Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children?

Timely Analysis of Immediate Health Policy Issues

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SUMMARY

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 gave states additional resources and tools aimed at improving participation in Medicaid and the Children's Health Insurance Program (CHIP). In 2007, five million uninsured children were eligible for Medicaid or CHIP, constituting 64 percent of all uninsured children. Nationwide, over 80 percent of eligible children participated in Medicaid/CHIP, but participation rates, as well as the characteristics of uninsured eligible children, vary dramatically across areas.

Efforts to streamline application and retention processes offer tremendous potential for increasing enrollment among the eligible children who are uninsured. Over 90 percent of low-income parents say they would enroll their uninsured child if he or she was eligible, but around half do not know that their child is eligible, do not know how to apply, or find the application processes difficult. In order to close coverage gaps, states may also need to undertake targeted outreach efforts aimed at teenagers, Hispanics, and other groups of children with lower than average participation rates, provide additional support for community-based application assistance, broaden their outreach strategies to include parents, and address existing barriers in their Medicaid and CHIP application and retention processes.

Since almost all uninsured low-income children live in families that participate in other government programs or file taxes, states have a number of promising vehicles for covering more eligible children. States can take advantage of new express lane provisions in CHIPRA to make use of more data-driven enrollment and retention processes in order to minimize burdens on families. This analysis indicates that states will likely succeed in further increasing participation and reducing uninsurance among children if they take steps to improve their enrollment and retention processes, and tailor their outreach strategies to the particular needs of the uninsured children who are eligible for coverage in their state. States will be aided in designing their outreach approaches by newly available data that provide detailed information about health insurance coverage at the state and local level.

However, uncertainty about the future role of Medicaid and CHIP in covering children combined with ongoing state budget difficulties may make states reluctant to move aggressively to cover more children in the near term. An extension of higher federal matching rates in Medicaid could mitigate this latter problem. Current health care reform proposals include a mandate requiring individuals to obtain health insurance coverage and expansions of Medicaid to cover more parents, both of which would likely increase participation among eligible children. These findings suggest that expanding Medicaid as a part of health care reform will be a successful strategy for reducing uninsurance, but that careful attention must be given to enrollment and retention processes so as to minimize gaps in coverage.

Introduction

According to new coverage estimates released in September 2009, the number of children lacking health insurance coverage declined by about 800,000 between 2007 and 2008, reaching its lowest level in over a decade.[2] In contrast, the number of uninsured adults rose by 1.5 million over this same time period. The reduction in uninsurance among children was accompanied by increases in public coverage through Medicaid and the Children's Health Insurance Program (CHIP). This gain in coverage for children was remarkable because uninsurance typically increases during recessionary periods.[3]

Since CHIP was enacted in 1997, all states have expanded eligibility for public coverage to children. By 2007, all but 9 states had eligibility thresholds for children that were 200 percent or higher of the federal poverty level (FPL).[4] In addition to the eligibility expansions enacted over the past decade, both Medicaid and CHIP programs adopted a number of policy changes aimed at increasing enrollment and retention in public coverage. Together

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these eligibility expansions and the increased outreach and enrollment simplification efforts led to increases in public coverage and decreases in uninsurance, particularly among low-income children, over the last decade.[5] The improvements in coverage for children were in sharp contrast to the growing uninsured rates experienced by adults over the same period.[6]

However, despite this progress, recent analysis indicates that an estimated five million uninsured children are eligible for Medicaid or CHIP coverage.[7] While states have adopted a host of policy changes aimed at increasing participation in Medicaid and CHIP over the last decade, barriers to enrollment and retention exist in many states, and very few states use mechanisms that automatically enroll and reenroll eligible children in public programs.[8] CHIPRA included a number of provisions aimed at increasing participation among children already eligible for Medicaid and CHIP, including new performance bonuses for states that adopt five of eight simplification/outreach processes and exceed Medicaid enrollment targets; $100 million for outreach and enrollment grants; higher federal match rates for translation and interpretation services; new options for express lane eligibility (which allows states to use data from other government programs when assessing eligibility for Medicaid and CHIP) and for complying with citizen documentation requirements. This brief examines the characteristics of the children who remain uninsured despite being eligible for Medicaid and CHIP and examines the prospects for enrolling them in public coverage. This analysis draws on estimates from 2007, providing the most up-to-date snapshot available on these children. It highlights both the challenges and opportunities facing states as they respond to the renewed focus on reducing uninsurance among eligible children as embodied in CHIPRA. The findings also have policy implications for current health care reform proposals, which build on Medicaid to cover a sizeable share of the uninsured.

