Best Practices in SHAP Outreach, Eligibility, and Enrollment Activities

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Introduction

The Affordable Care Act (ACA) requires that most Americans have health insurance by January 1, 2014. Through an expansion in Medicaid and a system of state-based and federal health insurance exchanges, an estimated 32 million newly eligible individuals will gain coverage under the law.1 To help achieve this coverage goal, the ACA also includes several provisions that call for major changes in state eligibility and enrollment processes currently used in public health insurance programs (see text box below). The aim is to make enrollment and renewal in Medicaid and exchanges easy, seamless, readily accessible, and consumer friendly.

To a great extent, much of the responsibility for creating these eligibility and enrollment systems resides with the states. This is a tall order, particularly given the short timeframe and, moreover, that many states currently have Medicaid eligibility and enrollment systems that are terribly outdated, with some still relying heavily on paper forms and processes that are not electronically connected to other state or federal programs.2

In this brief we draw on the experiences of five states—Colorado, Kansas, Minnesota, New York, and Oregon—that received federal grant funding to expand health coverage using approaches that included community-based outreach and improvements to Medicaid/CHIP eligibility and enrollment processes. We describe the promising approaches that these states shared with regards to activities related to outreach, streamlining application and enrollment processes, and modernizing eligibility determination systems; and consider the implications of these practices for implementing the ACA. Given that Kansas, New York, and Oregon were recipients of three of the seven Early Innovator grants initially awarded by the federal government in February 2011 to states for IT systems development, our study states include recognized leaders in terms of readiness and ability to develop eligibility and enrollment processes systems that will comply with provisions set out in the ACA.3

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3 For more information on Early Innovator grants, readers are referred to http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html
The State Health Access Program

Our five study states are part of group of thirteen states that received a grant from the Health Resources and Services Administration through the State Health Access Program (SHAP). Launched in 2009, prior to the passage of the ACA, SHAP grants were designed to help states expand access to affordable health care coverage to uninsured individuals. Though the program’s primary focus was to provide direct funding for coverage for populations not eligible for existing public health insurance programs, states used a variety of approaches to meet the coverage SHAP mission. These included funding community-based outreach grants, creating web-based applications and other efforts to streamline enrollment processes, and modernizing systems that determine eligibility for public coverage programs. For our five study states, eligibility and enrollment process improvements were key components of their SHAP grant.

For the study we conducted site visits to each state between March and August 2011 where we interviewed state officials involved in the SHAP grant generally as well as state enrollment and eligibility and state health information technology (IT) experts, and, in some cases, state IT vendors. We conducted cross-site analyses of study findings to identify common themes, promising approaches, and lessons learned, and to create this and a complementary brief, SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform.

Before presenting study findings, we provide a brief overview of each state’s SHAP grant as it pertains to eligibility and enrollment system improvements.

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<th>ACA Requirements for State Eligibility and Enrollment Processes</th>
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<td>The ACA envisions a streamlined, simplified, and coordinated system that determines eligibility for and enrolls individuals in all health subsidy programs (including Medicaid, CHIP, and exchange-based premium and cost-sharing subsidies) and that facilitates seamless transitions between programs when necessary. The system should allow for self-service enrollment and renewal and rely on electronic rather than paper-based processes. To meet these goals, the ACA requires states to:</td>
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<td>- Create a “no wrong door” system that includes an internet website and that screens people seeking coverage for all health subsidy programs and enrolls them in the correct program.</td>
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<td>- Use a single, streamlined enrollment application that allows individuals to apply for Medicaid, CHIP, and exchange-based subsidy programs and that can be submitted online, by mail, telephone, or in person. (the U.S. Department of Health and Human Services is developing an application states can use, or they can create their own.)</td>
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<td>- To the maximum extent possible, develop and use secure electronic interfaces to exchange available data to establish, verify, and update eligibility for health subsidy programs.</td>
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<td>State exchanges must also establish grant programs to award funding to “Navigators,” that is, trained entities that will provide fair and impartial public education, outreach and enrollment assistance to consumers.</td>
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4 SHAP was authorized for up to five years in the Omnibus Appropriations Act (P.L. 111-8). Congress appropriated program funds on an annual basis in federal fiscal years 2010 and 2011 but the program was not funded from federal fiscal year 2012 onward. No-cost extensions have allowed grantees to continue SHAP activities beyond federal fiscal year 2011. For more information about SHAP, see: http://www.hrsa.gov/statehealthaccess/, Accessed December 2011.
Summary of SHAP Activities in the Five Study States

Figure 1 presents a summary of study states’ SHAP grant activities concerning outreach, eligibility and enrollment processes, and system improvements.

