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Enrolling Children and Families in Health Coverage: The Promise of Doing More

Prepared by
Donna Cohen Ross and Laura Cox
Center on Budget and Policy Priorities

June 2002

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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Enrolling Children and Families in Health Coverage: The Promise of Doing More

A Report on a National Survey of Enrollment and Renewal Procedures in Medicaid and SCHIP

Prepared by
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Executive Summary

Over the past four years, the nation has been sharply focused on reducing the number of uninsured children. The enactment of the State Children's Health Insurance Program (SCHIP) in 1997 gave states new federal funds with which to expand children's health coverage programs and fueled a dramatic extension of coverage for low-income children through Medicaid and separate SCHIP programs. But, early experience revealed that expanding eligibility is only a first step toward covering more children and that simplifying program rules and procedures is instrumental to ensuring that children enroll in available programs.

The Center on Budget and Policy Priorities is conducting a series of surveys for the Kaiser Commission on Medicaid and the Uninsured on the enrollment and renewal procedures used by states in their child and family-based health coverage programs. The latest survey, which provides information on states' policies and procedures as of January 2002, indicates that states have generally designed their SCHIP-funded child health coverage programs to avoid the most prominent enrollment barriers and they have made significant efforts to import these design features into their existing Medicaid programs for children. Across the country, most states have adopted simplification strategies, including: shortening applications, removing asset tests and allowing forms to be submitted by mail without a face-to-face interview.

Yet, procedural barriers to health coverage remain. To address some of the factors that continue to deter the application process, states are gradually incorporating a host of other simplified enrollment procedures into their health coverage programs. They also are paying increased attention to simplifying and coordinating renewal procedures in children's Medicaid and SCHIP programs. The additional steps states are taking to facilitate enrollment and retention of coverage include: reducing verification requirements, adopting presumptive eligibility, guaranteeing children 12 months of health coverage regardless of changes in family circumstances, as well as other simplified renewal procedures.

In addition to these efforts, there is a pressing need to simplify procedures in family-based programs that extend coverage to parents along with their children. In most states, it remains more difficult for an income-eligible parent to obtain and retain health coverage than it is for her income-eligible child.

Key Survey Findings

Despite fiscal tension, the survey found that states have continued to expand eligibility for children and to improve their enrollment and renewal procedures. The level of such activity continued to be high, and procedural simplifications continued to evolve, through 2001.

States have continued to expand coverage for children. In 2001, fourteen (14) states expanded health coverage for children, so that currently:

- Forty (40) states, including D.C., make health coverage available to children in families with income up to 200 percent of the federal poverty line or higher.

- Forty-four (44) states, including D.C., disregard assets in determining eligibility for children's health coverage. (While this strategy can help some children qualify, states report that the real value of removing the asset test is that it can significantly simplify the application process.)

- Eighteen (18) states — including 11 SCHIP-funded Medicaid expansions and 7 SCHIP-funded separate programs — do not impose waiting periods in their SCHIP-funded programs.

States have continued to improve enrollment procedures and also have paid more attention to simplifying renewal procedures so that children have a better chance of retaining coverage for as long as they remain eligible (Figures 1 and 2). In 2001, twenty (20) states adopted at least one of the simplification strategies considered by this survey, so that currently:

- The vast majority of states **do not impose a face-to-face interview requirement** (47 states, including D.C.) on families applying for Medicaid for children or separate SCHIP programs.

- Of the 35 states with separate SCHIP programs, 33 allow families to **use a single form to apply** for Medicaid and SCHIP for their children.

- Most states (42 states, including D.C.) allow children to **renew coverage annually**, and (48 states, including D.C.) have **no face-to face interview at renewal**.

In addition to adopting the simplification strategies that are now almost universally in use, states are gradually implementing the following options:

- A growing number of states (13 states — up from ten in 2000) **do not require families to provide verification of the income** reported on their application, greatly reducing the paperwork burden faced by these families. These states generally verify income and other information by matching the information reported by the family with existing state databases.

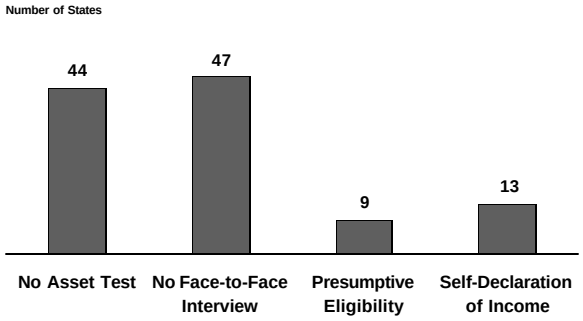
- A growing number of states (17 states — up from 13 in 2000) **guarantee a full 12 months of coverage for children,** regardless of changes in family circumstances.