Data and Methods

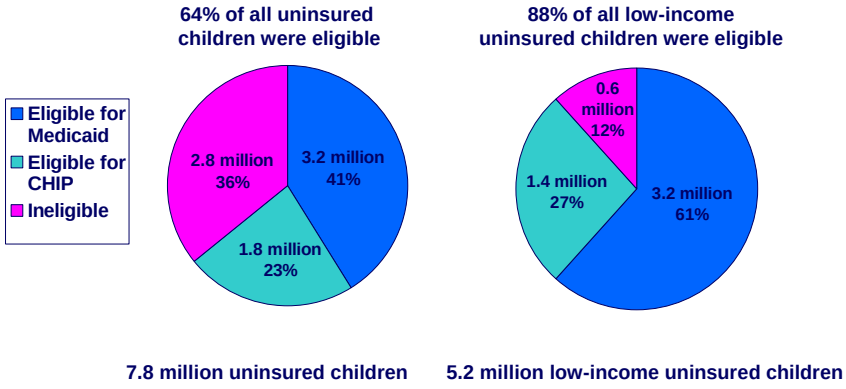
The main source of data for the analysis is the March 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS), representing income and health insurance coverage for 2007. This analysis relies on the Urban Institute's Health Policy Center Eligibility Simulation Model developed by Dubay and Cook to estimate the characteristics of the uninsured children who are eligible for Medicaid and CHIP.[9,10] The model simulates eligibility for Medicaid and CHIP in each state, using available information on 2007 eligibility guidelines for each program and state, including the amount and extent of disregards.[11,12] Family-level characteristics used in determining eligibility, such as income, are based on the health insurance unit (HIU).[13] Estimates of insurance coverage are adjusted to account for the underreporting of Medicaid on the CPS.[14] In this analysis, we interpret estimates of Medicaid and CHIP coverage as point-in-time, i.e., average monthly estimates for 2007.[15] The CPS includes questions on coverage through Medicaid and CHIP which we combine together and classify as Medicaid/CHIP coverage.[16]

We examine the uninsured children who are eligible for Medicaid/CHIP with respect to a number of characteristics, including their age, race/ethnicity, citizenship status, family income, family type, and region. We also examine participation rates and uninsured rates in Medicaid and CHIP by those same characteristics. Our participation rates are defined as the ratio of Medicaid and CHIP enrollees to Medicaid and CHIP enrollees plus the number of uninsured children who are eligible for coverage. Our core participation rates do not include the children who are reported to have public coverage but for whom no eligibility pathway can be determined.

We also present analyses of changes in coverage among all children and among low-income children (defined as children with family income less than 200 percent of the FPL) between 2007 and 2008. That analysis uses unadjusted CPS data that do not account for the underreporting of Medicaid and CHIP on the CPS. Because respondents can report more than one type of coverage on the CPS, overage is defined using a hierarchy that puts Medicaid/CHIP coverage at the top, followed by employer sponsored coverage, other federal coverage, and private non-group coverage.

In addition, we examine perceptions of Medicaid and CHIP among low-income parents with uninsured children using the 2007 Kaiser Survey of Children's Health Coverage.[17] We use the sample of low-income parents with incomes below 200 percent of the FPL as a proxy to represent the parents with uninsured children who are eligible for coverage. The survey is a nationally representative survey of parents with incomes below 300 percent of the FPL that was fielded in the last quarter of 2007. We present estimates from the survey on low-income parents with an uninsured child of awareness of Medicaid and CHIP and, for those who are aware of these programs, their willingness to enroll their child, their opinions about the program, whether they think their child is eligible for Medicaid/CHIP coverage, whether they know how to enroll their child, whether they view the enrollment processes as difficult, and whether they know where to get more information about the programs. We also examine the extent to which low-income families with uninsured children reported that they participated in other government programs, including the National School Lunch Program, the Supplemental Program for Women, Infants, and Children (WIC), Food Stamps, Social Security Disability Income (SSDI), Housing Assistance, and Temporary Assistance to Needy Families (TANF). In addition, we present estimates of the share of eligible uninsured children whose families file annual income tax forms based on a previous analysis.[18]

