

Medicaid and SCHIP Participation Rates: Implications for New CMS Directive

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In August 2007, the Centers for Medicare and Medicaid Services (CMS) issued a new directive that required, among other things, that states achieve public health insurance participation rates of 95 percent among children living in families with income under 200 percent of federal poverty level (FPL) as a prerequisite for using State Children's Health Insurance Program (SCHIP) funds to cover children with family incomes above 250 percent of the FPL (Smith 2007). This brief provides background on Medicaid and SCHIP participation rates, discusses methodological issues related to measuring participation at the state level, and assesses recent statistics released by CMS. It shows that achieving 95 percent participation will be very difficult under current program rules and financing levels and indicates that there are serious methodological challenges associated with obtaining valid state-level participation rate estimates given the currently available data. Finally, it also shows, that while there is ambiguity about how CMS will be defining participation rates, the state-level estimates recently released by CMS are lacking in face validity and are methodologically flawed.

Background

In an effort to reduce uninsured rates among low-income children, unprecedented outreach and enrollment simplification efforts were made following the 1997 enactment of SCHIP (Dubay et al. 2007; Kenney and Chang 2004).¹ As a consequence, participation in public health insurance programs increased among children since the late 1990s, reaching over 75 percent overall and over 80 percent in Medicaid (Hudson and Selden 2007; Dubay et al. 2007).² Despite this progress, the national participation rate in Medicaid and SCHIP falls short of the 95 percent threshold.³ Participation rates in public health insurance programs are below 100 percent, not because people are not interested in enrolling in them—in fact, research consistently shows a very high willingness to enroll uninsured children in Medicaid and SCHIP—but because of knowledge gaps and administrative barriers to enrollment and retention (Haley and Kenney 2007; Kenney, Haley, and Tebay 2003, 2004; Sommers 2005). Moreover, programs that have achieved substantially higher participation are ones that use automatic or default enrollment strategies, which are not currently available to Medicaid and SCHIP programs (Dorn forthcoming; Dorn and Kenney 2006).

In addition, a number of federal policies present obstacles to participation (for example, the citizen documentation and identity requirements in the 2005 Deficit Reduction Act have made it more costly and time consuming to enroll in Medicaid). A number of federal policy changes are being proposed as part of SCHIP reauthorization that would provide states with new tools and sufficient federal resources to achieve higher participation among the low-income children who are eligible for Medicaid and SCHIP coverage but not yet enrolled (Congressional Research Service [CRS] 2007; Center for Children and Families [CCF] 2007a, b). Without those changes, very few states are likely to achieve participation rates close to 95 percent.

Data and Methodological Challenges

A number of methodological challenges are associated with estimating state-level participation rates for low-income children.⁴ First, administrative data do not provide accurate counts of both the number of low-income children enrolled in Medicaid and SCHIP at a point in time and the number of low-income children eligible for Medicaid or SCHIP at that same point in time, but who do not have private coverage. Second, while national surveys can provide estimates of the number of eligible children derived from imputations of eligibility for Medicaid and SCHIP coverage that are based on eligibility rules in place in each state, these estimates involve measurement error.⁵

Third, obtaining valid state-level estimates poses additional problems. While multiple surveys can be used to assess national participation rates on an annual basis, only one—the Current Population Survey (CPS)—has a sample frame designed to provide reliable state-level estimates. However, many states have small CPS samples of low-income children, which introduces considerable imprecision into annual or even biannual estimates (Kenney, Holahan and Nichols 2006; Blewett et al. 2004; Davern et al. 2004). Moreover, measurement problems have plagued CPS insurance estimates, raising additional concerns about the validity of state-level estimates (Kenney et al. 2006; CBO 2003).⁶ Given these methodological and data limitations, it will be important for CMS to provide evidence on the reliability and precision of the state-level participation estimates that it uses as the basis for approving or denying state SCHIP plans.

CMS Approach to Measuring Participation Rates

At this point, it is not clear how CMS will define participation rates under the new directive. In late August 2007, CMS released estimates that indicated that only nine states *failed* to meet the 95 percent participation rate standard. After providing this list (which did not include New York among the nine states), CMS released a set of statistics for all 50 states and the District of Columbia that indicated that New York had achieved a participation rate of 144 percent (CMS 2007). However, in September 2007, CMS notified New York that it was denying its State Plan Amendment to expand coverage to children with family incomes above 250 percent partly on the basis of not enrolling at least 95 percent of low-income children (Weems 2007). The denial letter did not include any information about the basis for this aspect of its determination.

While there is ambiguity about how CMS will assess whether states have met the participation rate criterion, the methodology used by the CMS to define participation rates in the documents that it has released is flawed. To obtain its estimates, CMS divided administrative totals of children who were ever enrolled in Medicaid and SCHIP over the course of a year by the estimated number of children with family incomes below 200 percent of the FPL from the CPS. There are numerous problems with this approach.

