kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

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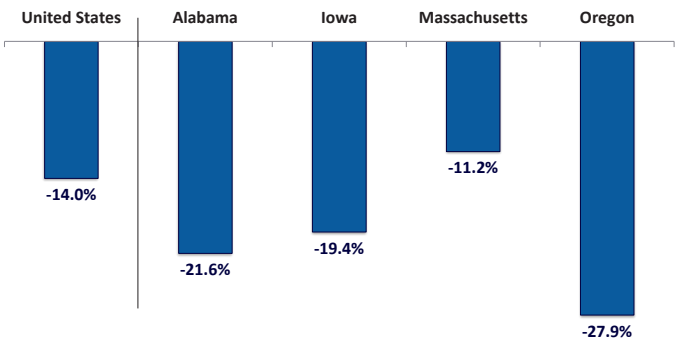
Secrets to Success:
An Analysis of Four States at the Forefront of the Nation's Gains in Children's Health Coverage

EXECUTIVE SUMMARY

While there has been continued growth in the uninsured rate for adults in recent years, the uninsured rate for children dropped to 8% in 2010, the lowest point ever achieved since the federal government began tracking this statistic in 1987.[1] To gain an increased understanding of factors contributing to the success in coverage of children, based on site visits and interviews with key stakeholders, this analysis examines the experiences of Alabama, Iowa, Massachusetts, and Oregon. Representing each geographic region of the country, these states are a diverse group that has significantly improved coverage of children in recent years (Figure 1).

Figure 1

Percentage Change in Number of Uninsured Children, 2008-2010



SOURCE: Georgetown University Center for Children and Families analysis of the 2008, 2009, 2010 U.S. Census Bureau American Community Survey.

KEY SUCCESS FACTORS

In reviewing the experiences of these four states, several common themes emerge that underlie their success:

- **At least one political leader in the state – and, in most instances, a number of political leaders over time – made coverage of children a top priority.** Moreover, a number of respondents across the states highlighted the importance of having an overarching culture focused on coverage and a strong commitment to children's coverage among a broad array of key stakeholders.
- **Expansive eligibility levels for children and adoption of a broad range of simplification strategies have been key elements of achieving progress.** All four states have expanded eligibility for children to 300% of the federal poverty level and have largely taken up available opportunities to streamline and simplify enrollment and renewal processes for families, increasingly using technology to reduce paperwork requirements.

- **Providers and other community partners play a vital role in helping families to enroll in coverage.** Medicaid and CHIP agencies in each of the four states have built and maintained strong relationships with providers and community based organizations to broaden outreach and enrollment efforts and assist the state in identifying opportunities for continued improvement.

- **Strong coordination between Medicaid and CHIP aid in outreach and enrollment efforts and smooth transitions between programs.** Each of the four states has taken steps to promote close alignment between Medicaid and CHIP, with Massachusetts and Oregon fully unifying the two programs.

REMAINING CHALLENGES AND NEXT STEPS

Another key element of success in these states is that they each continue to look for ways to improve coverage rates among children. Current key challenges and next steps identified by these states include:

- **Facing ongoing growth in enrollment amidst diminishing administrative resources.** All four states are facing staff shortages due to state fiscal problems and loss of senior administrators, even as caseloads grow. As a result, they continue to look for ways to gain increased efficiencies in program administration, often through greater use of technology.

- **Improving retention of eligible children.** Using a variety of strategies, these states are seeking to prevent eligible children from losing coverage at renewal. Their efforts include allowing families to renew online; greater use of administrative renewals and pre-populated forms; more attention to transitions between programs; and the use of "Express Lane" eligibility for renewals.

- **Updating outdated eligibility and enrollment systems.** All four of the profiled states are looking to take advantage of the availability of new enhanced federal matching funds to conduct major overhauls or upgrades of their systems.

- **Improving communications with families and obtaining better enrollment data.** Poorly worded and cumbersome notices remain an issue, as does the lack of high-quality data on the performance of enrollment efforts. Both issues are being tackled as part of efforts to improve eligibility and enrollment systems.

The four states in this analysis represent different regions of the country and have distinctive political and policy cultures, but share many features that appear to have contributed to their success in covering children. The experiences of these states provide important lessons learned for efforts to cover children in other states and may help inform efforts to enroll newly eligible individuals under the coverage expansion in 2014.

INTRODUCTION

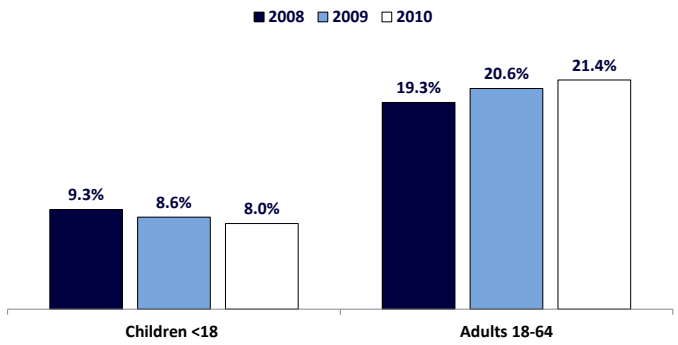
In recent years, the story of the nation's progress in covering children often has been overshadowed by the bleaker news of growth in the number of uninsured adults and high unemployment rates. However, in 2010, the latest year for which data are available, more of the nation's children had coverage than at any point since the federal government began tracking this statistic in 1987.[2] To gain an increased understanding into factors contributing to the success in coverage of children, this analysis examines the experiences of Alabama, Iowa, Massachusetts, and Oregon, four states that are at the forefront of successful efforts to cover America's children.

BACKGROUND: TRENDS IN COVERAGE OF CHILDREN

In recent years, the number of children with coverage has grown in most states and held steady in nearly all of the remainder, despite the weak economy, rising health care premiums, and notable deteriorations in employer sponsored coverage. In sharp contrast, these same factors have severely eroded the adult coverage rate. In 2010, the uninsured rate among children under age 18 in America was 8.0 percent compared to 21.4 percent among adults ages 18 to 65 (Figure 2). As notably, the number of uninsured children decreased from 6.9 million in 2008 to 5.9 million in 2010, even as the number of children living in poverty increased from 13.2 million to 15.7 million. In other words, despite a big increase in the number of children living in poverty, the number of uninsured children fell sharply.[3]

Figure 2

Uninsured Rates for Children and Adults, 2008-2010



SOURCE: T. Mancini, M. Heberlein, & J. Alker, "Despite Economic Challenges, Progress Continues: Children's Health Insurance in the United States from 2008-2010" Georgetown University Center for Children and Families (November 2011).

At the heart of these coverage gains has been the effort of state and federal policymakers, administrators, and community organizations to improve children's coverage across the country. Over the last ten years, states have expanded eligibility for uninsured children in low and moderate-income families and made it easier for eligible children to enroll in and keep Medicaid and CHIP. These efforts were bolstered by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, which reauthorized CHIP and provided states new coverage options, enrollment tools, and incentives for covering children. More recently, the gains achieved in covering children were protected against recession-driven budget cuts by a provision in the Affordable Care Act (ACA) that requires states to hold steady in their Medicaid and CHIP coverage.[4] As a result, Medicaid and CHIP have been able to provide coverage to many of the children in families struggling to gain their financial footing during difficult economic times.