Exhibit 1: Eligibility of Uninsured Children for Medicaid/CHIP Coverage, 2007



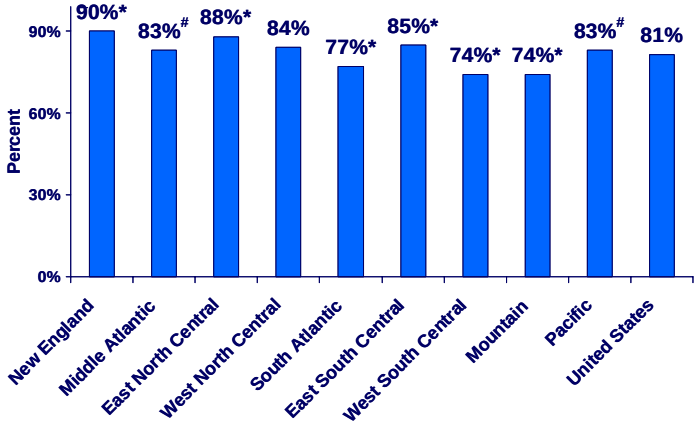
Note: Low-income children are defined as those with family income less than 200 percent of the federal poverty level. Uninsured estimates reflect an adjustment for the underreporting of public coverage on the CPS. Data may not sum to 100% due to rounding.
Source: Health Policy Center Simulation Eligibility Model based on data from the 2008 ASEC to the CPS

Findings

As of 2007, an estimated 5 million uninsured children were eligible for Medicaid or CHIP but not enrolled, constituting 64 percent of all uninsured children and 88 percent of all low-income uninsured children (Exhibit 1). This implies that achieving full participation in Medicaid and CHIP could reduce the number of uninsured children by 64 percent and the number of low-income uninsured children by 88 percent. More uninsured children are eligible for Medicaid than for CHIP (41 percent vs. 23 percent) which is consistent with findings from past studies and points to the importance of improving Medicaid enrollment and retention processes.[19] While public programs could reduce uninsurance by substantial amounts for children from all racial/ethnic backgrounds, the impacts of increasing take up in Medicaid/CHIP vary. Achieving full participation in Medicaid/CHIP could reduce the number of uninsured black children by 77 percent. By comparison, enrollment of all eligible white and Hispanic uninsured children could reduce the number of uninsured children by only about 60 percent and 65 percent, respectively (data not shown).

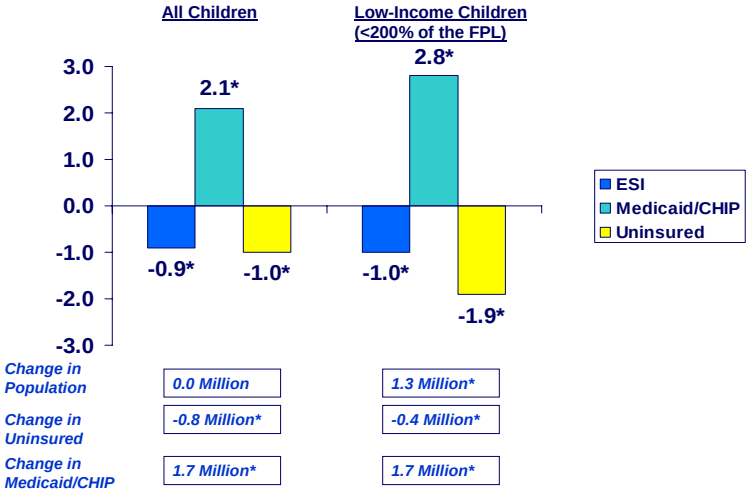
Nationally, participation was high in both Medicaid and CHIP. Overall, 81 percent of all eligible children participated in Medicaid/CHIP in 2007, with participation rates found to be 84 percent among Medicaid eligible children and 71 percent among CHIP eligible children (data not shown). These rates are substantially higher than the participation rates found in other government programs

Exhibit 2: Medicaid/CHIP Participation Rates by Census Division



*Indicates difference from national estimate is statistically significant (at the .05 significance level).
#Indicates difference from national estimate is statistically significant (at the .10 significance level).
Note: Participation rates reflect coverage that has been adjusted for the underreporting of public coverage on the CPS.
Source: Health Policy Center Eligibility Simulation Model based on data from the 2008 ASEC to the CPS

Exhibit 3: Percentage Point Changes in Health Insurance Coverage of Children, 2007-2008



*Indicates change between 2007 and 2008 is statistically significant (at the .05 significance level).
Note: Estimates do not reflect an adjustment for the underreporting of public coverage on the CPS.
Source: Urban Institute tabulations of the 2008 and 2009 ASEC to the CPS.

and reflect substantial growth over the last decade, particularly in CHIP.[20] However, participation rates varied substantially across census divisions, ranging from a low of 74 percent in the Mountain and West South Central divisions to a high of 90 percent in New England (Exhibit 2).[21] In addition, participation varied across states within census divisions (data not shown.) For instance, in the South Atlantic division, the share of children participating in Medicaid/CHIP varied across states by over 25 percentage points.

It is likely that participation in Medicaid/CHIP among children is even higher now given that the number of low-income uninsured children fell between 2007 and 2008 according to the new census data (Exhibit 3). The decline of 400,000 low-income uninsured children occurred despite a 1.3 million increase in the total number of low-income children. The share of low-income children without coverage declined by 1.9 percentage points between 2007 and 2008 while the share with Medicaid/CHIP coverage increased by 2.8 percentage points. Not only does this imply an increase in participation rates among eligible children, but it also suggests that Medicaid and CHIP prevented children from becoming uninsured, at least early in the current recession.

