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Health Policy Brief

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Enrolling More Kids in Medicaid and CHIP. The federal government wants states to find and enroll about 5 million eligible, uninsured children. What actions are being taken? Will they work?

WHAT'S THE ISSUE?

Both Medicaid and the Children's Health Insurance Program (CHIP) offer health insurance coverage to children in low- and moderate-income families. Enrollment has been increasing, and 40 million children were insured by Medicaid or CHIP in 2009. However, an estimated 7.3 million children remained uninsured in 2008, nearly two-thirds of whom were eligible for these programs but were not enrolled.

In early 2010, the US secretary of health and human services, Kathleen Sebelius, issued a challenge to find and enroll approximately 5 million uninsured children eligible for Medicaid or CHIP. This brief describes recent efforts to increase enrollment in these programs and how that experience may inform enrollment efforts under the planned expansion of Medicaid in 2014.

WHAT'S THE BACKGROUND?

All 50 states and the District of Columbia offer both Medicaid and CHIP programs, but the structure and eligibility criteria differ from state to state.

Medicaid—which also serves pregnant women, people with disabilities, and low-income senior citizens—offers a comprehensive benefits package to the lowest income children.

CHIP covers children at higher income levels, but generally has a less comprehensive benefit package than does Medicaid.

Both programs are jointly financed by the state and federal governments, but the federal government pays a greater percentage of CHIP costs (called an "enhanced match") up to state-specific limits. Exhibit 1 shows health insurance coverage of children in 2008.

In all but four states (Alaska, Idaho, North Dakota, and Oklahoma), children in families with income up to 200 percent of the federal poverty level are covered under one of the two programs. In 24 states and the District of Columbia, children in families with income up to or exceeding 250 percent of the poverty level may qualify (Exhibit 2).

ENROLLMENT INCREASED, BUT ROOM FOR IMPROVEMENT: During the recent economic recession, enrollment of children in these programs increased substantially. In 2008, 1.7 million children gained coverage through Medicaid and CHIP. This increased coverage was associated with a reduction in the number of uninsured children, despite reductions in employer-sponsored coverage occurring during the same time.

Even with this progress, an estimated 7.3 million children were still uninsured in 2008, and 65 percent of them, close to 5 mil-

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5 million

Uninsured, eligible children
The federal government is seeking to find and enroll about 5 million uninsured children eligible for Medicaid or CHIP.

lion, were eligible for public coverage, mostly through Medicaid. What's more, many uninsured children who had been enrolled in one of the two programs lost Medicaid or CHIP coverage the following year, despite continuing to be eligible for coverage. This loss was commonly due to burdensome or complicated requirements on families to renew coverage.

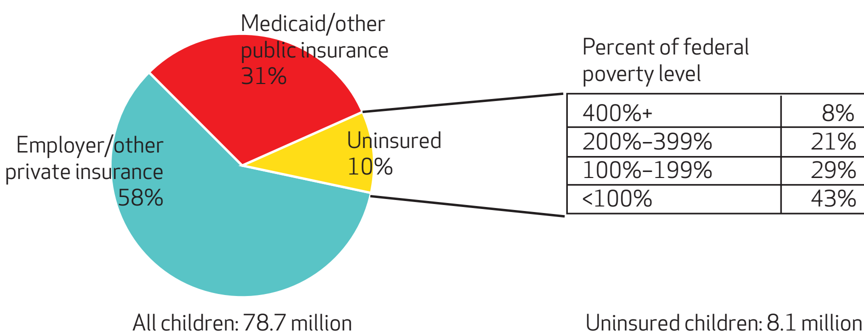
Overall, 82 percent of eligible children participate in Medicaid and CHIP, a participation rate that exceeds many other means-tested assistance programs, such as the State Nutrition Assistance Program ("food stamps"). There is significant variation in participation rates by states, ranging from 55 percent in Nevada to 95 percent in Massachusetts and the District of Columbia.