METHODS

To gain greater insights into state-level factors that have contributed to the recent coverage gains among children, the Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured conducted in-depth interviews and site visits during the summer of 2011 with state officials, community partners and other stakeholders in four states: Alabama, Iowa, Massachusetts, and Oregon. (See Appendix A for a profile of each state's Medicaid and CHIP programs and recent steps the state has taken to promote children's coverage.)

While many states have made striking gains in expanding coverage for children, this analysis was limited to one state from each of four geographic regions across the nation. The selection of a state from each region took into account several criteria and factors, including the uninsured rate for children under 18, recent progress in increasing coverage among children, and qualifying for federal performance bonus payments that were created by CHIPRA and earned by states that have adopted a series of simplifications in their Medicaid and CHIP programs and have met Medicaid enrollment targets for children. (See Appendix B for 50-state tables on children's uninsured rates and income eligibility limits for children's health coverage.)

The state selection process was designed to provide a diverse group of states that, together, could provide a portrait of common practices and themes in states that have significantly improved coverage of children. It was not designed to be a quantitative assessment of the "best" states in the country, and some states that were not included in this analysis likely have conducted equally notable work in covering children.

Massachusetts was selected from the Northeast**, Iowa** from the Midwest**, Alabama** from the South, and **Oregon** from the West (Table 1, next page). With 99.5 percent of its children covered as of 2010, according to a recent state-specific survey, **Massachusetts** is the clear national leader in covering children.[5] **Iowa** ranks first among Midwestern states and 6th among all states when it comes to coverage of children, largely because it has undertaken a comprehensive effort in recent years to expand coverage and enroll eligible children.

While **Alabama** and **Oregon** do not yet rank as high as Massachusetts and Iowa in national coverage rates, their coverage levels have improved in recent years and they have pursued a number of important outreach and enrollment efforts. Given their success enrolling eligible children in Medicaid, **Alabama** and **Oregon** qualified for performance bonuses in each of the three years that the bonuses have been awarded. In addition, **Oregon** cut its uninsured rate among children in half between 2009 and 2011, according to a recent state-specific survey.[6]

Table 1:
Uninsured Rates and Performance Bonuses for Profiled States

State	Percentage Change in Number of Uninsured Children 2008-2010	Uninsured Rate for Children (2010)[7]	National Rank for Children's Uninsured Rate	Regional Rank for Children's Uninsured Rate	2011 Performance Bonus**
AL	-21.6%	5.9%	21st	7th among 17 Southern states	$19.8 million
IA	-19.4%	4.0%	6th	1st among 12 Midwestern states	$9.6 million
MA	-11.2%	1.5%*	1st	1st among 9 Northeastern states	No Bonus
OR	-27.9%	8.8%*	36th	4th among 13 Western states	$22.5 million

*In recent state-specific surveys, Massachusetts and Oregon report somewhat different uninsured data (see text), but national data from the American Community Survey are used in this table to provide comparable information across the four states. Note that states such as Massachusetts with very high coverage rates can find it difficult to qualify for performance bonuses because they already cover nearly all of their children. To qualify for a bonus, a state must show marked *growth* in Medicaid enrollment over time.

**Performance bonus awards may be adjusted based on final or revised enrollment data from states.

Sources: Georgetown University's Center for Children and Families and the Centers for Medicare and Medicaid Services, "FY 2011 CHIPRA Performance Bonus Awards," December 2011.

KEY FINDINGS

Key Success Factors

Each of the four states profiled in this paper differ in how they operate their children's health programs, but, in reviewing their experiences, several common themes emerge that underlie their success.

In each of the four profiled states, at least one political leader in the state – and, in most instances, a number of political leaders over time – made coverage of children a top priority. Moreover, a number of respondents across states highlighted the importance of having an overarching culture focused on coverage and a strong commitment to children's coverage among a broad array of key stakeholders.

- In **Massachusetts**, for example, state officials and community partners both identified the state's deep and sustained commitment to children's coverage as a key ingredient in its success. This commitment was apparent well before the state adopted broader health care reform in 2006, and even pre-dated the creation of the Children's Health Insurance Program (CHIP) in 1997. It has held steady through both Democratic and Republican Administrations, and has been attributed to the political culture of the state, the leadership of state officials and policymakers, and the strong advocacy by consumer-based organizations.

- More recently, the leadership of Governor Kulongoski in early 2009 in **Oregon** helped the state to become an emerging leader on children's coverage. He actively sought legislative changes to expand eligibility for coverage, but when they were delayed, he also used his executive authority to adopt simplified enrollment and renewal procedures. Moreover, a key element to Oregon's success is that the state created a dedicated funding source for its expansion, called "Healthy Kids." This funding stream has allowed Oregon to protect Healthy Kids from budget cuts and provided it with the resources needed to promote its expansion through an aggressive marketing and outreach campaign.

- In **Alabama**, strong legislative support for children's coverage allowed it, in 2009, to become the only state in the South that covers children up to 300 percent of the federal poverty level. Support is particularly robust for the state's popular CHIP program, known as "ALL Kids," which is framed as an important public health initiative and is administered out of the state's public health agency. While largely out of the public eye, the state's Medicaid agency has worked with the CHIP agency to build on the successes of CHIP by incorporating comparable simplifications and improvements into Medicaid. Moreover, the extensive outreach and marketing efforts for ALL Kids have had a "welcome mat effect" on Medicaid enrollment – as families apply for CHIP, they are often found eligible for and enrolled in Medicaid.

- As in Alabama, **Iowa** traditionally has experienced strong legislative support for its CHIP program, known as "***hawk-i***," which has a robust identity as a health insurance program. The appeal and success of improvements in CHIP helped pave the way for similar improvements in Medicaid. In 2008 and 2009, the **Iowa** legislature adopted a range of new policies to expand and improve children's coverage. Along with expanding coverage to 300 percent of the federal poverty level, the state adopted a number of new policy options described below.

Expansive eligibility levels for children and adoption of a broad range of simplification strategies have been key elements of achieving progress among the profiled states. All four states have expanded eligibility for children to 300 percent of the federal poverty level, and have largely taken up available opportunities to streamline and simplify enrollment and renewal processes for families, often using technology to reduce paperwork requirements (Table 2).

- **Alabama**, for example, has quietly become a leader in using technology to reduce paperwork for families in need of coverage—it was one of the first states to launch an online application and allow electronic signatures, it became an early user of ELE, and it electronically verifies citizenship and income. The state also has provided 12-month continuous eligibility for children in Medicaid and CHIP for more than a decade.

- The sweeping legislative changes adopted in **Iowa** in the late 2000s allowed the state to implement numerous enrollment simplifications, including presumptive eligibility, ELE, and 12-month continuous eligibility for children. Despite the administrative challenges of adopting multiple changes simultaneously, the state's implementation of presumptive eligibility is emerging as a model for the country.[8] It operates an online system for training and certifying presumptive eligibility partners, and has established a web portal that the partners can use to temporarily enroll children in coverage while initiating a regular application on their behalf.