Characteristics of Uninsured Medicaid/CHIP Eligible Children. The uninsured children who are eligible for Medicaid or CHIP coverage but not enrolled are diverse in terms of their age, racial and ethnic composition, income, and family structure (Exhibit 4). Eligible but uninsured children were fairly evenly split across the three age groups examined, although children ages 13 to 18, who constituted 35 percent of the total, were overrepresented due to their lower participation in Medicaid/CHIP.

Nationwide, nearly as many non-Hispanic white children (1.8 million) as Hispanic children (1.9 million) were uninsured despite being eligible for Medicaid/CHIP, while non-Hispanic black children and children of other races made up the remainder of eligible but uninsured children, at 900,000 and 400,000 children, respectively. However, the racial and ethnic composition of the uninsured children who were eligible for coverage varied substantially across census regions (Exhibit 4). White children comprised the single largest group of uninsured children who are eligible for Medicaid/CHIP in the Northeast and the Midwest, at 51 and 57 percent, respectively, while Hispanics comprised the single largest group in the West and South, at 57 and 40 percent, respectively. Black children constituted just 6 percent of the uninsured eligible group in the West but made up 18 to 24 percent of this group in the other regions.

Hispanic children had participation rates that were lower than non-Hispanic white and black children (78 vs. 82 and 85 percent, respectively). The lower participation rates found among Hispanic children may be related to the fact that Hispanic children are more likely to have non-citizen parents (data not shown), which is associated with lower participation in Medicaid/CHIP.

An estimated 39 percent of eligible uninsured children lived in two-parent families, 42 percent were in two-parent families, and 19 percent were living with adults other than their parents or on their own. Lower participation rates were found among the children in this last group.

Uninsured children who were eligible for Medicaid/CHIP were concentrated in low-income families. Over 90 percent lived in families with income less than 200 percent of the FPL, and over half lived below 100 percent of the

Exhibit 4

Characteristics of Uninsured Children Who are Eligible for Medicaid/CHIP and Participation and Uninsured Rates Among Eligible Children

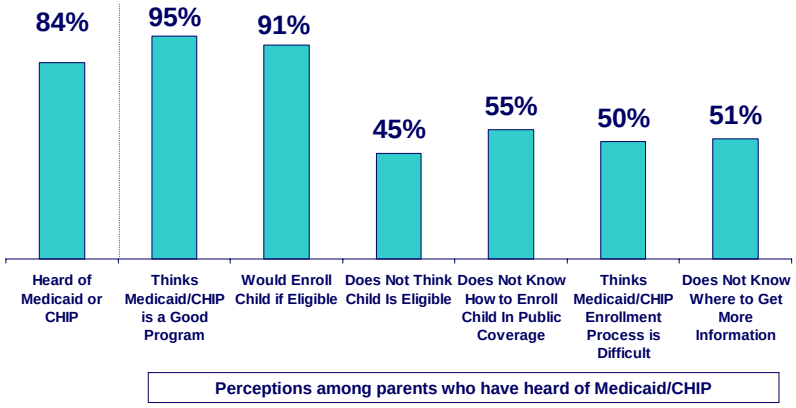
	Eligible Uninsured (millions)	Percent of Eligible Uninsured	Participation Rate (Eligible enrollees)	Uninsured Rate Among Eligible Children
Total	**5.0**	**100.0%**	**81.2%**	**13.5%**
Age				
0-5	1.6	31.7%	84.4% *	12.1% *
6-12	1.6	32.8%	81.6%	12.8%
13-18	1.8	35.5%	76.4% *	15.8% *
Race/Ethnicity				
White only (non-Hispanic)	1.8	35.8%	81.7%	11.4% *
Black only (non-Hispanic)	0.9	18.2%	85.4% *	11.3% *
Hispanic	1.9	38.5%	77.9% *	17.9% *
Other	0.4	7.4%	79.7%	14.5%
Citizenship				
U.S. citizen with one or more non-citizen parents	1.2	23.1%	77.5% *	18.7% *
U.S. citizen with citizen parents	2.8	55.9%	84.1% *	10.7% *
U.S. citizen, not residing with parents	0.9	17.1%	74.3% *	21.3% *
Non-U.S. citizen	0.2	3.9%	66.8% *	28.2% *
Family Poverty Level				
<100%	2.6	51.3%	83.9% *	14.6% #
100-199%	2.0	40.1%	77.9% *	13.7%
200-299%	0.4	8.1%	72.3% *	8.8% *
300%+	0.0	0.6%	74.1%	7.3% *
Family Type				
1 Parent	2.1	42.2%	84.5% *	12.0% *
2 Parents	2.0	39.1%	79.3% *	12.7%
Children living independently	0.9	18.7%	73.2% *	22.2% *
Parental Medicaid Eligibility				
No eligible unenrolled parents	2.4	48.1%	86.6% *	8.7% *
One or more eligible but unenrolled parent	1.7	33.3%	67.4% *	31.2% *
Not residing with parents	0.9	18.7%	73.2% *	22.2% *
Metropolitan Status				
MSA	4.2	83.1%	80.8%	13.7%
Non-MSA	0.8	16.1%	82.9% #	12.5%
Unidentified	0.0	0.8%	83.3%	12.7%
Race/Ethnicity Within Region - Northeast	**0.7**	**13.2%**	**84.8%** *	**9.7%** *
White only (non-Hispanic)	0.3	51.0%	81.6%	9.8% *
Black only (non-Hispanic)	0.1	18.8%	87.1% *	8.9% *
Hispanic	0.1	22.2%	88.4% *	9.5% *
Other	0.1	8.1%	82.5%	12.7%
Race/Ethnicity Within Region - Midwest	**0.7**	**14.0%**	**86.3%** *	**9.4%** *
White only (non-Hispanic)	0.4	56.6%	84.9% *	9.3% *
Black only (non-Hispanic)	0.1	18.3%	90.0% *	8.0% *
Hispanic	0.1	19.2%	84.6%	11.9%
Other	0.0	5.8%	88.0% #	8.3% *
Race/Ethnicity Within Region - South	**2.4**	**48.7%**	**77.6%** *	**17.3%** *
White only (non-Hispanic)	0.7	30.7%	80.2%	13.9%
Black only (non-Hispanic)	0.6	24.0%	83.6% #	13.1%
Hispanic	1.0	39.6%	67.8% *	27.4% *
Other	0.1	5.7%	73.6% #	20.9% *
Race/Ethnicity Within Region - West	**1.2**	**24.1%**	**80.7%**	**13.6%**
White only (non-Hispanic)	0.3	25.8%	80.0%	11.8%
Black only (non-Hispanic)	0.1	6.2%	83.4%	11.7%
Hispanic	0.7	56.5%	80.9%	15.0%
Other	0.1	11.4%	79.1%	13.9%