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<th>State (Grantee(s))</th>
<th>Planned Outreach, Eligibility and Enrollment Activities¹</th>
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<tr>
<td><strong>Colorado</strong>&lt;br&gt;State Department of Health Care Policy and Financing</td>
<td>Contract with community-based organizations to conduct outreach and enrollment for coverage programs; develop and implement an online application; create interfaces for electronic verification of information needed to process eligibility; and begin an Express Lane Eligibility program.</td>
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<td><strong>Kansas</strong>&lt;br&gt;Kansas Health Policy Authority</td>
<td>Place out-stationed outreach and enrollment workers at clinic sites around the state; develop an online application and presumptive eligibility tool; and develop a new modernized eligibility and enrollment system.</td>
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<tr>
<td><strong>Minnesota</strong>&lt;br&gt;State Department of Human Services</td>
<td>Develop an online application and created interfaces for electronic verification of information needed to process eligibility.</td>
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<tr>
<td><strong>New York</strong>&lt;br&gt;State Department of Health/Health Research Inc.</td>
<td>Establish a statewide enrollment center for consumer assistance and renewal processing (via mail, telephone); develop an online eligibility screening tool; and create a more user-friendly interface for eligibility caseworkers.</td>
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<tr>
<td><strong>Oregon</strong>&lt;br&gt;State of Oregon</td>
<td>Contract with community-based organizations to conduct outreach and enrollment for coverage programs; create interfaces for electronic verification of information needed to process eligibility; hire staff to focus exclusively on eligibility transformation; support Health Insurance Exchange planning; and conduct an evaluation of outreach and enrollment activities (including a state Health Insurance Survey).</td>
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Notes: (1) This column shows planned activities, as reported in state’s SHAP grant proposals. Some states were not able to carry out planned activities completely due to funding cuts.

Though the five study states’ existing eligibility and enrollment systems are unique, each shares the need for modernization and major improvements to comply with ACA requirements. Systems range in age from seven years (in Colorado) to more than forty years old (in Oregon). All the study states have integrated eligibility and enrollment systems that are used for Medicaid and social services programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). One state, New York, has two eligibility and enrollment systems serving different parts of the state (upstate and New York City).

Each of the states but Kansas had a county-administered Medicaid program, though New York recently announced its plans to...
transition to a state-administered program, contributing added complexity to updating its systems. All five states relied on paper-based application processes, for instance, requiring signed paper application and renewal forms, or hard copy documentation of income and citizenship/residency. Though some of the study states previously established electronic data verification interfaces, these were done on a batch-file basis and could not be used to verify information in “real time.” In total, when the states began modernization their existing eligibility and enrollment systems were far from where they needed to be in compliance with ACA requirements that Medicaid eligibility determination and enrollment be real-time, web-based, user-friendly, and seamless with the processes for enrolling in exchange-based coverage.

**Promising Approaches in SHAP Outreach, Eligibility, and Enrollment Activities**

**Reaching and Enrolling the Uninsured**

SHAP was launched in 2009 when the country was deep in an economic recession and when virtually all states nationwide struggled to balance their budgets in the face of declining revenues.5 In this environment, most of the five states were funding very little or no outreach of their own. Correspondingly, several of the study states dedicated SHAP grant funds to outreach aimed at identifying and enrolling residents eligible under new public coverage expansions—a growing population due to the recession. Though SHAP grant funds were targeted to expanding affordable coverage to uninsured individuals, outreach efforts that also brought in individuals already eligible for coverage but not enrolled were sanctioned by the SHAP initiative so long as these individuals were not the primary focus of the efforts. These states:

- **Built an “outreach army” of trusted community partners.** Colorado and Oregon established contracts with community-based organizations to conduct outreach in well-known and trusted locations in communities around the state. Using a “trusted hand” model, Colorado funded outreach in diverse locations such as schools, YMCAs, and 7-11 convenient stores. Oregon's outreach subcontractors included local organizations providing family support services, schools, and Community Based Organizations targeting subpopulations such as immigrants, refugees, rural families, and communities of color. Using a slightly different approach, Kansas out-stationed outreach and eligibility workers in Federally Qualified Health Centers (FQHC) throughout the state; these workers were based in the clinics but also worked more broadly in the community. Notably, both Colorado and Kansas reported that the outreach conducted under SHAP marked the first time the state had ever undertaken this type of effort.

- **Used a mix of targeted outreach messages and approaches to reach newly-eligible populations.** States that used SHAP funds for outreach described a variety of innovative outreach methods that aimed to reach a range of populations that were newly eligible for health insurance under state coverage expansions. These included creating and distributing print materials and health program-branded ‘giveaways,’ participating in health fairs, and providing in-person education and enrollment assistance at nontraditional community locations such as group prenatal classes. Colorado officials shared an example of one outreach grantee that printed information about health coverage options on the paper placemats used by McDonald's restaurants. Oregon described an aggressive social marketing campaign to advertise children’s coverage programs using Facebook, Myspace, Twitter, YouTube, and other social networking applications to create resources accessible to both outreach partners and consumers themselves. The state tested different outreach messages to determine which ones would be most useful to reach their target populations which included low-income children and adults. Oregon officials noted that messaging was complex because part of its coverage expansion targeted low-income adults eligible for Oregon Health Plan (OHP) Standard, a program that regularly caps enrollment and employs a waitlist.

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• **Addressed training and technical assistance needs of outreach partners, and created avenues for sharing lessons learned.**

Colorado conducted individualized training sessions for each of its outreach grantees and established reporting requirements in addition to a schedule of site visits to monitor grantee progress. Officials in the state reported that some Community Based Organizations needed intensive technical assistance with grant-writing and in future rounds of their outreach grant program, they planned to focus on these needs in order to engage more nontraditional outreach partners (such as groups providing services to homeless individuals). In addition, Oregon and Colorado convened regular statewide or regional conferences for grantees, which provided training as well as opportunities for outreach partners to meet face-to-face and share lessons learned regarding different approaches to reaching target populations.

Program staff described their SHAP-funded outreach efforts as preparation for the considerable task of identifying and enrolling uninsured residents eligible for coverage under the ACA insurance expansions that take effect in 2014. In Colorado, outreach contracts were compared to ‘seed money’ for Community Based Organizations likely to be involved in conducting outreach for the ACA expansions, for instance as Navigator contractors or subcontractors. SHAP, while not a long-term source of funding for these Community Based Organizations, built organizational capacity and skills to continue conducting outreach. In Oregon, outreach focused primarily on uninsured children; program staff saw these efforts as laying a foundation for ACA-related outreach to uninsured parents of these children, many of whom are likely to be eligible for Medicaid or exchange-based subsidies under the ACA.

**Developing Web-Based Applications for Public Coverage**

Three states—Colorado, Kansas, and Minnesota—used SHAP funds to develop a web-based application for public health insurance programs. Each was creating an integrated application that could be used by Medicaid as well as other human services programs (e.g., SNAP, TANF), but all noted that Medicaid was the topmost priority in application development due to the ACA deadlines and the availability of 90/10 federal matching funds for Medicaid eligibility and enrollment system improvements. The online applications created by the states, at least in their initial forms, do not result in ‘real-time’ eligibility determinations (i.e., an immediate notification of eligibility or ineligibility). Rather, they require caseworker involvement in transferring information collected through the online application to existing legacy databases that determine eligibility. The states are moving towards real-time determination, however, once new eligibility systems (described in the next section) are in place. These states:

• **Created ‘intelligent’ web-based application forms that only collect the information necessary to determine eligibility.** Each state reported using ‘intelligent data design’ to create its web-based application, meaning that applications are tailored based on the information the applicant provides (i.e., a response determines the next question asked) so that only the questions necessary for eligibility determination are asked. States also expressed interest in developing an application that could be automatically populated with information about an applicant—such as address, employment, and income information—by pulling in data from external databases once the applicant has entered some basic identifying information (e.g., full name or social security number). The

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6 States are eligible for an enhanced federal Medicaid matching rate of 90 percent for design and development of new Medicaid eligibility systems and a 75 percent matching rate for maintenance and operations. States must meet certain conditions, including seamless coordination with the exchanges, in order to qualify. The 90 percent matching rate is available for eligibility systems until December 31, 2015, and the 75 percent match is available beyond that date.
applicant would then be asked to verify the auto-filled information as part of the application process. In addition to making the application process more efficient and less burdensome for consumers, pre-populating application and renewal forms reduces the possibility of error from applicants directly entering the information themselves.

- **Engaged eligibility and enrollment workers during the web-based application development and implementation process.** As part of its online application development, Colorado launched an outreach initiative targeting both county eligibility and enrollment staff and community partners. Using a ‘train-the-trainer’ model, the initiative included educating caseworkers and community-based enrollment workers on how to use the online application by providing hands-on training sessions, user guides, and outreach/marketing materials. SHAP program staff in two states, Colorado and Minnesota, noted that county eligibility workers expressed concern about increases in caseload application as a result of the online applications. In response, state eligibility and enrollment staff reasoned that the data provided through the online application should be higher-quality and the process smoother, which should reduce caseworker burden. States had modest expectations for the proportion of applications that would be web-based in the first year or two of implementation but expected a slow, steady increase over time. Minnesota, for instance, set a goal of receiving 10% of all applications via online submissions in the first six months after the online application became available.

Officials in Colorado, Kansas, and Minnesota agreed that developing a web-based application under the SHAP grant gave them a significant head-start in implementing the ACA, since the law requires that applicants for all health subsidy programs (e.g., Medicaid, CHIP, and exchange-based subsidies) be able to apply for coverage online as well as by mail, telephone, and in-person. They described their efforts to create the online application (in addition to other initiatives to streamline the enrollment process, described below) as key to managing the expected increase in caseload volume that would result from ACA coverage expansions in 2014. As one official noted, “we are working on reducing caseworker workload now, to prepare for the expansion later.”

**Creating Electronic Interfaces to Verify Eligibility Data**

Two states—Colorado and Minnesota—used SHAP funds to create interfaces between Medicaid eligibility systems and various state databases for electronic verification of data required for eligibility determination. In Colorado, these interfaces involve the transfer of data on applicant income (from the state Department of Labor and Employment), residency (from the state Department of Motor Vehicles), and identity (from the Social Security Administration and the state Department of Vital Statistics). The interfaces developed in Minnesota involve the transfer of data on wages (from the state Department of Education and Economic Development) and identity (from the Social Security Administration). These states:

- **Invested in building relationships with other state agencies whose partnership was critical to interface development.** Both Colorado and Minnesota found that partnering with other agencies to create electronic interfaces could be challenging. Other agencies’ concerns ranged from data confidentiality to loss of income. For instance, in Colorado a partnering agency stood to lose income generated from providing birth certificate copies to applicants, since the interface would create a pathway for verifying that information electronically. According to officials, starting that collaboration as early as possible is important to allow enough time to work through the issues.
- **Established interagency agreements and collaborated with partner agencies to design and implement electronic interfaces.** Establishing an interagency agreement is a critical step in development of database interfaces. At a minimum, this agreement must be between the two agencies that are sharing the data. In states with a separate agency for information technology, such as Colorado’s Governor’s Office of Information Technology (established in 2009 to consolidate information technology services across all executive branch agencies), the IT agency also needed to be part of the agreement. Decisions about the design and function of the interfaces must be approved by all agencies, which states reported could be a time-consuming process. The partnering agencies involved in sharing data with Medicaid-administering agencies through the interfaces were not compensated in either state, though Colorado noted that they structured their SHAP grant to include funding for the resources that these other agencies would need (such as information technology improvements) to carry out the interface work. Another issue raised by state officials was that generally the partnering agency has no incentive—financial or otherwise—to be involved in the effort, which makes it challenging to solicit attention and resources for interface development from these agencies.