- Nine (9) states have adopted the **presumptive eligibility** option for children in Medicaid and six (6) states have used the option in both their Medicaid and separate SCHIP programs.

- Twenty-one (21) out of 35 states with separate SCHIP programs allow families to **use a joint form to renew coverage** for children's Medicaid and SCHIP.

Figure 1

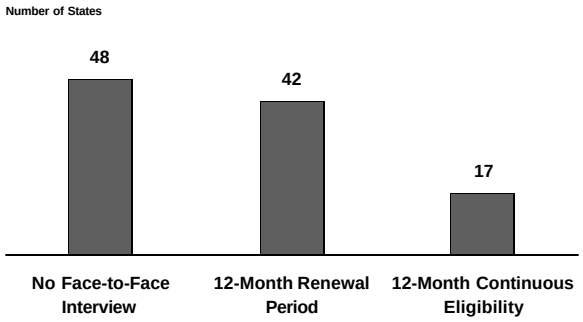
Simplifying Enrollment:
Strategies States are Using in Children's Health Coverage Programs, Jan. 2002



SOURCE: Center on Budget and Policy Priorities, National Survey of State Enrollment/Renewal Procedures, 2002 conducted for the Kaiser Commission on Medicaid and the Uninsured

Figure 2

Simplifying Renewal:
Strategies States are Using in Children's Health Coverage Programs, Jan. 2002



SOURCE: Center on Budget and Policy Priorities, National Survey of State Enrollment/Renewal Procedures, 2002 conducted for the Kaiser Commission on Medicaid and the Uninsured

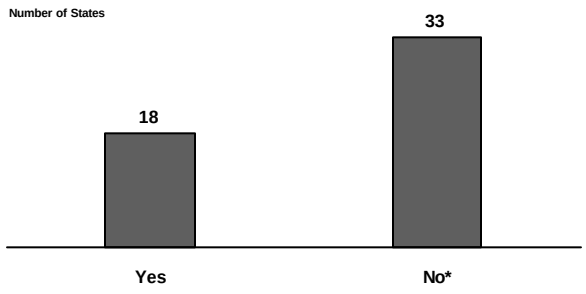
Many states have imported procedural simplifications from their separate SCHIP programs into their children's Medicaid programs, resulting in closer alignment of some, but not all, aspects of children's Medicaid and separate SCHIP programs.

An important step states can take to foster greater coordination between children's Medicaid and separate SCHIP programs is to remove the traditional "age-based" income eligibility guidelines in Medicaid, so that all children in a single family qualify for the same program, meaning families need only navigate one set of program rules and procedures. Currently:

- Eighteen (18) states have a uniform income-eligibility standard for all children in a single family (Figure 3). (In April 2002, after the survey was complete, New York removed Medicaid's age-based distinctions so that all children ages one through 18 in families with income at or below 133 percent of the federal poverty line qualify for Medicaid. Virginia recently passed legislation that would make all children birth through age 18 in families with income below 133 percent of the federal poverty line eligible for Medicaid.)

Figure 3

All Children in Same Family Enrolled in Same Program (Medicaid or SCHIP), Jan. 2002



* These 33 states base Medicaid and SCHIP eligibility on income and age, resulting in eligibility "steps" where children in the same family may qualify for different programs depending on their age.
SOURCE: Center on Budget and Policy Priorities, National Survey of State Enrollment/Renewal Procedures, 2001 conducted for the Kaiser Commission on Medicaid and the Uninsured

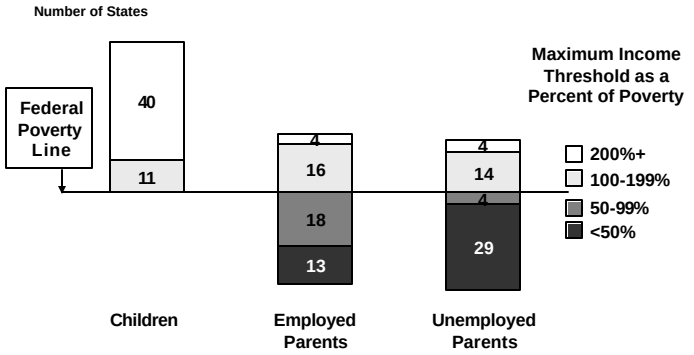
While some states are beginning to expand coverage to low-income parents and tackle the challenge of simplifying the enrollment and renewal procedures used for families, it remains harder in most states for parents and children to secure coverage when they apply as a family unit, than it is for children who apply without other family members (Figures 4 and 5).