Source: 2007 Health Policy Center Eligibility Simulation Model, based on data for children ages 0-18 from the 2008 ASEC to the Current Population Survey.

* Indicates difference from national estimate is statistically significant (at the .05 significance level).

# Indicates difference from national estimate is statistically significant (at the .10 significance level).

Exhibit 5: Perceptions of and Barriers to Enrollment in Medicaid/CHIP Among Low-Income Parents with Uninsured Children



Note: Low-income parents are defined as those with family income less than 200 percent of the federal poverty level.
Source: Kaiser Commission on Medicaid and the Uninsured tabulations of the 2007 Kaiser Survey of Children's Health Coverage.

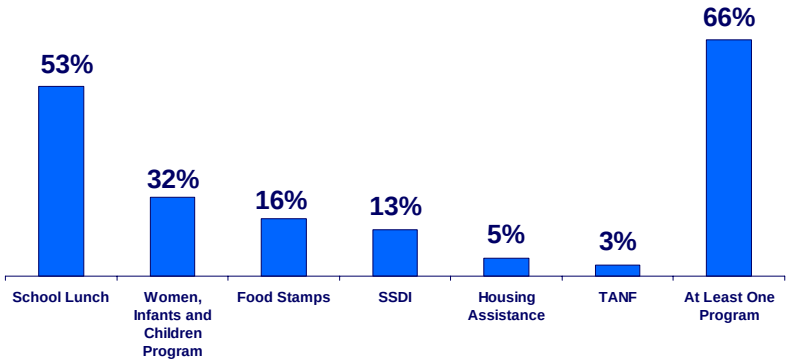
FPL. One third of the uninsured children who were eligible for Medicaid/CHIP also had an uninsured parent who was eligible for public coverage, which suggests that enrollment efforts may need to target families as well as children.

While nationwide, 83 percent of the uninsured children who were eligible for Medicaid/CHIP lived in Metropolitan Statistical Areas (MSAs), this varied across regions and states (data not shown). For example, in the Midwest, 28 percent of eligible uninsured children lived outside of MSAs while only 6 percent did so in the West. Nationwide, participation rates were very similar for children living in MSAs compared to those living outside MSAs (at 81 and 83 percent, respectively).