BARRIERS TO ENROLLMENT: A recent analysis published in *Health Affairs* found that the majority of eligible uninsured children are concentrated in the most populous states. In states with low participation rates, there appear to be many barriers to enrolling and retaining eligible children in the two programs.

Complicated application processes and requirements, including extensive and sometimes duplicate requirements for other programs, may discourage parents from applying. Enrollment can also be limited by parents' lack of familiarity with how to apply, inaccurate assumptions about whether or not their children would qualify, the perception that applying is difficult or humiliating, or that the programs provide limited or poor-quality care.

EXHIBIT 1

Health Insurance Coverage of Children, 2008



SOURCE Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 US Census Bureau Current Population Survey/Annual Social and Economic Supplement. **NOTES** Federal poverty level was $22,025 for a family of four in 2008. Data may not total 100% due to rounding. Numbers do not include adjustments for the underreporting of Medicaid/CHIP and likely overstate the number of uninsured children.

However, studies show that the vast majority of parents say that they would enroll their uninsured child in Medicaid or CHIP if the child was eligible.

Until 1996, Medicaid eligibility determinations for many children were closely tied to determinations for cash-assistance programs like welfare. However, even after Medicaid was unlinked from cash assistance, the complicated eligibility determination processes used in some states still resembled those that were used to determine eligibility for welfare. There was some improvement following the creation of CHIP in 1997, when many states streamlined and simplified their eligibility determination process for Medicaid.

WHAT'S IN THE LAW?

Congress reauthorized CHIP in 2009 through the Children's Health Insurance Reauthorization Act (CHIPRA). This law gives the US Department of Health and Human Services (HHS) and the states additional resources and tools to improve enrollment.

States that implement certain program features (described below) and exceed targets for Medicaid enrollment qualify for annual bonus payments. HHS also received $100 million to promote outreach and enrollment, including $10 million for a national outreach campaign and $90 million for grants to community-based organizations, states, schools, providers, and other entities so that they can develop enrollment strategies.

There is no simple solution to increase enrollment of eligible children in Medicaid or CHIP. In February 2010, HHS Secretary Sebelius challenged public and private stakeholders to collaborate in finding ways to enroll 5 million eligible uninsured children in Medicaid or CHIP. HHS identified potential strategies for achieving this goal based on successful state experiences, including using new technologies to reduce paperwork and administrative hassle for both families and states; creating numerous enrollment opportunities for families during their day-to-day activities; and partnering with other public agencies to maximize the use of existing data on families to determine if their children might be eligible for the programs.

RETAINING ELIGIBLE CHILDREN: States are also encouraged to find ways to limit disruptions in coverage when eligibility for Medicaid or CHIP must be redetermined. States are

required to redetermine eligibility at least once a year and some states do so more often. Because this process is often complicated or burdensome for parents, many eligible children drop out of the program, only to later reapply and be reenrolled. This process, called "churning," increases the administrative burden on states without helping them enroll more eligible children.

$100 million

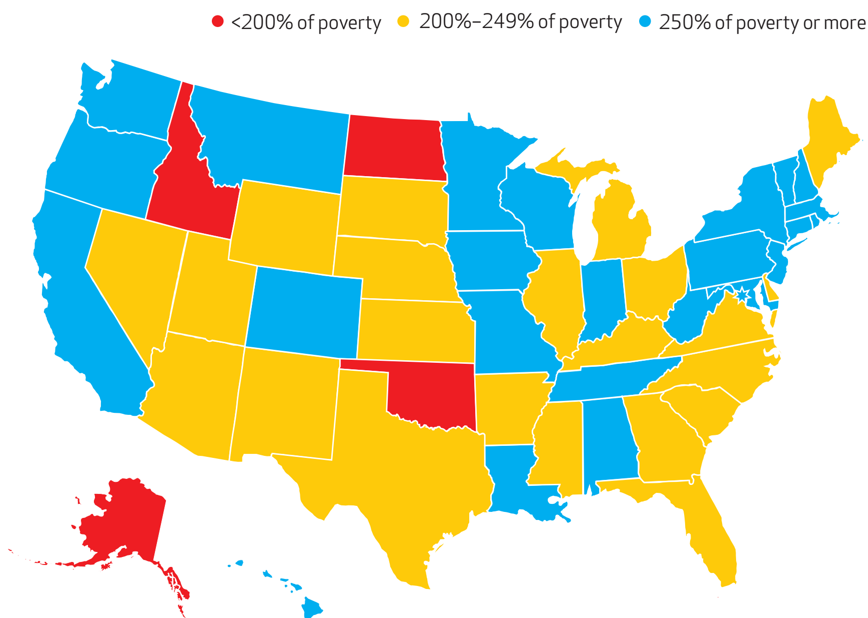
Funds for outreach
HHS has received $100 million to find and enroll uninsured children into Medicaid or CHIP.