- Twenty (20) states, including D.C., have expanded coverage to parents with income up to the federal poverty line or higher, as compared to 40 states that cover children in families with income up to 200 percent of the federal poverty line or higher.

- Nineteen (19) states, including D.C., have eliminated the asset test in determining eligibility for parents, as compared with 44 states that have done so for children.

Figure 4

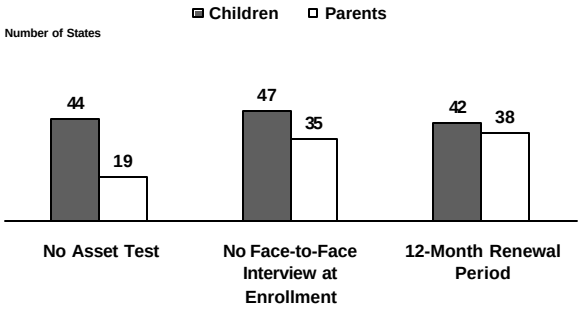
Differences in Medicaid/SCHIP Income Eligibility for Parents and Children, June 2001



The federal poverty line for a family of three in 2001 was $14,630
SOURCE: Guyer J., "Low-Income Parents' Access to Medicaid Five Years After Welfare Reform," KCMU June 2002

Figure 5

States Have Not Simplified Medicaid for Parents to the Extent They Have for Children's Health Coverage Jan. 2002



SOURCE: Center on Budget and Policy Priorities, National Survey of State Enrollment/Renewal Procedures, 2002 conducted for the Kaiser Commission on Medicaid and the Uninsured

- Twenty-three (23) states, including D.C., allow parents and children to apply for health coverage using a single application. (In all states, families can apply as one unit if they use the combined TANF, Food Stamp and Medicaid application. The applications referred to here generally are for health coverage only, covering both Medicaid and SCHIP, and do not require parents to fill out additional forms to obtain coverage for themselves.)

- Thirty-five (35) states, including D.C., no longer require families to have a face-to-face interview when applying for coverage for a parent, as compared with 47 states that have dropped this requirement when applying for a child.

- Thirty-eight (38) states, including D.C., allow parents to renew their health coverage every 12 months, as compared with 42 states that allow children to renew every 12 months. (In the remaining states, health coverage must be renewed more frequently.)

- Thirty-five (35) states, including D.C., have dropped the face-to-face interview requirement for parents at renewal time, as compared with 48 states that have done so for children.

In a few states that expanded Medicaid coverage for parents, enrollment or renewal procedures for parents covered under "regular" Medicaid are different from the procedures for parents covered under the state's expansion. Such discrepancies often mean that lower-income parents have a more difficult time obtaining and retaining their coverage than do eligible moderate-income parents.

In 2001, despite widespread concern among the states about the weak economy and state budget shortfalls, only two states rescinded simplification strategies.

- **Kentucky** retracted its policy that allowed families to self-declare their income on children's health insurance applications, and now requires them to provide pay stubs or other documentation. The state also reinstated the face-to-face interview at the time health coverage is renewed.[1] **Virginia** no longer has joint forms families can use to apply for and renew coverage in Medicaid and the separate SCHIP program.[2]

During at least some portion of 2001, three states stopped enrolling children in their separate SCHIP programs, due to state budget concerns.

- **North Carolina** had closed enrollment in its separate SCHIP program during 2001, but has now re-opened the program. **Utah** plans to re-open enrollment for a short period in June 2002. SCHIP enrollment in **Montana** remains closed.

Although the Center's survey did not address the issue, news accounts and discussions with state officials and advocates indicate that some states are reducing or eliminating their outreach campaigns aimed at educating families about the availability of coverage.

In the face of the current economic downturn it is important to preserve — and continue to advance — simplification and outreach efforts to ensure children and parents who are eligible for publicly-financed health coverage programs can enroll and retain coverage.

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[1]Kentucky reportedly plans to go back to allowing families to renew children's coverage without an in-person interview, but will reinstate the face-to-face interview requirement at initial enrollment.

[2]Virginia plans to reinstate the joint application for children's Medicaid and the state's separate SCHIP program, FAMIS, in September 2002.