While participation rates are relatively high, an estimated 13 percent of eligible children remain uninsured. Uninsured rates are higher than the national average for children who have family incomes less than 100 percent of the FPL, who have non-citizen parents, who are 13 to 18 years of age or who are Hispanic. In addition, over 30 percent of eligible children with eligible but unenrolled parents are uninsured. Uninsured rates among eligible children vary across the country, with the highest uninsured rates in the South (17.3 percent), and the lowest in the Midwest (9.4 percent).

Potential for Additional Progress Under Current System. The prospects for enrolling more uninsured children in Medicaid and CHIP under the current system

Exhibit 6: Participation of Low-Income Families with Uninsured Children in Other Public Programs



Note: Low-income families are defined as those with income less than 200 percent of the federal poverty level.
Source: Kaiser Commission on Medicaid and the Uninsured tabulations of the 2007 Kaiser Survey of Children's Health Coverage.

are very good given that in 2007 almost all low-income parents with an uninsured child said they would enroll their child if he or she was eligible for coverage (Exhibit 5). Over 90 percent of low-income parents with uninsured children who know of the programs said that they were willing to enroll their children in Medicaid/CHIP and that Medicaid/CHIP was a good or very good program (91 and 95 percent, respectively.) However, close to half (45 percent) did not think their child was eligible for coverage, 55 percent said they did not know how to enroll their child, 50 percent thought that the enrollment process was difficult, and 51 percent did not know where to get more information about enrollment.

Many low-income uninsured children were in families that participated in some other government program (Exhibit 6). Over half (53 percent) of these families reported participating in the National School Lunch Program; 32 percent participated in WIC; 16 percent participated in Food Stamps; 13 percent participated in SSDI; and five percent or fewer reported receiving either housing assistance or TANF. Taken together, two thirds reported participating in one or more of these programs. Relying on the tax system also appears to be a very effective tool for reaching and enrolling more eligible uninsured children since 89 percent were estimated to be in families who filed federal tax returns in 2004.[22]

Discussion

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 gave states additional resources and tools aimed at improving participation in Medicaid and CHIP. In 2007, five million uninsured children were eligible for Medicaid or CHIP, constituting 64 percent of all uninsured children and 88 percent of all low-income uninsured children. Nationwide, over 80 percent of eligible children participated in Medicaid/CHIP, but participation rates, as well as the characteristics of uninsured eligible children, varied dramatically across areas.

Efforts to streamline application and retention processes offer tremendous potential for increasing enrollment among eligible children who are uninsured. Over 90 percent of low-income parents say they would enroll their uninsured child if they knew he or she was eligible, but around half do not know that their child is eligible, do not know how to apply, or find the application processes difficult. In order to close coverage gaps, states may also need to undertake targeted outreach efforts aimed at teenagers, Hispanics, and other groups of children with lower than average participation rates, provide additional support for community-based application assistance, broaden their outreach strategies to include parents, and address existing barriers in their Medicaid and CHIP application and retention processes.

The wide variation in participation rates found across areas suggests that there is considerable scope for reducing uninsurance among eligible children, particularly in the states in which a smaller fraction of eligible children are enrolled. Massachusetts has achieved very high rates of participation in public coverage following the enactment of a comprehensive health care reform effort that included a Medicaid expansion, generous subsidies and an individual mandate that applies to all adults for whom affordable coverage is available, among other changes.[23] Massachusetts also undertook an extensive public relations campaign, funded community based outreach and enrollment efforts, gave providers new incentives to enroll patients into Medicaid, used automatic eligibility strategies, and implemented an application and enrollment system that allowed most low-income families to enroll without completing application forms.[24]

Since almost all uninsured low-income children live in families who participate in other government programs or file taxes, states have a number of promising vehicles for covering more eligible children. States can take advantage of new express lane provisions in CHIPRA to make use of more data-driven enrollment and retention processes in order to minimize burdens on families. This analysis indicates that states will likely succeed in further increasing participation and reducing uninsurance among children if they take steps to improve their enrollment and retention processes and tailor their outreach strategies to the particular needs of the uninsured children who are eligible for coverage in their state. States will be aided in designing their outreach approaches by newly available data that provide detailed information about health insurance coverage at the state and local level. The American Community Survey (ACS), which includes a sample of over two million households each year, added questions about health insurance coverage in 2008 for the first time.[25] With its large sample size, the ACS provides much more detailed information on coverage and the composition of the uninsured at the state and local level than was previously available.[26]

However, uncertainty about the future role of Medicaid and CHIP in covering children may make states reluctant to move aggressively to cover more children under existing programs. In particular, to the extent that CHIP is eliminated as part of health reform, states may be much less likely to work towards increasing the participation of children in CHIP, which may have spillover effects on Medicaid programs as well. Moreover, the economic downturn, combined with ongoing state budget problems, may make it difficult if not impossible for states to continue their efforts to enroll more eligible children in Medicaid and CHIP. The American Recovery and Reinvestment Act of 2009 increased federal matching rates in Medicaid for states that maintained their eligibility levels through the end of 2010 to encourage states not to cut back on their programs during the economic downturn. Some federal reform proposals include an increase in matching rates beyond 2010 which would likely increase the likelihood that states maintain and even increase Medicaid and CHIP coverage at least in the near term.