- After adopting 12-month continuous eligibility, eliminating the asset test, and expanding coverage to 300 percent of the federal poverty level in 2009, **Oregon** created a new Healthy Kids office dedicated to children's coverage. This new office embarked upon numerous efforts to simplify enrollment procedures—it revised and simplified the state's application; created an online version of its application, instituted the use of pre-populated forms at renewal, and began checking other databases to see if it already had information available before asking families to provide it (i.e., "ex parte" renewals).

- To a surprising extent, given its uniquely high coverage rate, **Massachusetts** has lagged in its use of some of the simplification strategies adopted by other leading states. For example, it does not provide 12-month continuous eligibility to children. (However, as discussed in more detail below, Massachusetts very recently secured approval via a waiver to begin using Supplemental Nutrition Assistance Program (SNAP) data to renew coverage for parents using ELE and is in the process of securing approval to use the same procedures to renew children's coverage.) There are likely several reasons for the state's success despite not relying on some of the simplification strategies adopted by other states. First, state officials and other stakeholders believe that the health reform law adopted in 2006 has contributed greatly to the state's coverage of children. Even though children are not subject to the state's coverage mandate, the state now has a "culture of coverage." Second, the state has developed strong relationships with advocates and community partners that, as discussed in more detail below, play an instrumental role in facilitating the enrollment of people in coverage. Finally, the state agency's longstanding culture of supporting eligibility and enrollment also may play an important role.

Table 2:
Eligibility Limits and Selected Enrollment and Renewal Simplifications for Children in Medicaid and/or CHIP in Profiled States, January 2012

	AL	IA	MA	OR
ELIGIBILITY				
Upper Income Limit (Percent of the FPL)	300%	300%	300%	300%
Lawfully-Residing Immigrants Without 5-Year Wait		Y	Y	Y
ENROLLMENT PROCEDURES				
Presumptive Eligibility		Y	Y	
Express Lane Eligibility at Enrollment	Y	Y		Y
SSA Data Match to Verify Citizenship	Y	Y	Y	Y
Electronically Submitted Application	Y	Y	*	Y
Administratively Verify Income at Enrollment	Y	Y	Y	Y
RENEWAL PROCEDURES				
12-Month Continuous Eligibility	Y	Y		Y
Express Lane Eligibility at Renewal	Y		Pending	
Administratively Verify Income at Renewal	Y	Y	Y	Y

*In Massachusetts, authorized community partners can submit online applications on behalf of families through the Virtual Gateway system.
Note: A state is indicated as having adopted a simplification if it has been adopted in either its Medicaid or CHIP program.
Source: M. Heberlein, et al., "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured, January 2012.

Across the profiled states, providers and other community partners play an important role in helping families enroll in coverage and in providing feedback to the state. Medicaid and CHIP agencies in each of the four states have taken action to build and maintain strong relationships with providers and community based organizations that further outreach and enrollment efforts and aid the state in identifying opportunities for continued improvement.

- In **Massachusetts**, in particular, community partners, including hospitals, community health centers and community-based organizations, are essential to the state's enrollment efforts. While individuals cannot yet directly submit online applications, community partners can do so on their behalf through a system known as the "Virtual Gateway." Overall, six in ten families enroll in public

coverage through the Virtual Gateway with the assistance of a community-based partner or provider. Moreover, Massachusetts meets with its community partners on a regular basis. This includes monthly advocate meetings to address budget, policy, program and operational issues with MassHealth. Advocates help to develop the agenda for each meeting. These meetings provide the community partners an opportunity to raise issues with the state, while they offer the state the opportunity to identify and address problems and improve the way it handles enrollment and retention. The state also routinely hosts trainings and roundtables with community partners and other stakeholders to disseminate information on state policy and program changes. This process of routinely exchanging information with and eliciting feedback from the field is widely credited by stakeholders as contributing significantly to the state's coverage success.

- In **Iowa**, county public health agencies are given grant funding out of Maternal and Child Health funds (Title V) to conduct outreach with providers, schools, faith-based organizations, and vulnerable groups, including children in immigrant families. By engaging trusted community partners in outreach and enrollment, and, in particular, by authorizing many of them to conduct presumptive eligibility determinations, the state has been able to facilitate the enrollment of significant numbers of families. Presumptive eligibility has given the state another tool to engage community partners, and the state has been extremely successful in recruiting school nurses to participate.

- Outreach is one of the areas most vulnerable to state budget cuts, but **Alabama** has consistently funded regional outreach coordinators who are responsible for promoting coverage and building partnerships throughout the state. State officials proactively work through professional affiliations to engage providers, school officials, and community leaders in the state's outreach efforts, and solicit their feedback on opportunities for improvement. Alabama supplements this community-based outreach with ongoing marketing and public education campaigns. Even during a very brief time when enrollment in CHIP was frozen during 2003, the state continued its outreach efforts to ensure that families with children who were eligible for Medicaid would continue to access coverage.

- Finally, **Oregon** invested nearly $3 million during the 2009 – 2011 biennium in grants to community-based organizations to conduct outreach and serve as local application sites where families can receive personalized assistance. The state trains and pays other organizations, including insurance brokers, a $75 fee for helping families complete an application that leads to at least one child or teen getting enrolled. The state also has dedicated outreach staff, including full-time coordinators for school-based partnerships and reaching communities of color. Further, Oregon embarked on an aggressive marketing and public education campaign to promote Healthy Kids and raise awareness of the 2009 coverage expansion.

Strong coordination between Medicaid and CHIP maximizes outreach and enrollment efforts and smooth transitions between programs. Each of the four states has taken steps to promote close alignment between Medicaid and CHIP, with Massachusetts and Oregon relying on a fully unified approach.

- In **Massachusetts** and **Oregon**, Medicaid and CHIP are administered out of the same agencies and use the same eligibility system, allowing these states to avoid many of the challenges of interagency coordination encountered in states with separate CHIP programs. These states use a single name to describe their coverage initiatives—MassHealth in Massachusetts and Healthy Kids in Oregon—and do not publicly distinguish between families that are eligible for Medicaid or CHIP. While there are

somewhat different rules for the two programs (e.g., different federal matching rates), Massachusetts and Oregon determine which children qualify for which program behind the scenes, and families are not expected to know the differences between the programs.

- In **Alabama** and **Iowa**, Medicaid and CHIP each have a distinct identity, as well as different rules and eligibility systems. However, both states have taken steps to minimize the resulting coordination challenges. Alabama, for example, conducts a unified outreach campaign for both CHIP and Medicaid, and it strives to coordinate coverage as children shift between programs. To this end, it has aligned many of its eligibility rules for the two programs, such as elimination of the asset test and use of the same disregards and deductions when evaluating eligibility. In Iowa, the state electronically refers applications between Medicaid and ***hawk-i***, and if sufficient information is available from the referred application, automatically enrolls the child using ELE. In both instances, however, it is possible that coverage rates would be even higher if there was more seamless coordination between the programs and eligibility systems.

In sum, while there is no single recipe for success in covering children, the four states reviewed in this analysis demonstrate that there are some common key elements that can make a significant difference—strong political leadership, expansive eligibility and use of simplified enrollment and renewal strategies, robust community partnership and engagement, and strong coordination between Medicaid and CHIP. Even among the four states, however, there is variation in the extent to which each of these factors contribute to success, indicating there is a wide range of potential strategies that states may pursue to promote coverage in ways that best fit their political and policy climate.