When families experience the loss of a job or curtailed work hours, more children and parents become eligible for Medicaid or SCHIP. Prompt enrollment ensures continuity of care for an individual with a current medical condition and protects families from financial exposure should a medical need arise. Simplification takes on added importance as a way to help families hurt by the economic downturn. Priorities for simplification during difficult economic times include:

- **Maintaining simple, aligned procedures in Medicaid and SCHIP.** State procedures should allow for the smooth transfer of a child from the state's separate SCHIP program into Medicaid if financial hardship warrants the change. A shift into Medicaid would relieve the family of any cost-sharing requirements imposed by the SCHIP program and would assure the family of the other protections the Medicaid program provides.

- **Adopting strategies that assure children health coverage without delay.** Strategies to get children and families Medicaid or SCHIP coverage without delay reduce the danger that they will experience a gap in care if their families have lost private coverage. In addition to implementing basic simplifications, eliminating periods during which children are required to be uninsured before they can apply for SCHIP-funded programs ("waiting periods") and adopting presumptive eligibility are two important strategies. Even in states that do not impose waiting periods, it may take several weeks to fully process an application.

- **Taking steps to enroll children through other public benefit programs.** Families affected by increased unemployment are likely to seek other benefits to help them weather hard times. Since most of the information needed to make a health coverage eligibility determination is collected when a family applies for other programs, states need to take affirmative steps to ensure that, for example, families are enrolled in both food stamps and Medicaid at the same time.

- **Implementing easy renewal procedures.** During an economic downturn it is particularly important to help families retain Medicaid and SCHIP for as long as they are eligible, since they are less likely to be leaving the program because they have found private coverage through an employer.

Outreach also will continue to be crucial during hard economic times, although states may be under pressure to dispense with high-profile public education campaigns. Suspending outreach activities can be particularly harmful to families made eligible as a result of the economic downturn. Such families are likely to be unaware of available coverage if they have had a longstanding stable work history, employer-based coverage, or have not interacted with public assistance programs in the past. Ensuring that families can get help applying from community-based organizations and institutions — and when they seek assistance from other public benefit programs — will be even more important than before.

Figure 6
Expanding Eligibility and Simplifying Enrollment: Trends in Children's Health Coverage Programs (July 1997 to January 2002)

State Strategies	July 1997[1]	November 1998[1]	July 2000[2]	January 2002
Covered children under age 19 in families with income at or above 200 percent of FPL	6*	22	36	40
Joint application for Medicaid and SCHIP	N/A	not collected	28	33
Eliminated asset test	36	40 (Medicaid) 17 (SCHIP)	42 (Medicaid) 31 (SCHIP)	45 (Medicaid) 34 (SCHIP)
Eliminated face-to-face interview at enrollment	22**	33*** (Medicaid) not collected (SCHIP)	40 (Medicaid) 31 (SCHIP)	47 (Medicaid) 34 (SCHIP)
Adopted the Medicaid presumptive eligibility option for children	option not available	6 (Medicaid) not collected (SCHIP)	8 (Medicaid) 4 (SCHIP)	9 (Medicaid) 5 (SCHIP)
Adopted self-declaration of income	not collected	not collected	10 (Medicaid) 7 (SCHIP)	13 (Medicaid) 11 (SCHIP)
Eliminated face-to-face interview at renewal	not collected	not collected	43 (Medicaid) 32 (Medicaid)	48 (Medicaid) 34 (SCHIP)
Adopted 12-month continuous eligibility option for children	option not available	10 (Medicaid) not collected (SCHIP)	14 (Medicaid) 22 (SCHIP)	18 (Medicaid) 23 (SCHIP)
TOTALS:	**51 Medicaid**	**51 Medicaid** **19 SCHIP**	**51 Medicaid** **32 SCHIP**	**51 Medicaid** **35 SCHIP**

1. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups).

2. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups) and SCHIP-funded separate programs, as indicated.

* In addition, two states, Massachusetts and New York, financed child health coverage to this income level using state funds only.

** Seven (7) states still required telephone interviews; face-to-face interviews were left to county discretion in one state.

*** Thirty-three (33) states had eliminated the face-to-face interview for children applying for Medicaid. Six (6) states eliminated the face-to-face interview only for families using the joint Medicaid/SCHIP application to apply for coverage. No data was collected specifically about separate SCHIP programs.