First, the CMS methodology is not useful for gauging how well states are doing with respect to covering low-income children eligible for Medicaid and SCHIP or for determining how many resources states would need to cover the remaining children who are eligible but uninsured, both of which require point-in-time estimates.

Second, there are numerous methodological problems with how the rates were calculated:

- The numerator double-counts some children who have moved between Medicaid and SCHIP during a year. It is not uncommon for children to move between the programs as their family income fluctuates (and, in some cases, as they grow older);
- The numerator includes children who were enrolled in Medicaid and SCHIP for as little as one day over the course of a year;
- The numerator and the denominator are inconsistent with one another in terms of time frame (ever enrolled over the course of a year vs. low-income at a point in time). To be consistent with the ever-enrolled estimate in the numerator, the denominator should reflect the number of children in families that have incomes under 200 percent of the FPL at any point over the course of the year—data not available on the CPS;
- The denominator does not exclude the millions of low-income children who have private coverage;
- The numerator includes children of all incomes who are eligible under a given state's rules while the denominator includes only those with incomes below 200 percent of the FPL;
- In some states, the numerator includes Medicaid enrollees aged 19 to 21 while the denominator includes children up to age 18; and
- No information is presented on the precision of the state-specific estimates.

Third, these estimates lack face validity. The method CMS uses yields a national rate of 120 percent, with rates over 100 percent in 39 states and a rate over 200 percent in one state. The implication is that *all* low-income children are enrolled in Medicaid or SCHIP at some point during the year in these states. Clearly, participation rates cannot exceed 100 percent. The fact that this method yields an average so far above 100 percent nationally and that over two-thirds of the states have participation rates above 100 percent suggests serious methodological flaws, as does CMS's failure to use its own participation rates in the one decision it has made applying its 95 percent participation standard.

In addition, these estimates are inconsistent with the fact that household surveys consistently find double-digit uninsured rates among low-income children. All three federally supported household surveys find substantial uninsurance among low-income children. For example, in the most recent CPS, almost one in five low-income children age 18 and under was reported to be uninsured and recent data from the National Health Interview Survey finds an uninsurance rate of 14 percent among low-income children (Urban Institute tabulations of the Current Population Survey 2007; Ku 2005). Furthermore, in Texas, which has a CMS estimate of over 100 percent participation, almost 3 in 10 low-income children lacked coverage in 2004–05 (Schwartz et al. 2007). These uninsurance rates indicate that participation among low-income children in Medicaid and SCHIP is far from 100 percent nationally.

Summary

The new CMS directive requiring that states enroll at least 95 percent of eligible children in families with income below 200 percent of the federal poverty line before using SCHIP funds to cover higher-income children raises a number of important issues. As demonstrated here, without adequate federal financing and a number of related federal policy changes, very few states are likely to reach 95 percent participation among low-income children. In addition, there are serious methodological challenges and data limitations that will need to be resolved before CMS can develop reliable state-level estimates as the basis for approving or denying state SCHIP plans.

Notes

1. States introduced numerous simplifications to their enrollment and renewal processes and invested in both mass media and community-based outreach.
2. The increases in Medicaid and SCHIP participation, in turn, contributed to declines in uninsured rates among children, particularly among those in low-income families, at a time when uninsured rates were rising for adults (CBO 2007; Kenney and Yee 2007).
3. This is not surprising given past experience in other means-tested government programs like Food Stamps and WIC, which have had even lower participation rates compared to public health insurance programs (U.S. GAO 2005).
4. Computing accurate participation rates requires valid estimates of both the number of low-income children enrolled in Medicaid and SCHIP at a point in time and the number of low-income children who are eligible at that same point in time but who do not have private coverage (see Selden et al. 2004; Hudson and Selden 2007; Dubay et al. 2002, 2007; Davidoff et al. 2004).
5. Eligibility simulations inherently involve measurement error because of inaccuracy in reporting of income and insurance coverage on national surveys and because of critical gaps in information (such as immigration status) that is used in the eligibility determination process (Kenney, Holahan, and Nichols 2006; Dubay 2007; Dubay, Haley, and Kenney 2002).
6. Until the CPS adopts a more straightforward insurance sequence that asks respondents about insurance coverage at the time of the survey, this will remain an issue. Ultimately, the American Community Survey (ACS), which has a much larger sample size than the CPS and which plans to include a point-in-time insurance coverage sequence in the 2008 round, may provide a mechanism for estimating more reliable state-level participation rates than are currently available. However, the reliability of the new ACS estimates will need to be assessed at the state and national levels.

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