Remaining Challenges and Next Steps

Another illustration of why the four states profiled in the analysis are among the nation's leaders on children's coverage is that they actively look for opportunities for continued improvement. Respondents within the four states identified several key remaining challenges to covering children that they are seeking to address. They also are taking a number of steps to begin preparing their eligibility and enrollment processes and systems for the broad coverage expansion and new streamlined, technology-driven enrollment requirements that will go into place in 2014 under the ACA.

Each of the four states noted the challenge of maintaining strong enrollment and renewal processes amidst diminishing administrative resources. All four states are facing staff shortages due to state fiscal problems and loss of senior administrators even as caseloads grow. **Iowa,** for example, has lost significant numbers of staff due to an early retirement option and hiring freeze. A nearly identical dynamic is arising in **Alabama** where dwindling administrative resources have made it challenging for Medicaid eligibility staff to keep pace with the substantial growth in applications. In **Oregon**, the administrative funding pressures are less intense because the state has a dedicated funding stream for Healthy Kids until September 2013. Nevertheless, families and community partners report problems such as processing errors, missing paperwork, and variation in how policy is executed from office to office and worker to worker that the state has found difficult to address due to a lack of training resources and staff. In **Massachusetts**, community partners report a notable increase in wait times for families who need assistance with their applications. However, within all four states, state officials are seeking to address these challenges by looking for ways to gain increased efficiencies in program administration, often through the increased use of technology.

Improving retention of eligible children is a key focus among all four states. Iowa, for example, recently provided families with an additional 14-days to return renewal documents for Medicaid, and it is working to allow families to renew online (an option already available for children in ***hawk-i***). In the face of data suggesting that a majority of individuals who lose coverage are re-enrolled within six months, **Oregon** has adopted a pre-populated renewal form that requires only a signature if there are no changes in family circumstances. **Massachusetts** is making greater use of administrative renewals. Initially it is implementing such renewals for groups that rarely experience a change in circumstances, such as those whose only source of income is from the Social Security Administration, but, over time, it may adopt more expansive changes. For example, the state will begin to use Supplemental Nutrition Assistance Program (SNAP) data to renew coverage through adoption of an ELE renewal process for children and their parents. MassHealth has already received approval to use ELE to renew coverage for parents through its Section 1115 waiver, and is in the process of filing a state plan amendment for approval to use ELE to renew coverage for children. Finally, **Alabama** is seeking to reduce coverage losses and gaps at renewal, particularly for children transitioning from Medicaid to CHIP.

The profiled states are engaged in efforts to update outdated eligibility and enrollment systems. A common concern among the four states in the analysis is the antiquated nature of their Medicaid eligibility and enrollment systems. These four states, and many of their counterparts around the country, are looking to take advantage of the availability of new enhanced federal matching funds to conduct major overhauls or upgrades of their systems, which will be key in helping them prepare for the new eligibility and enrollment requirements under the ACA. **Oregon** and **Massachusetts** have begun major efforts to replace their outdated eligibility determination systems and strengthen family-friendly online application opportunities. In **Iowa**, the state currently relies on an outdated legacy system for its Medicaid eligibility determinations, while ***hawk-I*** is better served by an updated system. However, the state is in the process of procuring a new eligibility and Medicaid Management Information System for Medicaid, which it anticipates will allow for continued improvements in the enrollment process. **Alabama** also has received federal approval of its plan to upgrade its eligibility system going into 2012.

Respondents indicated that as part of upgrades to eligibility and enrollment systems they are seeking to improve communications with families and obtain better enrollment performance data. Poorly worded and cumbersome notices were identified as a coverage barrier in a number of the states, which are closely linked to the outdated eligibility and enrollment systems. This is one of the key areas the states plan to improve as part of the upgrades in their eligibility and enrollment systems. Moreover, a number of respondents indicated that the limited capabilities of current systems restrict their ability to obtain data to assess the success of their enrollment and renewal processes, particularly within Medicaid. As such, a number of respondents indicated a focus on and interest in increasing their capacity to obtain performance data as part of eligibility and enrollment system improvements.

Some of the states also identified broader administrative and cultural changes underway to further strengthen their child health coverage initiatives and prepare for the coverage expansions under reform. For example, **Oregon** recently shifted responsibility for eligibility of medical-only cases to the Oregon Health Authority which houses the Healthy Kids office, making it easier for the state to align eligibility, enrollment and retention policies and practices with its coverage goals. Similarly, **Massachusetts** is reviewing its policies and processes to identify ways in which it may need to modify its own earlier reform efforts to meet the requirements of the new federal law. **Alabama** is in the process of re-engineering how it delivers services, and as part of this effort, it is transforming its local eligibility offices into regional service centers with a strong emphasis on customer service.

Conclusion

The four states in this analysis represent different regions of the country and have distinct political and policy cultures, but each share common themes that have contributed to their success in covering children. In each of the states, strong leadership on the issue of children's coverage has played a vital role in the coverage gains, as has the willingness of state officials to expand eligibility, simplify eligibility and enrollment procedures, develop strong relationships with community partners, and promote coordination between Medicaid and CHIP. These states continue to look for ways to improve coverage for children with a strong focus on keeping eligible children enrolled, reducing paperwork, and improving interactions with families, and many of these efforts are taking place hand in hand with broader efforts to prepare for implementation of the ACA. The experiences of these states provide important lessons learned for other states' efforts to cover children and may help inform efforts to enroll newly eligible individuals under the ACA coverage expansion in 2014.

This brief was prepared by Jocelyn Guyer and Tricia Brooks with the Center for Children and Families at Georgetown University's Health Policy Institute and Samantha Artiga with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The authors would like to thank the state officials and other stakeholders who were interviewed for this analysis and, in some instances, offered tours of state facilities. Their assistance was invaluable. Any errors in this issue brief should be attributed to the authors and not to the state officials and stakeholders interviewed for this project.

Appendix A: State Profiles

- **Alabama**
- **Iowa**
- **Massachusetts**
- **Oregon**

Unless otherwise noted, data on uninsured rates in this Appendix are based on an analysis by Georgetown University's Center for Children and Families of the U.S. Census Bureau's American Community Survey while information on income thresholds in Medicaid/CHIP for children are taken from M. Heberlein, et al., "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured, January 2012.

ALABAMA

Children's coverage rate, 2010	**5.9%**
Change in number of uninsured children, 2008-2010	**-21.6%**
Income eligibility limit for children	**300% FPL**

Overview of Eligibility and Enrollment

Alabama is the only Southern state to cover children through Medicaid and CHIP (known as ALL Kids) up to 300 percent of the federal poverty level and has one of the lowest uninsured rates (5.9%) in the South. The success of the state's outreach and enrollment efforts earned Alabama CHIPRA performance bonuses for Medicaid enrollment in each of the three years (2009 – 2011) that states have been able to qualify for bonuses.