I. The Promise of Doing More

Introduction

During the past four years, the nation has been sharply focused on reducing the number of uninsured children. A thriving economy and the infusion of federal dollars allocated to states as a result of the enactment of the State Children's Health Insurance Program (SCHIP) fueled dramatic coverage expansions for low-income children. States used the new resources to expand Medicaid, to create separate children's health coverage programs, or to do both. Their early experience revealed that expanding eligibility and conducting outreach campaigns are not sufficient by themselves to get children enrolled. Rather, a combination of these strategies bolstered by serious efforts to simplify eligibility rules and application procedures is needed.

Simplification has now gained broad acceptance as an essential strategy for boosting enrollment. Since 1997, simplified enrollment procedures have become a key design feature of SCHIP-funded Medicaid expansions and separate SCHIP programs in nearly all states, and most states also have removed the most prominent procedural barriers from their existing "regular" Medicaid programs for children. Even through 2001, as a weakening economy imposed new fiscal pressures on state budgets, efforts to expand children's health coverage and simplify enrollment continued to evolve.

It appears that these efforts are helping. Although 6.7 million low-income children remain uninsured, the percentage of low-income children who were uninsured fell from 23.1 percent in 1999 to 21.3 percent in 2000.[1] The major reason for this change was an increase in Medicaid and SCHIP enrollment.

Still, significant barriers to coverage persist and doing more to simplify procedures could bring the nation closer to realizing the promise of covering the vast majority of low-income, uninsured children — 84 percent of whom are eligible for Medicaid or SCHIP.[2] A recent Urban Institute study found that complicated enrollment procedures continue to be at the root of problems getting eligible children covered. Among low-income families with uninsured children that inquired about Medicaid and SCHIP, 38 percent cited administrative "hassles" as the main reason for not applying.[3] This suggests that while most states have implemented critical simplification strategies — such as shortening application forms, using clearer, friendlier language on application forms, and allowing families to apply

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[1]Based on March Current Population Survey, 2000 and 2001, Kaiser Commission on Medicaid and the Uninsured.

[2] Lisa Dubay, Jennifer Haley and Genevieve Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*, Urban Institute, March 2002.

[3] Genevieve Kenney and Jennifer Haley, *Why Aren't More Children Enrolled in Medicaid and SCHIP?*, Urban Institute, May 2001.

by mail without having an in-person interview — additional techniques are needed to get "below the surface" to tackle deeper problems with application procedures.

For example, a striking feature of the application process in many states is that families often are expected to provide numerous documents to verify the information on their applications even when such verification is not required under federal law. Experience from several states indicates that paring back the number of documents families are required to submit can remove obstacles for applicants and also can yield administrative advantages.

Moreover, facilitating enrollment *and* helping children retain health coverage for as long as they qualify are parallel paths to the goal of reducing the number of uninsured children. Clearly informing families about the need to renew their child's coverage and simplifying the renewal process could prevent children from being dropped from coverage programs even though they remain eligible. In 2001, states paid more attention to the "back end" of the process than they had in the past, but additional efforts are needed to encourage states to use all available options to improve retention of coverage.

Simplifying Procedures in Family Coverage Programs Can Leverage Enrollment for Children as Well as Their Parents

While efforts have focused on expanding coverage to children, some states also have begun to expand coverage to low-income parents. Such measures have not been pursued as vigorously as they have for children in the majority of states, largely because an enhanced federal funding stream analogous to SCHIP has not been made available explicitly to support parent coverage programs. Still, more than one-third of the states have managed to extend coverage to parents with income up to the federal poverty line or higher using their authority under Medicaid law or by obtaining Medicaid or SCHIP waivers. At this point in time, simplification strategies have not been applied to parent coverage programs to the same extent they have been adopted for children's coverage. Thus, in most states it is more difficult for an income-eligible parent to enroll in coverage than it is for her income-eligible child.

There is a pressing need to take stock of the innovations that have been used to simplify and improve enrollment in children's coverage programs and apply those principles to family coverage programs. Aligning application procedures for parents and children will preserve the effectiveness of simplification measures initially put in place for children. For example, if a face-to-face interview is required for a parent to obtain health coverage, that requirement undermines the advantage of having removed the interview when applying solely for a child. To neglect the lessons learned from designing simplified children's coverage programs is to risk losing the achievements made on behalf of children when families apply together as a unit.

