2%	75.3%	79.6%
Minnesota	69.7%	65.6%	69.9%
Mississippi*	85.0%	84.5%	85.0%
Missouri	80.8%	76.1%	80.4%
Montana	79.8%	74.9%	79.2%
Nebraska	74.8%	70.5%	74.9%
Nevada	78.2%	73.9%	78.2%
New Hampshire	69.3%	65.0%	69.3%
New Jersey	69.3%	65.0%	69.3%
New Mexico*	85.0%	81.3%	85.0%
New York	69.3%	65.0%	69.3%
North Carolina	81.7%	77.4%	81.7%
North Dakota	71.9%	66.1%	70.4%
Ohio	79.2%	74.5%	78.9%
Oklahoma	82.2%	77.2%	81.5%
Oregon	76.5%	72.2%	76.6%
Pennsylvania	71.2%	66.4%	70.7%
Rhode Island	72.8%	67.8%	72.1%
South Carolina	83.9%	79.4%	83.8%
South Dakota	75.4%	69.7%	74.1%
Tennessee	80.8%	76.3%	80.6%

Appendix Table 4. CHIP Enhanced Federal Medical Assistance Percentage (eFMAP) (cont'd)

State	FY 2022 (Oct 1, 2022 – Sept 30, 2023)	FY 2023 (Oct 1, 2023 – September 30, 2024)	
	eFMAP with FFCRA 4.34 percentage point bump through the quarter in which PHE ends	CHIP Enhanced Federal Medical Assistance Percentage (eFMAP)	eFMAP with FFCRA 4.34 percentage point bump through the quarter in which PHE ends*
Tennessee	80.8%	76.3%	80.6%
Texas	76.9%	71.9%	76.3%
Utah	81.1%	76.1%	80.5%
Vermont	73.9%	69.1%	73.4%
Virginia	69.3%	65.5%	69.8%
Washington	69.3%	65.0%	69.3%
West Virginia*	85.0%	81.8%	85.0%
Wisconsin	76.3%	72.1%	76.4%
Wyoming	69.3%	65.0%	69.3%
America Samoa	72.8%	68.5%	72.8%
Guam	72.8%	68.5%	72.8%
North Mariana Islands	72.8%	68.5%	72.8%
Puerto Rico	72.8%	68.5%	72.8%
U.S. Virgin Islands	72.8%	68.5%	72.8%

Sources: FY 2022: *Federal Register*, November 30, 2020 (Vol 85, No. 230), pp 76586-76589; FY 2023: *Federal Register*, November 26, 2021 (Vol 86, No. 225), pp 67479-67482; CCF analysis of eFMAP in states receiving additional federal reimbursment of 4.34 percentage point through the end of the quarter in which the PHE ends.

* CHIP eFMAP is capped at 85%.

Endnotes

[1] Williams, E., Rudowitz, R., and Corallo, B., "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends" (Washington, D.C.: Henry J. Kaiser Family Foundation, May 2022), available at https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/.

[2] Centers for Medicare and Medicaid Services, "December 2021 and January 2022 Medicaid and CHIP Enrollment Trends Snapshot," available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/dec-2021-jan-2022-medicaid-chip-enrollment-trend-snapshot.pdf.

[3] Cohen, R.A. et al., "Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2021" (Hyattsville, Maryland: National Center for Health Statistics, May 2022), available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202205.pdf.

[4] Alker, J. and Brooks, T., "Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them From Becoming Uninsured?" (Washington, D.C.: Georgetown University Center for Children and Families, February 2022), available at https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/.

[5] States submit quarterly CHIP expenditures on Form CMS-21 through the automated State Children's Health Insurance Program Budget and Expenditure system (CBES). CMS aggregates the quarterly reports into an Annual CHIP Financial Management Report posted by the agency, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

[6] In 2020, 49 states did not reach their 10 percent cap on CHIP administrative expenditures compared to 48 states in 2019 and 2018.

[7] Roygardner, L., Schneider, A., and Steiger, D., "Promoting Health Coverage of American Indian and Alaska Native Children" (Washington, D.C.: Georgetown University Center for Children and Families, September 2019), available at https://ccf.georgetown.edu/wp-content/uploads/2019/09/AI-AN-health-coverage.pdf.

[8] Whitener, K. and Corcoran, A., "Getting Back on Track: A Detailed Look at Health Coverage Trends for Latino Children" (Washington, D.C.: Georgetown University Center for Children and Families, June 2021), available at https://ccf.georgetown.edu/2021/06/08/health-coverage-trends-for-latino-children/.

[9] In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457.

[10] Under Section 2108(a) of the Social Security Act, states are required to assess the operation of their CHIP programs annually. CHIP Annual Reports are available at https://www.medicaid.gov/chip/reports-evaluations/index.html for 2017 through 2019.

[11] According to CMS, expenditures reported on CMS-21 primarily include those made to initiate and expand coverage to uninsured, low-income children in separate CHIP programs. However, this is not consistent across states. For example, Maryland, an M-CHIP state, consistently reported outreach expenditures between 2018 and 2020. And other M-CHIP states itemize specific administrative costs in the financial management reports.

[12] Qualifying states are those that expanded Medicaid coverage for children up to 185 percent FPL prior to the enactment of CHIP in 1997. These states may use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid financed uninsured children whose family income exceeds 150 percent FPL up to 20 percent of their CHIP allotment. For this analysis, Georgetown CCF combined expenditures for the three categories.

[13] See for example Pollitz, K., Tolber, J., and Hamel, L., et al., "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need" (Washington D.C.: Henry J. Kaiser Family Foundation, August 2020), available at https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/ and Assistant Secretary for Planning and Evaluation Office of Health Policy, "Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment," (October 2021), available at https://aspe.hhs.gov/sites/default/files/documents/b7c9c6db8b17c6fbfd6bb60b0f93746e/aspe-remaining-uninsured-outreach-enrollment.pdf.

[14] United States Census Bureau, "Table HIC-5 ACS. Health Insurance Coverage Status and Type of Coverage by State – Children Under 19, 2008-2019," (September 2020), available at https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/acs/hic05_acs.xlsx.

[15] Kenney, G. et al., "Gains for Children: Increased Participation in Medicaid and CHIP in 2009" (Washington, D.C.: Urban Institute, August 2011), available at https://www.urban.org/research/publication/gains-children-increased-participation-medicaid-and-chip-2009; Haley, J. et al., "Uninsurance Rose among Children and Parents in 2019" (Washington, D.C., Urban Institute, July 2021), available at https://www.urban.org/sites/default/files/publication/104547/uninsurance-rose-among-children-and-parents-in-2019.pdf.

[16] Source: S. Gollust, et al., "Health Insurance Television Advertising Content and the Fifth Open Enrollment period of the Affordable Care Act Marketplaces," *Health Affairs*, November 2018; K. Pollitz, et al., "Data Note: Further Reductions in Navigator Funding for Federal Marketplace States," Kaiser Family Foundation, September 2018.

[17] Brooks, T., Park, E., and Roygardner, L., "Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again" (Washington, D.C.: Georgetown University Center for Children and Families, May 2019), available at https://ccf.georgetown.edu/wp-content/uploads/2019/06/Enrollment-Decline.pdf.

[18] Alker, J. and Corcoran, A., "Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade," (Washington, D.C.: Georgetown University Center for Children and Families, October 2020), available at https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/.

[19] Haley, J. et al., "Uninsurance Rose among Children and Parents in 2019," op cit.