Although Medicaid and CHIP in Alabama are distinctly different, the state promotes coverage for both programs through an umbrella approach to outreach and strives to coordinate coverage as children shift between programs. CHIP is administered by the Alabama Department of Public Health and benefits are provided through Blue Cross Blue Shield of Alabama. Medicaid is administered as a fee-for-service program by the Alabama Medicaid Agency. While operating Medicaid and CHIP as separate programs, the state has aligned many of the eligibility rules for the two programs. It does not have an asset test in either program and relies on the same disregards and deductions when evaluating eligibility.

Families can apply for coverage through the mail, in-person, at kiosks in public health departments and community health centers, or directly through an online application. The state has adopted 12-months continuous eligibility, as well as a number of streamlining measures in its application and renewal processes. CHIP allows self-attestation of income while Medicaid uses data from government and private databases to verify income (except for families with self-employment). Alabama was one of the first states to implement ELE for Medicaid using the state's SNAP program. Both Medicaid and CHIP offer online renewals and provide for administrative renewals, using pre-populated forms that require only that families sign and return the form to continue coverage if there are no other changes.

Key Reasons for Success

Public health approach. The creation of ALL Kids, Alabama's version of CHIP, under the Alabama Department of Public Health (ADPH) emphasized the importance of health coverage as a means to promote preventive services essential to childhood development and health. This "public health" approach was strongly supported by the state's provider community and is attributed with advancing public and political support for ALL Kids.

Strong legislative support for children's coverage. Alabama leads the region in covering children with the highest CHIP eligibility threshold among Southern states. Its commitment to children's coverage has held steady in a generally conservative state with one exception in 2003, when the state capped enrollment in CHIP and instituted a waiting list for eight months. The most recent expansion of coverage to 300 percent of the poverty level in 2009, was achieved by the state's legislature, which successfully overturned a gubernatorial veto of the budget needed to fund the expansion.

Sustained outreach and community partnerships. Since the inception of CHIP, Alabama has made a strong investment in public education by dedicating regional outreach coordinators to promote coverage and build community partnerships. (Even during the CHIP enrollment freeze, outreach continued, minimizing the chilling effect generally associated with enrollment caps.) Program administrators also are extremely proactive in working through professional affiliations to engage providers, school officials and community leaders as partners in the state's outreach effort, and in soliciting their feedback on opportunities for improvement.

Consistent improvement in enrollment and renewal procedures. Alabama is engaged in an ongoing effort to reduce paperwork, simplify procedures and improve coordination between programs. Program officials indicate that participation in learning collaboratives (such as the Eligibility Process Improvement Collaborative and the Maximizing Enrollment project)[9] challenges them to make ongoing improvements and adopt proven strategies and best practices from other states. Most notably, Alabama increasingly is using technology to reduce paperwork, such as by launching an online application with an electronic signature option. It also electronically verifies eligibility criteria such as citizenship and income, and is implementing a document-imaging system.

Remaining Challenges and Opportunities for Improvement

Loss of coverage at renewal. Like many states, a priority for Alabama is to reduce churning due to a loss of coverage at renewal or as children transition from Medicaid to CHIP. Medicaid lacks data to quantify the extent of the problem but Alabama's CHIP office reports that 18 percent to 20 percent of children fail to have their coverage renewed; of these, 80 percent owe premiums.

Reductions in staff. With dwindling administrative resources resulting from budget cuts, Medicaid eligibility staff is hard-pressed to keep pace with the substantial growth in enrollment and to complete determinations within the required 45-day federal time limit. Although an electronic data interface exists between systems, the low volume of electronic applications and differences in data fields between the two systems perpetuates a continued reliance on paper applications and renewal forms and results in further delays as forms are transferred between agencies.

Lack of performance data. While the CHIP agency has developed mechanisms for collecting and reporting data on its performance, the state's aging Medicaid eligibility system lacks the ability to provide vital management information. Program officials report that they are missing the data they need to quantify problems and assess the impact of their strategies to improve enrollment.

Next Steps

Both Medicaid and CHIP are committed to implementing and improving their document management systems, and promoting the online application, so that forms and applications may be easily transferred between agencies. The state also is pursuing the use of ELE for low-income parents. Alabama also is in the process of re-engineering its delivery of client services by transforming its local eligibility offices for public benefits into regional service centers where customer service is a top priority.

IOWA

Children's coverage rate, 2010	**4.0%**
Change in number of uninsured children, 2008-2010	**-19.4%**
Income eligibility limit for children	**300% FPL**

Overview of Eligibility and Enrollment

Throughout 2008 and 2009, Iowa implemented a range of policies to expand children's coverage through Medicaid and its separate CHIP program known as "***hawk-i***." The state increased children's eligibility to 300 percent of the federal poverty level; eliminated the five-year wait for coverage for lawfully-residing immigrant children; and implemented presumptive eligibility, ELE, and 12-month continuous eligibility. In adopting these policies, the state also increasingly aligned procedures between Medicaid and ***hawk-i***. Following implementation of these policies, the state experienced increased enrollment in coverage and earned a CHIPRA bonus in FY2010 in recognition of its success. As of 2010, the uninsured rate for children in Iowa was at 4%, the lowest rate among Midwest states.

Although policies for Medicaid and ***hawk-i*** have become increasingly aligned, the program applications, administration, and eligibility systems remain separate, with ***hawk-i*** administered by a third-party administrator. To coordinate coverage, the state electronically refers applications between Medicaid and ***hawk-i***, and if sufficient information is available from the referred application, automatically enrolls the child using ELE. For both Medicaid and ***hawk-i***, families have the option to apply online, but must follow-up with paper documentation of income. Families can renew ***hawk-i*** online but do not yet have this option in Medicaid. There also are some differences between Medicaid and ***hawk-i*** in the timing of renewal notices and procedures.

Key Reasons for Success

Strong support for CHIP, with spillover effects for Medicaid. Since its inception, ***hawk-i***, has had strong support, much of which derived from legislators and the public viewing it as a health program separate from welfare. Moreover, as the program developed, it incorporated simplifications that had not yet been adopted in Medicaid, which garnered strong public appeal. As a result of the broad support and outreach for CHIP, more families applied for coverage, many of whom had children who actually were eligible for and enrolled in Medicaid. Further, the appeal and success of simplifications in CHIP helped pave the way for simplifications in Medicaid. Legislators' recognition of the popularity of CHIP simplifications spurred them to make further simplifications in Medicaid. The CHIPRA performance bonus provided additional incentive for the state to move forward with Medicaid simplifications.

Adoption of a broad range of expansion and simplification policies. As Iowa took steps to strengthen and improve children's coverage, it adopted a broad range of policies that expanded eligibility to more children and simplified the enrollment process. The combination of the improvements was important for success since it enabled the state to address multiple barriers to coverage.

Continued movement to paperless processes. Iowa's implementation of online applications for Medicaid and ***hawk-i*** and use of an electronic data match with the SSA to verify citizenship also were important improvements in the enrollment process. Since correcting some initial technical problems with the online application, it has been very successful. In May 2011, more than half (58 percent) of the

applications the state received for CHIP were submitted online. Further, prior to implementation of the data match with the SSA, providing documentation had created a significant enrollment barrier for families. This problem has been largely eliminated through the high rate of successful matches with the SSA.