The deterrent effects of maintaining different enrollment procedures for parents and children may be a factor behind the lag in health insurance enrollment among children in families with income below the federal poverty line. In 2000, 25.8 percent of children in families with income below the federal poverty line were uninsured, as compared with 16.5 percent of children in families with income

between 100 percent and 200 percent of the federal poverty line.[4] Such disparities may be more prevalent in states that have been slow to properly "delink" eligibility for Medicaid and cash assistance. In such states, parents applying for Medicaid with their children often are subject to application and renewal procedures reminiscent of those commonly used when families apply for welfare. These more difficult procedures often are not imposed on families with higher incomes applying for Medicaid or SCHIP for their children alone. Addressing the simplification issues in parent coverage programs also can help prevent perpetuating a situation in which large numbers of parents are eligible for coverage, but do not get enrolled — the same dilemma the nation faced with children's Medicaid just prior to the implementation of SCHIP.

This report presents the findings of a national survey of enrollment and renewal procedures in health coverage programs for low-income children and families, conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. It updates and augments the information from an earlier Center survey published by Kaiser in October 2000 in *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*. States' progress over time and in 2001 with respect to simplifying enrollment and renewal procedures in children's coverage programs is highlighted, as well as promising strategies states can employ to further simplify their programs. The report also presents the status of enrollment and renewal procedures in parent coverage programs and explores the extent to which states have aligned them with the rules and procedures in place in children's coverage programs.

Why Do More to Simplify and Align Enrollment and Renewal in Children's Health Coverage Programs?

States have made great strides in simplifying enrollment and renewal procedures for children's health coverage programs. Procedural reforms have advanced efforts to transform children's health coverage programs so they more closely resemble private insurance. A streamlined application and enrollment process not only makes it easier for families to obtain coverage for their children; a simple application also is a powerful outreach tool that can position community-based organizations and institutions to offer families direct enrollment assistance. States also have reported administrative advantages associated with simplifying application and renewal procedures, citing cost savings and increased productivity.[5]

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[4] *Health Insurance Coverage in America, 2000 Data Update*. Kaiser Commission on Medicaid and the Uninsured, February 2002.

[5] These issues are more fully discussed in: Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2000. Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*, Center on Budget and Policy Priorities, December 2001. Vernon Smith, Eileen Ellis and Christina Chang, *Eliminating the Medicaid*

(continued...)

A host of fundamental simplification measures have been almost universally adopted. For example, most states have created joint application forms for their Medicaid and separate SCHIP programs that incorporate straightforward, friendlier language and attractive graphics. Almost all states disregard assets in determining eligibility and do not require face-to-face interviews, a change that is especially helpful to working families unable to leave their jobs to apply in person at a government office.

But despite significant reform, surveys of families with eligible children suggest that application procedures still are too complicated and continue to pose difficult barriers to coverage. As noted, the Urban Institute's 2001 survey findings reveal that administrative "hassles" are still a major application barrier. An earlier survey conducted for the Kaiser Commission on Medicaid and the Uninsured yielded similar results — 57 percent of parents with uninsured children eligible for Medicaid who tried to enroll were unsuccessful, often because they could not complete the process. A majority of the families surveyed said they would be "much more likely" to enroll their children if they could enroll by mail or phone, complete paperwork after obtaining coverage, and enroll at their child's health care provider, school or child care center.[6] Families have identified similar problems with renewal procedures. A survey conducted by the National Academy of State Health Policy recently found that 44 percent of families whose children's coverage had lapsed said the verification required for renewal can be difficult to obtain.[7]

To address these concerns, further simplification is needed. Strategies to consider for further improving application procedures include paring back verification requirements, adopting presumptive eligibility to immediately enroll children who appear eligible for coverage pending a final eligibility determination, guaranteeing 12 months of coverage and using information the state has on hand to renew health coverage without requiring families to provide that information a second time. Taking these steps may be instrumental in continuing to reduce the number of uninsured children by helping to sustain the enrollment gains achieved to date and by protecting investments in eligibility expansions and outreach. In 2001, a growing number of states initiated these promising strategies. In the future, tight state budgets could prompt increased interest in reliable strategies that reduce application processing time and improve retention.

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[5](...continued)
Asset Test for Families: A Review of State Experiences, The Kaiser Commission on Medicaid and the Uninsured, April 2001.

[6] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, *Medicaid and Children Overcoming Barriers to Enrollment Findings from a National Survey,* The Kaiser Commission on Medicaid and the Uninsured, January 2000.

[7] Cynthia Pernice, Trish Riley, Michael Perry, and Susan Kannel, *Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment,* National Academy for State Health Policy, February 2002.