Reducing barriers to identifying and retaining eligible children in Medicaid and CHIP has numerous potential benefits. The number of uninsured children is reduced. Children with coverage are more likely to receive recommended preventive services and needed care. Children with disrupted coverage are less likely to have a regular source of medical care, and appear to be at greater risk of being hospitalized for preventable conditions. Simplifying the application and renewal processes can reduce the administrative costs to the states.

Although many uninsured children are already eligible for public programs under current law, finding and enrolling them now will increase spending on Medicaid and CHIP at a time when most state budgets are severely stretched. Additionally, streamlining enrollment and retention processes may involve costly system changes.

EXHIBIT 2

Children's Eligibility for Medicaid/CHIP by Income, January 2011



SOURCE Kaiser Commission on Medicaid and the Uninsured, based on a national survey conducted by KCMU and the Georgetown University Center for Children and Families, 2011. **NOTES** Federal poverty level (FPL) was $18,310 per year for a family of three in 2010. Illinois uses state funds to cover children up to 300% FPL. Oklahoma has a premium assistance program for certain children up to 200% FPL. Arizona's CHIP program is currently closed to new enrollment.

A project called Maximizing Enrollment for Kids (sponsored by the Robert Wood Johnson Foundation, which also supports Health Policy Briefs) aims to help eight participating states increase enrollment and retention of eligible children in Medicaid and CHIP. This ongoing project has identified weaknesses in the eligibility and enrollment systems, including in automating and exchanging data contained in older computer systems.

Streamlining the administrative steps involved in making eligibility determinations may reduce red tape and costs, but it might also result in enrolling children who do not meet the eligibility criteria. As part of its efforts to improve accuracy in Medicaid, the federal government evaluates errors in each state Medicaid program, including errors in eligibility.

States must consider both the positive impact of a change on improving enrollment and the possibility that errors may increase. Experiences in states such as Louisiana, which uses multiple approaches for minimizing the burden on parents of renewing coverage and has an error rate that is a quarter of the national average, suggest that it is possible to appropriately balance these concerns.

QUALIFYING FOR BONUSES: The CHIP reauthorization law of 2009 identified eight potential program simplification measures for states to implement (Exhibit 3). To qualify for bonus payments, states must implement five of the eight measures and show an increase in Medicaid enrollment beyond what would have been expected due to the state's population growth of children and continuing difficult economic conditions.States that exceed the target enrollment by more than 10 percent qualify for the largest bonuses. In 2010, HHS awarded 15 states a total of $206 million in bonuses, more than twice the $75 million awarded to 10 states in 2009.

Many states that did not receive bonuses have already adopted one or more of these features. For example, almost all states have eliminated asset tests, which can disqualify children for coverage if their families own property such as a car. Almost all states also have eliminated in-person interviews of family members before deciding on eligibility for their children.

82%

Overall participation rate
82 percent of eligible children participate in Medicaid and CHIP, exceeding "food stamps" and many other federal assistance programs.