Community level outreach and presumptive eligibility. Iowa contracts with its county public health agencies through its Title V Maternal and Child Health grant to conduct outreach for ***hawk-i***. Under these contracts, each county agency that receives Title V funding employs an outreach coordinator to conduct grassroots outreach with providers, schools, faith-based organizations, and vulnerable groups, including children in immigrant families. The outreach coordinators are a key resource for reaching eligible children since they are trusted individuals that have established relationships within the community, for example, with school nurses, other public health staff in WIC and immunization clinics, and medical providers. Moreover, the state recently implemented presumptive eligibility, which allows outreach coordinators, along with other qualified entities such as school nurses and providers, to immediately enroll children who appear eligible so they can begin receiving care while their final eligibility determination is being processed. Iowa is now widely viewed as one of the nation's emerging leaders in implementing presumptive eligibility.

Challenges

Diminished administrative capacity. Due to continuing state budget problems there has been a significant reduction in state staff as a result of an early retirement option and hiring freeze. This has had a significant impact on program operations and is affecting enrollment. In combination with rising numbers of applications, the Medicaid staff is increasingly overwhelmed with the volume of applications and applications are backing up.

Coverage losses at renewal. Although the implementation of 12-month continuous eligibility has significantly reduced churning, the state continues to look for ways to reduce the loss of coverage at renewal. In particular, the 10-day timeframe during which families must return documents to renew coverage for Medicaid can sometimes be challenging for families. In response, the state recently implemented a 14-day grace period for households that fail to turn in their document during the initial 10-day timeframe (for both the Medicaid and ***hawk-i*** program), effectively giving families 24 days to return documents. A further challenge at renewal is that, although families can renew ***hawk-i*** coverage online, this option currently is not available for Medicaid.

Limitations in the Medicaid eligibility system. ***Hawk-i*** uses a contractor-based eligibility system that has evolved and improved over time. In contrast, Medicaid continues to operate using a legacy system. Limitations in this system hinder the state's ability to make program simplifications and improvements, such as creating simpler beneficiary notices. The system also has limited data reporting capabilities.

Next Steps

The state is continuing to explore opportunities to use technology to improve eligibility and enrollment processes. Specifically, the state is in the process of procuring a new eligibility and Medicaid Management Information System (MMIS) for Medicaid, which it anticipates will allow for continued improvements in the enrollment process. The state also is exploring the potential of allowing applicants utilizing the online application to scan and email documentation.

MASSACHUSETTS

Children's coverage rate, 2010	**98.5%/99.5%***
Change in number of uninsured children, 2008-2010	**-11.2%**
Income eligibility limit for children	**300% FPL**
*State-specific data from Massachusetts indicate it had a 99.5 percent coverage rate of children in 2010. See endnote 5.	

Overview of Eligibility and Enrollment

The 2006 health reform law in Massachusetts was designed to ensure affordable insurance is available to nearly everyone in the state. For children, coverage is available through Medicaid and CHIP (known as "MassHealth" in Massachusetts) up to 300 percent of the federal poverty level.[10] In addition, Massachusetts has a program called the Children's Medical Security Plan which provides certain uninsured children and adolescents at any income level with primary and preventative medical and dental coverage. Parents and other adults are covered through a combination of Medicaid, related programs and Commonwealth Care, a subsidized coverage program similar to the Exchanges included in the ACA. No asset test is required, and the state evaluates eligibility using a gross income test rather than a system of disregards and deductions.

Families can apply for coverage through mail, fax, or in-person. In addition, authorized community partners can submit applications through an online system known as the "Virtual Gateway." When applying through the Virtual Gateway system, families (or community partners acting on their behalf) still must send a signature page (via mail only) and any other required verifications, such as recent pay stubs (via mail or fax), to complete the application. The state has taken up the option to use presumptive eligibility for children, but has not adopted 12-months continuous eligibility.

Key Reasons for Success

Deep and sustained commitment to children's coverage. Massachusetts led much of the country in covering children even prior to creation of the Children's Health Insurance Program (CHIP) in 1997. This commitment has held steady through both Democratic and Republican Administrations, and has been attributed to the political culture of the state, the leadership of state officials and policymakers, and strong advocacy by consumer-based organizations. State officials and other stakeholders universally pointed to this deep-rooted commitment to coverage as a key element that has contributed to the state's coverage success.

Unique partnership with community partners. In Massachusetts, community partners, including hospitals, community health centers and community-based organizations, play a substantial role in enrolling children and others in coverage, often through the online Virtual Gateway. Overall, six in ten families enroll in public coverage through a community-based partner or provider. The community partners conduct outreach, assist families in applying for and renewing coverage using the Virtual Gateway, gather necessary paperwork, and track the outcome of enrollment status over time. Providers, especially hospitals, have strong financial incentives to help individuals apply for coverage because people must complete the Virtual Gateway application to be eligible for the state's free care pool if they are ultimately determined ineligible for Medicaid, CHIP, or Commonwealth Care. To support the partnership, the state has developed a system of regular communication with its partners that include

monthly meetings and roundtable discussions, as well as more informal emails and phone calls between meetings. The system is used to disseminate information about policy changes, but just as importantly, to receive feedback on issues that are arising in the enrollment process. A leading community partner, Health Care for All (HCFA), helps to set the agenda for these meetings.

Broad coverage increases under health reform. Adopted in 2006, the Massachusetts health reform law (Chapter 58) brought sweeping changes to the state's health care system, and significantly increased coverage options for low-income adults. In light of far-reaching media coverage of the new law, active outreach campaigns, and the individual mandate, many families sought coverage following the law's enactment. In the process, many enrolled their children in Medicaid or CHIP. Moreover, the surge in applications that followed passage of reform spurred the state to adopt additional enrollment simplifications and make greater use of technology, which in turn has eased the process by which families apply for and renew coverage. Without the enrollment simplifications and enhanced use of technology, state officials report they could not have kept pace with the deluge of applications that appeared after passage of Chapter 58.

Remaining Challenges and Opportunities for Improvement

Loss of coverage at renewal. State officials and advocates alike pointed to the need to reduce the rate at which eligible children lose coverage at renewal. To address this issue, Massachusetts recently secured approval via a waiver to use SNAP data to renew coverage for parents and has filed a state plan amendment to do so for children as well. MassHealth also will use administrative renewal to evaluate ongoing eligibility. Efforts to adopt 12-months continuous eligibility were not successful this year, but could be raised again in future years. Finally, the state is considering strategies to address gaps in coverage that arise as people move from Medicaid to Commonwealth Care.

Limits on administrative capacity. The flat funding of administrative costs in the face of dramatically expanding caseloads (see Figure 1 in the text) has created tremendous pressure on the eligibility staff that are processing applications. While, as discussed above, this has spurred simplification of the enrollment process, it also has resulted in eligibility workers being more apt to misplace documents and to get backlogged in answering phone calls from families needing help.

Next Steps

Massachusetts is looking to make greater use of administrative renewals. It is beginning by identifying groups that rarely experience a change in circumstances, such as those whose only source of income is from the Social Security Administration. The state also is in the midst of implementing an electronic data management system. It anticipates this system will help eliminate paper files and will enable eligibility workers to find case information regardless of where they are located. Moreover, as discussed above, the state will now use SNAP data to renew coverage through ELE for children and their parents.