Aligning Procedures in Medicaid and SCHIP Advances Simplification Efforts

Abolishing procedural differences between Medicaid and separate SCHIP programs makes the process for obtaining children's health coverage less confusing for families and facilitates smooth transfer of children from one program to another if family circumstances change, preventing gaps in coverage. Aligning Medicaid and SCHIP procedures also makes it easier for states to administer a dual-program system, allowing them to effectively meet their responsibility to determine the appropriate coverage program for children applying for benefits. States are required to screen all children who apply for coverage under the separate SCHIP program to identify those who appear to qualify for Medicaid, and children found eligible must be enrolled in Medicaid. This federal rule has become known as the "screen and enroll" requirement. The federal SCHIP regulations also require states to assist families in applying for the separate SCHIP program if their children apply for Medicaid and are found ineligible.

When eligibility rules and enrollment procedures in the separate SCHIP program are different from the rules in Medicaid, children may not make it into the correct program or they could miss out on coverage altogether. In non-aligned programs, families with children applying for the SCHIP program who turn out to be eligible for Medicaid may be asked to complete additional paperwork to complete the Medicaid eligibility process. This extra burden on families, and the logistics involved in transferring the application to Medicaid, can result in the delay or denial of coverage for an eligible child if the family has difficulty assembling the additional information within the time allotted.

Wyoming's Medicaid Enrollment Jumps With SCHIP Coordination

Wyoming's separate SCHIP program — KidCare — was designed with several features that originally were not available in the state's Medicaid program for children. For example, KidCare did not require a face-to-face interview and allowed families to self-declare their income. State data showed that, as of March 2001, 86 percent of SCHIP-eligible children had been enrolled in the program, while only 44 percent of Medicaid-eligible children had been enrolled in Medicaid. The Wyoming Department of Health attributed this difference largely to the fact that families with children eligible for Medicaid were subject to more difficult and time-consuming enrollment procedures. In April 2001, these procedural differences were eliminated, with a dramatic effect on Medicaid enrollment. As of July 2001, state estimates show that 97 percent of SCHIP-eligible children have been enrolled in KidCare, and 84 percent of Medicaid-eligible children have received Medicaid coverage.

* Correspondence with Kristina Musante, Covering Kids Project Manager, Wyoming KidCare Program, Wyoming Department of Health, February 11, 2002.

Why Do More to Expand and Simplify Parent Coverage Programs?

While strategies to simplify health coverage programs have had an important impact, exclusively targeting children's programs misses a significant fact of life — *children live in families*. Thus, it is reasonable that a family-based benefit will have advantages for parents that will help their children too. Expanding eligibility to cover more parents and simplifying application and renewal procedures so more eligible parents can become enrolled are two critical strategies that need to be pursued simultaneously.

Low-income parents are much more likely than their children to be uninsured — in 2000 32 percent of parents with income below 200 percent of the federal poverty line were uninsured compared to 21 percent of low-income children.[8] While chances are good that children in working families are eligible for health coverage, the prospects are dim for working parents, who in most states qualify for Medicaid only if they have income far below the federal poverty line. In the typical state, a working parent in a family of three loses Medicaid eligibility when her income surpasses 69 percent of the federal poverty line. A parent working full time at $7.00 per hour earns too much to qualify for Medicaid in 28 states.[9] However, about one-third of states have used the flexibility they have under current law to cover parents in working families and future parent expansions are under discussion elsewhere.

A growing body of evidence suggests that providing health coverage to low-income parents helps boost the number of children enrolled in Medicaid. A recent Urban Institute study found that in states that have expanded coverage for parents under Medicaid, 81 percent of eligible children participate in Medicaid, compared to only 57 percent of children in states without family-based coverage programs. New research also finds that children in Medicaid are more likely to get well-child care if their parents also are enrolled in the program.[10]

The Urban Institute analysis goes on to state that 7.4 million of the nation's 10.6 million uninsured parents could be eligible for health insurance if states expanded coverage to include parents at the same income level that they now cover children. Of these 7.4 million, about three million have children who already are participating in Medicaid or SCHIP.[11] Just how easily these parents could become enrolled would depend on states' efforts to adopt simplification procedures in parent coverage programs, removing barriers for this population in the same way states have removed them for children.

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[8] Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America, 2000 Data Update*, Washington, D.C., 2002.

[9] Jocelyn Guyer, *Low-Income Parents' Access to Medicaid Five Years After Welfare Reform.* The Kaiser Commission on Medicaid and the Uninsured. June 2002.

[10] Lisa Dubay and Genevieve Kenney, *Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2001.

[11] Ibid.