The work Colorado and Minnesota did to create electronic interfaces under SHAP was described as “an obvious precursor to the ACA” because the federal health reform law stipulates that states must—to the maximum extent possible—develop and use secure electronic interfaces to exchange available data to establish, verify, and update eligibility for health subsidy programs. These interfaces are key to realizing the ACA’s goal of electronic rather than paper-based eligibility processes. Even study states that did not use SHAP funds to build interfaces directly suggested that their experiences under SHAP had improved their understanding of different electronic databases that could be used to verify eligibility data—as a state official in New York noted, “[SHAP] build capacity for understanding the information technology infrastructure in our state.”

**Other Efforts to Streamline Application, Enrollment, and Renewal Processes**

The study states described other efforts to streamline their application, enrollment, and renewal processes using SHAP grant funding. These states:

- **Created a dedicated staff position to examine eligibility and enrollment policies and make recommendations for improvement.** Oregon used the SHAP grant funds to create a new full-time position of eligibility transformation manager (ETM). The ETM’s sole focus is to examine the state’s Medicaid application and eligibility determination process and identify system needs and improvements, including through research and discussions to identify best practices in other states. Oregon made incremental changes to the application process in response to the ETM’s recommendations, including revising the application for improved comprehension and consumer-friendliness, creating a pre-populated renewal form, and reducing unnecessary income documentation requirements. The ETM is also playing a critical role in planning for Oregon’s exchange, and serves as a liaison between the Medicaid-administering agency and the exchange, recently established as a public corporation in the state.

- **Began the centralization of eligibility and enrollment processes using a phased-in approach.** In an effort to administer its public health coverage programs more effectively and improve enrollment continuity, New York used SHAP funds to create a statewide Enrollment Center, an
infrastructure for centralizing eligibility and enrollment processes in most of the state (except New York City, which has its own unique eligibility and enrollment system). An essential component of this infrastructure is the Healthcare Eligibility Assessment and Renewal Tool (HEART), a new electronic interface that interacts with the state’s legacy eligibility and enrollment systems, allowing lightly-trained Enrollment Center staff (i.e., those who have not gone through the more intensive training required to use the state’s legacy eligibility systems) to process public health insurance applications and renewals. The state implemented the Enrollment Center in several phases. The initial phase involved consolidating call center operations for multiple public coverage programs into a single consumer assistance call center. Successive phases included processing mail-in renewal forms and conducting renewals by telephone. Future plans for the Enrollment Center include administration of small ‘boutique’ programs, such as the Family Health Plus Premium Assistance Program, which can sometimes be challenging for counties to administer.

New York officials stressed the importance of phasing in initiatives like its Enrollment Center through an incremental approach. Colorado and Minnesota expressed a similar sentiment when describing the introduction of their web-based applications, with use of the application limited to certain ‘pilot’ counties at first. An incremental approach allows the state to “work out the kinks” of new technology and business processes before a statewide rollout (or, in the case of New York, before building additional capacities in the Enrollment Center).

**Investing in New or Upgraded Eligibility Systems**

All five states used a portion of their SHAP grant funds to invest in new or upgraded eligibility systems for Medicaid and CHIP. Most were developing an integrated system that would be used to determine eligibility for Medicaid, CHIP, and the exchange, describing their efforts as part of a culture change prompted by federal health reform that envisioned Medicaid as one type of coverage along a continuum of health insurance options. As one official noted, “we are building an insurance system, not a Medicaid system.”

SHAP funds were generally used for planning eligibility system overhauls or upgrades (e.g., identifying IT needs or developing Requests for Proposals for IT vendors) rather than for the actual purchase or building of these systems. This was a consequence of limited grant funds that were spread across multiple project components (not just eligibility system improvements) and in recognition of the availability of other funding sources for modernizing Medicaid eligibility systems, primarily the 90/10 federal Medicaid matching funds from CMS as well as the federal Early Innovator grants.