Longer term, federal health care reform that includes a mandate requiring individuals to obtain health insurance coverage, coupled with expansions in Medicaid to cover more parents, would likely increase participation in public programs and reduce uninsurance among eligible children. Past research has demonstrated that expanding eligibility to include the whole family increases participation. At the same time, federal health reform will also affect how easy or difficult it is for families to enroll in coverage and to stay covered. Therefore, it is critical that the administrative systems set up to determine eligibility for public health insurance programs and subsidies under health reform are seamless, with a common application form and a single, integrated system for determining eligibility and that they use data-driven strategies as much as possible. It will also be important that states have the resources they need to cover all eligible children and adults under health care reform and that, with those resources, they be held accountable for doing so. The experience of covering children through expansions in public programs suggests that expanding Medicaid as part of health care reform will be a successful strategy for reducing uninsurance, but that careful attention must be given to the eligibility and enrollment processes that are developed to support health care reform efforts so as to minimize gaps in coverage. Otherwise, low-income children and their parents risk falling through the cracks.

Notes

[1] This is an update of the analysis by the same title released in November 2009. The findings have been updated to reflect refinements to Medicaid and Children's Health Insurance Program (CHIP) eligibility and coverage estimates. These refinements had the effect of increasing the estimated participation rates in Medicaid and decreasing the estimated participation rates in CHIP, as well as decreasing the share of eligible but uninsured children in Medicaid and increasing the share of eligible but uninsured children in CHIP (presented in Exhibit 1). The refinements had little effect on the estimates presented in Exhibits 2 and 4.

[2] Holahan, J. and A. Cook. "Changes in Health Insurance Coverage, 2007-2008: Early Impact of the Recession" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2009; DeNavas-Walt, C., B. Proctor, and J. Smith. US Census Bureau, Current Population Reports, P60-235. "Income, Poverty, and Health Insurance Coverage in the United States: 2008." Washington, DC: Government Printing Office, September 2009.

[3] Dorn, S., B. Garrett, J. Holahan, and A. Williams. "Medicaid, SCHIP, and Economic Downturn: Policy Challenges and Policy Responses." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2008.; Holahan, J. and A.B. Garrett, "Rising Unemployment, Medicaid and the Uninsured." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2009.

[4] Cohen Ross, D., A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2008.

[5] Kenney G., L. Dubay, and J. Haley. "Health Insurance, Access, and Health Status of Children Findings from the National Survey of America's Families." Washington, DC: Urban Institute, 2000.; Dubay L. and G. Kenney. "Assessing SCHIP effects using household survey data: promises and pitfalls." *Health Services Research* 2000; 35 (5 Pt 3): 112–127; Hudson, J. and T. Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 2007; 26(5): w618-w629.; Dubay L., J. Haley, and G. Kenney. "Children's Eligibility for Medicaid and SCHIP: A View from 2000." Assessing the New Federalism No. B-41. Washington, DC: Urban Institute, 2002.

[6] Kenney, G. and J. Yee. "SCHIP At A Crossroads: Experiences To Date and Challenges Ahead" *Health Affairs* 2007; 26(2): 356–369.

[7] Dubay, L., A. Cook, and B. Garrett. "How Will Uninsured Children Be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2009.

[8] Cohen Ross, D., A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2008.; Georgetown Center for Children and Families. "Reaching Eligible but Uninsured Children in Medicaid and CHIP." Washington, DC: Georgetown University Health Policy Institute, March 2009.

[9] Dubay, L. and A. Cook. "How Will the Uninsured Be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2009.

[10] The eligibility model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Ecomonic Supplement to the CPS to simulate the eligibility determination process. Because the CPS does not collect information on monthly income, it is not possible to determine how eligibility status changes as a result of income fluctuations throughout the year. To account for the possibility that some foreign born individuals are unauthorized immigrants and therefore not eligible for public health insurance coverage, the model takes into account immigrant status. Immigrant status is predicted based on a model of immigrant status derived from the March 2004 CPS. March 2004 CPS estimates of immigrant status were developed by Passell, and estimates derived from the two sample estimation technique are consistent with those produced using the March 2008 CPS (Passel, J. and D. Cohen. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center, April 2009).