OREGON

Children's coverage rate, 2010	**8.8%/5.6%***
Change in number of uninsured children, 2008-2010	**-27.9%**
Income eligibility limit for children	**300% FPL**
*State-specific survey data from Oregon indicate that the state's uninsured rate among children was 5.6% in 2011. See endnote 6 for details.	

Overview of Eligibility and Enrollment

In late 2009, the Oregon Legislature adopted sweeping legislation—the Healthy Kids Act—to expand children's health coverage and remove barriers to enrollment. Wasting no time, Oregon kicked into high gear in early 2010 to implement the new law, which expanded Oregon's Medicaid and CHIP programs (Oregon Health Plan) to 200 percent of the federal poverty level and created a separate cost-sharing CHIP program (called Healthy Kids) through 300 percent of the federal poverty level. The law also allows families with incomes above this limit to purchase Healthy Kids coverage at full cost and covers legally residing immigrant children. While administration of all Oregon health coverage programs is centralized under the umbrella of the Oregon Health Authority, the Healthy Kids legislation created a new office dedicated to aggressive outreach and marketing. Recently, the responsibility of the Healthy Kids office has been expanded to include oversight of a centralized eligibility unit dedicated to medical-only programs.

To remove barriers to enrollment in advance of the expansion, Oregon also adopted 12-months continuous eligibility and eliminated its asset test. The state developed a new streamlined application with the option to apply online in addition to applying through the mail or in-person at community partner sites statewide. Although applicants still are required to submit income via mail or fax, families receiving other public assistance such as SNAP are not required to provide duplicative income verification. At renewal, the state attempts to determine ongoing eligibility through an ex parte review of other programs and enrollees can also renew by telephone or online. The state's aggressive efforts have resulted in the new enrollment of 106,000 children in the past year, slashing the rate of uninsurance among Oregon children by more than half, down to 5.6 percent.

Key Reasons for Success

Governor's leadership, supported by advocacy. For many years, Oregon fell in the middle of the pack among states in covering children. At 185 percent of the federal poverty level, its eligibility level was among the lowest in the country. Then in 2007, Governor Kulongoski secured legislative approval to expand coverage up to 300 percent of the federal poverty level, financed by an increase in the tobacco tax. Ultimately, a well-financed campaign by tobacco interests overturned the revenue source in a subsequent ballot initiative. Bolstered by strong advocacy, Governor Kulongoski continued to press to increase children's coverage, first by implementing 12-month continuous eligibility through executive order and then by actively pushing for the eligibility expansion. In 2009, the Oregon legislature approved the Healthy Kids Act.

Aggressive outreach and marketing. The launch of the Healthy Kids expansion was accompanied by an extensive and multi-faceted outreach and marketing campaign. Healthy Kids coverage has been heavily promoted in magazines and at malls, on billboards and buses, and in cinemas and on radio. Targeted outreach campaigns are focused on schools, communities of color and businesses unable to offer health coverage to employees or their dependents.

Strong investment in community partnerships. In addition to its broad-based outreach and marketing activities, Oregon invested more than $3 million in grants in the biennium 2009 - 2011 to community-based organizations to conduct outreach and serve as local application sites where families can receive personalized assistance. The state also pays other organizations, including insurance brokers, a $75 fee per application for helping families complete the application. Outreach coordinators work with partners in schools and safety net and rural clinics, providing training and materials for display or distribution.

Forging ahead on multiple policy and procedural fronts. Oregon's adoption of key simplification policies—12-month continuous eligibility, elimination of the asset test, ex parte redeterminations, pre-populated renewal forms, and adoption of an online application and streamlined application process—have supplemented its aggressive outreach and marketing. In sum, state officials have embarked upon a multi-faceted effort to maximize enrollment through outreach, simplification, and culture change.

Remaining Challenges and Opportunities for Improvement

Getting data and refocusing performance standards. State officials express the need for routine, reliable data to measure the state's success in covering children and identify opportunities for improvement. Data on volume, source and disposition of both new applications and renewals are high on the state wish list. Program administrators are interested in revising performance standards to measure their progress in ensuring that all eligible children are enrolled and retained, as well as to measure timeliness and the accuracy of eligibility determinations.

Improving eligibility processes and procedures. Families and community application assistors report difficulties arising from processing issues, missing paperwork and variation in how policy is executed from office to office and worker to worker. Inadequate staffing and limited training resources make it more difficult for the state to tackle these issues.

Need to emphasize retention. Although data are limited, reports show that a majority of individuals who lose coverage are re-enrolled within six months. The state recently deployed a new simplified renewal process using a pre-populated renewal form that requires only a signature if there are no changes in family circumstances. However, program administrators continue to look for more ways to support renewal efforts and prevent eligible children from experiencing gaps in coverage.

Client communications. Program officials acknowledge that notices in particular often convey conflicting and confusing information to families, impeding their ability to comply with requirements. There is the recognition that notices need to be clearer and easier for families to understand.

Next Steps

Recently, Oregon shifted responsibility for eligibility for medical-only cases under the Oregon Health Authority, which will be closely aligned with the Healthy Kids outreach strategies. This realignment provides an opportunity for program administrators to delve into the eligibility process and procedures with an eye toward further streamlining and program improvements. For example, program administrators want to examine opportunities to simplify eligibility verification for seasonal workers and self-employed individuals. Healthy Kids officials also plan to work more closely with managed care plans to help ensure that eligible children do not slip through the cracks at renewal. Additionally, the staff is looking ahead to implementation of health reform and ensuring there is strong coordination of coverage for children and families regardless of its source.