Kansas was the only exception to this. The state’s K-MED project, which includes creation of an online application and procurement of a new eligibility system, was funded through SHAP. At the time of our site visit in April 2011, Kansas planned to use a combination of federal Early Innovator grant, SHAP grant, and 90/10 funds to procure an integrated (Medicaid, CHIP, and exchange) eligibility and enrollment system but in August the state returned its innovator funding. The project consequently revised its plan to focus solely on building a new eligibility system for Medicaid and CHIP, developed an RFP for the development of the KEES eligibility system (formerly known as K-MED), and awarded a 5-year contract to Accenture in November 2011.
The study states:

**Included experts in eligibility and enrollment policies early and throughout the planning process.** When developing systems, states made sure to include officials with expertise in eligibility and enrollment policy rather than just information technology experts. Eligibility and enrollment policy experts were integral in organizing business processes—a critical first step to designing new eligibility and enrollment systems that involves identifying the information necessary for determining eligibility, the questions that must be asked to collect that information, whether and how information is shared across programs, and the roles and responsibilities of different agencies (and their staff) in eligibility determination and program enrollment.

**Engaged eligibility and enrollment caseworkers in the planning process too.** The study states also noted the importance of including eligibility and enrollment caseworkers when modernizing systems. Officials noted that these stakeholders can make important contributions to improving eligibility and enrollment systems, since they have ‘on-the-ground’ experience interacting with Medicaid applicants and are aware of challenges in the existing eligibility and enrollment processes. Local caseworkers were also described as important partners in implementation. One official noted that they would be the “face of web-based enrollment” in the future and would be an important contact point for public education and assistance with state’s new online eligibility and enrollment systems.

Including eligibility caseworkers at the table also helped to get their buy-in regarding system changes, which was particularly important in states with county-administered eligibility determination (Colorado, Minnesota, New York, and Oregon). Counties were described as powerful and influential stakeholders, and some states reported that caseworkers were uncertain and concerned about the implications of new eligibility and enrollment systems for their work. State officials acknowledged that the responsibilities of traditional caseworkers would change as new, highly automated systems are implemented, but at the same time, officials understood that caseworkers would still be needed to manage the most complex eligibility cases. Each study state envisioned eligibility caseworkers as playing a redefined but still essential role in their modernized systems. Several state officials noted the importance of a well-organized change management process—a structured process for facilitating the transition of staff and resources from current roles and responsibilities to future roles and responsibilities, and that ensures caseworkers are not overburdened with too many changes at once.

Each state emphasized the importance of being able to devote considerable staff resources to the system development process, and of having independent funding to support these efforts. They credited the SHAP grant for allowing them to focus so intently on the changes necessary to modernize their system, even before the ACA was passed, and noted that receiving the SHAP grant put them in a good position to receive other funding for system improvements such as the 90/10 federal matching funds from CMS and the Early Innovator grants. The companion to this brief, *SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform* provides greater detail on the study states’ activities related to eligibility system modernization and their implications for ACA implementation.

**Conclusion**

The SHAP grant allowed states to pursue their goals of expanding health coverage by providing dedicated funding for outreach and eligibility and enrollment system improvements. When SHAP began—prior to the passage of the ACA—these goals were related to states’ own health reform efforts (e.g., implementing incremental expansions of Medicaid or CHIP, or supporting state-led initiatives for eligibility modernization),
but ultimately SHAP also put these states on the right track to meet the goals put forth by federal health reform. Undoubtedly, SHAP gave states a head start on making the changes the ACA requires for outreach, eligibility determination, and enrollment systems.

The activities initiated under SHAP, and continued as part of ACA implementation, represent major changes in the way that public health insurance programs are administered in the states. States’ experiences under the SHAP grant offer important insights for other states as they consider how to best prepare for the major coverage expansions that will occur in 2014 as a result of the ACA, and to comply with the law’s many requirements for eligibility and enrollment system improvements. The promising approaches in outreach, streamlining application and enrollment processes, and in upgrading (or overhauling) eligibility systems shared by the five study states may serve as useful examples for states that are in earlier stages of implementing the federal health reform law.

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**About SHADAC**

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