[11] National Center for Children in Poverty. "Public Health Insurance for Children." New York: Columbia University Mailman School of Public Health. http://www.nccp.org/profiles/index_32.html (Accessed 5 Nov 2009).; Cohen Ross, D., A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2008; Cohen Ross, D., A. Horn, R. Rudowitz, and C. Marks. "Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2008.

[12] In cases where complete eligibility information was not available for 2007, other available sources were used. The model takes into account childcare expenses, work expenses and earnings disregards in determining eligibility, but does not take into account child support disregards.

[13] Health insurance units (HIUs) include the members of a nuclear family, including the family head, spouse, and own children under 19 years of age, or own full-time student children, 19-22 years of age. HIUs are derived from information available on household structure from the CPS and are used as the family unit of analysis because they more closely align with the family groupings used by states when determining eligibility than with census households or families.

[14] The undercount adjustment partially adjusts estimates of Medicaid coverage on the CPS to administrative estimates of Medicaid. This adjustment has the effect of reducing the number of uninsured children by 1.1 million (from 8.9 million to 7.8 million) and increasing the number of children with Medicaid coverage by 3.2 million, resulting in an increase in the total number of children with public coverage from 21.7 million to 24.9 million. This adjustment narrowed but did not close the gap between the administrative enrollment totals for Medicaid and estimates of Medicaid coverage in our analysis (Ellis, E.R., D. Roberts, D.M. Rousseau, and T. Schwartz. "Medicaid Enrollment in 50 States: June 2008 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2009). CHIP enrollment totals were found to be very similar to administrative enrollment totals and were not adjusted. (Centers for Medicaid and Medicare Services, "FY 2007 Second Quarter – Program Enrollment Last Day of Quarter by State – Total SCHIP", http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/SecondQuarterFFY2007PIT.pdf (Accessed 7 December 2009)) .

[15] A long standing debate exists regarding whether insurance estimates from the CPS represent people who responded by providing their coverage at the time of the survey or responded about their health insurance coverage over the course of the year (as intended) but with recall error because of the long reference period. The Census Bureau has commented on this issue and stated that CPS estimates are more closely in line with point in time estimates of the uninsured.

[16] Because many states use the same names for their Medicaid and CHIP programs and because many families are confused about the specific type of public coverage their child has, it is not possible to reliably distinguish between Medicaid and CHIP coverage on the CPS (Nelson, C.T. and R.J. Mills. "The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey." Washington, DC: U.S. Bureau of the Census, August 2002). Instead, we define Medicaid enrollees as those identified by our model as having public coverage who meet the eligibility criteria for Medicaid; CHIP enrollees are those with public coverage who meet the eligibility criteria for CHIP. Estimates of Medicaid and CHIP coverage derived from the CPS were benchmarked against unpublished MEPS estimates of Medicaid and CHIP coverage and were found to be very similar.

[17] For more detail on the survey, see: Paradise J., C. Marks, K. Schwartz, and B. Lyons. "Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009.

[18] Dorn, S., B. Garrett, C. Perry, L. Clemans-Cope, and A. Lucas. "Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and CHIP," Washington, DC: Urban Institute, January 2009.

[19] Hudson, J, and T. Selden. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 2007; 26(5): w618-w629.

[20] Dorn, S. "Eligible But Not Enrolled: How SCHIP Reauthorization Can Help." Washington, DC: Urban Institute, September 2007.

[21] States are divided into census divisions as follows: New England Division: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut; Middle Atlantic Division: New York, New Jersey, Pennsylvania; East North Central Division: Ohio, Indiana, Illinois, Michigan, Wisconsin; West North Central Division: Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas; South Atlantic Division: Delaware, Maryland, District Of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida; East South Central Division: Kentucky, Tennessee, Alabama, Mississippi; West South Central Division: Arkansas, Louisiana, Oklahoma, Texas; Mountain Division: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada; Pacific Division: Washington, Oregon, California, Alaska, Hawaii

[22] Dorn, S., B. Garrett, C. Perry, L. Clemans-Cope, and A. Lucas. "Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and CHIP." Washington, DC: Urban Institute, January 2009.

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[24] Dorn, S., I. Hill, and S. Hogan, "Secrets of Massachusetts' Success: Why 97 percent of State Residents Have Health Coverage." Washington, DC: Urban Institute (forthcoming).

[25] Davern, M., B. Quinn, G. Kenney, and L. Blewett. "The American Community Survey and Health Insurance Coverage Estimates: Possibilities and Challenges for Health Policy Researchers." *Health Services Research 2009;* 44(2pl): 593-605.

[26] Kenney, G., V. Lynch, S. Zuckerman, and S. Phong, "Variation in Insurance Coverage Across Congressional Districts: New Estimates from 2008." Washington, DC: Urban Institute, October 2009.

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