Other features are not as widely used. As of January 2011 only six states (Alabama, Iowa, Louisiana, Maryland, New Jersey, and Oregon) had been approved to use Express Lane Eligibility, a new option included in the CHIP reauthorization law that allows states to use findings from other programs when evaluating Medicaid eligibility. With this option, parents do not have to resubmit information that they have already provided to another government agency.

States may have a strong incentive to continue adopting simplified practices in order to become eligible for bonus payments. Researchers at the Georgetown University Center for Children and Families believe that economic conditions have already increased program rolls to the point that many states would meet the targets to qualify for bonuses.

WHAT'S NEXT?

Changes resulting from the Affordable Care Act heighten the need for efficient eligibility determinations. Beginning in 2014, Medicaid coverage will expand to cover individuals up to 133 percent of the federal poverty level and will include childless adults who are not currently eligible for coverage in most states, as well as additional parents in many states.

The law also includes new requirements for HHS and states to provide information and facilitate enrollment, including the creation of a single, streamlined application that states may use to allow individuals to apply for all health subsidy programs. The standards developed by HHS require that individuals seeking coverage be screened for all health subsidy programs—and processed through to enrollment—without requiring additional application forms or multiple eligibility determinations.

In general, states are expected to continue to improve their enrollment efforts, even though the severity of the budget crisis in many states may limit these activities. States are also preparing for new requirements under the Affordable Care Act. With the Medicaid expansion in 2014, stakeholders have identified potential investments needed to improve outreach efforts. These include refining messages to reach newly eligible populations; conducting outreach in new locations, such as job training programs and community colleges; and using data and technology to minimize the burden on applicants and the administrative resources needed to make enrollment determinations.

Expanded coverage for parents under Medicaid is also expected to improve enrollment and retention of eligible children who might otherwise not have received coverage. The Congressional Budget Office estimates that by 2019, 16 million more children and adults will be enrolled in Medicaid because of the expansion, a key factor leading to an estimated

EXHIBIT 3

Program Simplification Measures for Performance Bonuses Under CHIPRA

Measure	Description
Continuous eligibility in Medicaid and CHIP	Once children become eligible for program benefits, they remain so for 12 months.
Liberalization of assets and resource requirements	States either do not require asset tests for eligibility or, if they do, generally do not require documentation for Medicaid or CHIP eligibility.
Elimination of in-person interview	States do not require face-to-face interviews for determination or renewal of Medicaid or CHIP eligibility.
Same application and renewal forms	States use the same or interchangeable renewal forms and procedures for Medicaid and CHIP.
Automatic/administrative renewals	Parents or guardians receive pre-printed forms and are told that renewal is based on that information, unless otherwise provided (administrative redetermination). Or a state could make a redetermination based on information already available, either through the Medicaid file or other program, without sending out a renewal form (*ex parte* redetermination).
Presumptive eligibility	Children who appear to be eligible can be enrolled temporarily and receive benefits before full determination is made.
"Express Lane Eligibility"	States can rely on eligibility determinations from other need-based programs, such as the State Nutrition Assistance Program ("food stamps") or the National School Lunch Program to evaluate components of Medicaid and CHIP eligibility.
Program assistance subsidies	States subsidize premiums of employer-sponsored coverage for children who have access to such coverage and who also qualify for Medicaid or CHIP, when it is cost-effective to do so.

SOURCE US Department of Health and Human Services. **NOTE** CHIPRA is Children's Health Insurance Program Reauthorization Act of 2009 (PL 111-3).

increase from 83 percent to 94 percent in the share of the population with insurance.

The Medicaid expansion will also reduce the variation across states in eligibility for Medicaid and will put more pressure on eligibility and enrollment systems in states that currently have the most restrictive eligibility requirements. To encourage the use of technology to improve and coordinate access to insurance programs, HHS recently issued a proposed rule that would provide for a significant increase in federal support of eligibility systems improvements over the next five years.■

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