Appendix B

Table 1: Uninsured Rates of Children by State, 2008-2010

State	2008		2009		2010		% Change in Number of Uninsured '08-'10
	Rate (%)	Number	Rate (%)	Number	Rate (%)	Number	
United States	**9.0**	**6,878,540**	**8.6**	**6,369,023**	**8.0**	**5,918,388**	**-14.0**
Alabama	7.6	85,409	5.9	66,730	5.9	66,958	-21.6
Alaska	11.6	20,964	13.6	24,993	12.2	22,843	9.0
Arizona	15.1	258,339	12.0	207,853	12.8	207,967	-19.5
Arkansas	8.1	56,501	6.2	44,061	6.6	46,495	-17.7
California	10.0	930,526	9.5	890,998	9.0	832,752	-10.5
Colorado	13.8	165,912	10.2	124,366	10.1	124,128	-25.2
Connecticut	4.6	37,355	3.8	30,433	3.0	24,114	-35.4
Delaware	7.5	15,403	5.5	11,310	5.3	11,012	-28.5
District of Columbia	3.6	4,003	2.8	3,198	2.3	2,309	-42.3
Florida	16.7	667,758	14.8	600,537	12.7	506,934	-24.1
Georgia	11.0	278,016	10.9	281,144	9.8	244,004	-12.2
Hawaii	3.4	9,667	2.5	7,066	3.7	11,116	15.0
Idaho	12.7	52,368	11.2	46,971	10.5	45,004	-14.1
Illinois	5.2	164,817	4.5	142,269	4.5	140,105	-15.0
Indiana	9.6	152,166	8.8	140,011	8.9	142,672	-6.2
Iowa	5.1	36,054	4.6	32,312	4.0	29,046	-19.4
Kansas	7.4	51,930	8.2	57,717	8.2	59,783	15.1
Kentucky	6.5	64,851	6.3	64,407	6.0	61,180	-5.7
Louisiana	7.2	80,093	6.5	72,758	5.5	61,718	-22.9
Maine	6.6	18,103	5.6	15,194	4.0	10,935	-39.6
Maryland	5.0	66,719	4.8	64,548	4.8	64,298	-3.6
Massachusetts	1.7	24,422	1.4	19,816	1.5	21,682	-11.2
Michigan	4.8	114,388	4.6	106,809	4.1	95,103	-16.9
Minnesota	5.8	72,493	6.6	83,057	6.6	84,165	16.1
Mississippi	11.6	88,587	10.3	78,509	8.4	63,502	-28.3
Missouri	6.8	96,227	6.9	98,465	6.2	88,145	-8.4
Montana	13.0	28,734	12.9	28,470	12.4	27,558	-4.1
Nebraska	6.8	30,090	6.3	28,000	5.6	25,734	-14.5
Nevada	19.4	129,655	17.8	121,386	17.4	115,339	-11.0
New Hampshire	4.9	14,262	4.7	13,476	4.8	13,679	-4.1
New Jersey	6.7	137,372	6.4	129,835	6.0	123,456	-10.1
New Mexico	13.3	66,639	11.4	58,739	10.2	52,891	-20.6
New York	5.3	231,735	4.6	204,997	4.8	208,461	-10.0
North Carolina	9.4	211,252	8.2	185,902	7.7	176,700	-16.4
North Dakota	7.1	9,990	5.6	7,951	6.5	9,703	-2.9
Ohio	6.8	185,154	6.4	172,347	6.0	161,954	-12.5
Oklahoma	12.4	111,575	11.2	102,678	10.0	92,521	-17.1
Oregon	12.1	105,038	10.4	90,527	8.8	75,751	-27.9
Pennsylvania	5.8	158,688	5.3	147,428	5.2	144,184	-9.1
Rhode Island	5.2	11,794	5.4	12,293	5.6	12,490	5.9
South Carolina	11.7	124,889	10	107,439	9.4	101,857	-18.4
South Dakota	8.1	15,770	7.6	14,751	8.3	16,695	5.9
Tennessee	6.5	95,673	5.9	87,306	5.3	79,244	-17.2
Texas	17.0	1,137,867	16.3	1,119,685	14.5	996,493	-12.4
Utah	12.7	107,821	10.3	89,132	10.9	94,691	-12.2
Vermont	3.7	4,749	3.2	3,989	2.0	2,627	-44.7
Virginia	7.3	132,546	6.6	121,583	6.6	121,380	-8.4
Washington	7.6	116,656	6.9	107,540	6.4	101,614	-12.9
West Virginia	6.2	23,685	5.5	21,133	4.5	17,518	-26.0
Wisconsin	4.8	62,877	5.0	65,407	5.0	67,110	6.7
Wyoming	8.6	10,958	9.0	11,497	7.9	10,768	-1.7

Source: Analysis by Georgetown University's Center for Children and Families of the 2008, 2009, and 2010 U.S. Census Bureau's American Community Survey.

Table 2:
Upper Income Eligibility Limit for Children's Coverage by State, 2008-2010

State	2008	2009	2010
Total ≥ 250% FPL	**16**	**19**	**24**
Total ≥300% FPL	**10**	**11**	**16**
Alabama	200	200	300 ▲
Alaska	175	175	175
Arizona	200	200	200
Arkansas	200	200	200
California	250	250	250
Colorado	200	205 ▲	205
Connecticut	300	300	300
Delaware	200	200	200
District of Columbia	300 ▲	300	300
Florida	200	200	200
Georgia	235	235	235
Hawaii	300	300	300
Idaho	185	185	185
Illinois	200	200	200
Indiana	200	250▲	250
Iowa	200	200	300 ▲
Kansas	200	200	241 ▲
Kentucky	200	200	200
Louisiana	200	250 ▲	250
Maine	200	200	200
Maryland	300 ▲	300	300
Massachusetts	300	300	300
Michigan	200	200	200
Minnesota	275	275	275
Mississippi	200	200	200
Missouri	300 ▲	300	300
Montana	175 ▲	175	250 ▲
Nebraska	185	185	200 ▲
Nevada	200	200	200
New Hampshire	300	300	300
New Jersey	350	350	350
New Mexico	235	235	235
New York	250	400 ▲	400
North Carolina	200	200	200
North Dakota	140	150 ▲	160 ▲
Ohio	200	200	200
Oklahoma	185	185	185
Oregon	185	185	300 ▲
Pennsylvania	300 ▲	300	300
Rhode Island	250	250	250
South Carolina	150	200 ▲	200
South Dakota	200	200	200
Tennessee	250 ▲	250	250
Texas	200	200	200
Utah	200	200	200
Vermont	300	300	300
Virginia	200	200	200
Washington	250	250	300 ▲
West Virginia	220	220	250 ▲
Wisconsin	185	250 (300) ▲	300
Wyoming	200	200	200

Notes: ▲ denotes an increase in the eligibility limit. Wisconsin 2009 data is classified as at or above 250% FPL.
Source: M. Heberlein, et al., "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured, January 2012.

ENDNOTES

[1] G. Kenney, *et al*., "Improving Coverage for Children Under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," Health Affairs 30(12): 2371-2381 (December 5, 2011).
[2] G. Kenney, *et al*., "Improving Coverage for Children Under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," Health Affairs 30(12): 2371-2381 (December 5, 2011).
[3] Both the 2010 increase in child poverty and the decrease in uninsured children represent statistically significant changes from 2009 at the 90 percent confidence interval.
[4] With respect to children, the ACA requirement prevents states from scaling back their Medicaid and CHIP eligibility thresholds and from adopting more onerous application and renewal requirements through 2019.
[5] L. Phadera & S. K. Long, "Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2010 Massachusetts Health Insurance Survey," Health Care Finance and Policy (November 2010).
[6] See Oregon Health Authority, "New Survey Results Show Oregon Has Reduced by Half the Number of Uninsured Children," July 2011.
[7] United States Census Bureau, American Community Survey (2010).
[8] T. Brooks, "Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage," Center for Children and Families (May 2011).
[9] Collaboratives are working groups that convene to discuss strategies and best practices, often for maximizing enrollment and retaining coverage in Medicaid and CHIP. Alabama is currently participating in the Maximizing Enrollment project. The state's initiative, Perfecting Enrollment for Alabama's Kids (PEAK), seeks to identify barriers to enrollment and application completion, streamline enrollment and eligibility determination systems, implement Express Lane Eligibility, and utilize technology and maximize state resources to identify, enroll and retain eligible children. In November 2011, CMS announced funding to support Medicaid and CHIP learning collaboratives (MAC Collaboratives) that will bring together state and federal partners to address common challenges, pursue innovations, and enable expedient implementation of the Affordable Care Act.
[10] The differences between Medicaid and CHIP are not apparent to families, and are largely limited to the different matching rates and a requirement that families who have dropped employer-sponsored coverage have children who have been uninsured for six months before they can be enrolled in CHIP.

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