As states contemplate implementing family coverage programs, they can draw upon many of the same options they had at their disposal to simplify enrollment and renewal for children. Doing so will help ensure that as many eligible parents as possible get enrolled, but also will protect the simplifications designed for children's health coverage programs. Aligning eligibility rules — for example, by eliminating asset tests for parents if the test has been eliminated for children — will make it more feasible to design a single application that can be used for the whole family. Moreover, aligning application procedures for parents and children will preserve the effectiveness of simplification measures put in place for children. For example, requiring a face-to-face interview for a parent to get enrolled subverts the advantage of having removed this requirement for children when both parents and children are applying.

Finally, whether states have expanded coverage for parents or have yet to do so, it is critical to ensure that state cash assistance and health coverage programs are properly "delinked." This is fundamental to ensuring that children and parents in the lowest income families can obtain health coverage just as easily as eligible children and parents in higher income families. Procedures for applying for TANF may be more difficult than the procedures for applying for Medicaid and should in no way thwart or delay the process for obtaining Medicaid coverage.

Why Do More to Simplify During Hard Economic Times?

The recent economic downturn makes the future uncertain. States are under pressure to curtail spending and, although enrollment of children and parents is not the driving force behind increasing Medicaid costs, they may consider a range of actions, including retracting eligibility or imposing enrollment caps in their SCHIP programs. Yet, many working families have lost jobs or have had their work hours cut back, and as a result may either have lost their employer-based health insurance or their ability to pay out-of-pocket premiums and deductibles. Many parents may now discover that their children — or the entire family — can qualify for coverage under Medicaid or SCHIP.

As state officials contemplate possible responses to the dilemma they face, it is important to give ample weight to the consequences of cutting back eligibility or reinstating barriers to coverage. Taking such steps will reverse the much-heralded recent progress achieved in reducing the number of uninsured children. In addition, keeping eligible uninsured children and families out of federally-financed coverage programs will mean states will not be able to take advantage of federal matching funds when those individuals are in need of medical treatment.

It is important that families affected by increased unemployment that become eligible for Medicaid and SCHIP be able to obtain health coverage for their children without delay. Prompt enrollment in Medicaid or SCHIP ensures continuity of care for an individual with a current medical condition and protects families from financial exposure should a medical need arise. Preserving simplified procedures and outreach efforts will help eligible parents and children gain access to existing health coverage programs and help mitigate the degree to which elevated unemployment causes a surge in the number of uninsured individuals.

Simplification takes on added importance as states respond to help families hurt by the economic downturn. Priorities for simplification include:

- **Maintaining simple, aligned procedures in Medicaid and SCHIP.** State procedures should allow for a smooth transfer from the state's separate SCHIP program into Medicaid if financial hardship warrants the change. A shift into Medicaid would relieve the family of any cost-sharing requirements imposed by the SCHIP program and would assure the family the other protections the Medicaid program provides. Families should be apprised that such a transfer is possible when the need arises, even if the child is in the midst of the SCHIP enrollment period. The family should not have to submit a new application, although documentation of the family's new income may be requested.

- **Adopting strategies that assure children health coverage without delay.** Although federal law requires states to enroll in their SCHIP-funded programs only children who are uninsured, and monitor the extent of "crowd-out," or substitution of public coverage for private coverage, it does not require them to impose waiting periods. However, many states have imposed waiting periods in their programs, during which children must be uninsured before they can apply for SCHIP-funded coverage. Such policies may be harmful, particularly for children with urgent or chronic medical conditions. Strategies to get children coverage without delay reduce the danger that they may experience a gap in care if their families have lost private coverage. As a critical step, states can eliminate their SCHIP waiting period. If they maintain a waiting period, states can shorten its duration or exempt families who have recently been laid off or whose premiums are considered unaffordable because they exceed a certain percentage of family income.

  Authorizing presumptive eligibility determinations also can speed the enrollment of children who appear to qualify for Medicaid or SCHIP and allow their families time to gather documents the state requires. It may be crucial to allow health care providers to make such determinations, for example, to prevent children in their care from losing coverage while treatment is ongoing.

- **Taking steps to enroll children through other public benefit programs.** Families affected by increased unemployment are likely to seek other benefits to help them weather hard times. From October 2000 to October 2001, the number of food stamp participants increased by 1.4 million.[12] Approximately three-quarters of food stamp households contain children. Since participation among households with children is more sensitive to the economy than participation among the elderly and disabled, it is likely that children accounted for more than half of the increase. Since most of the information needed to make a health coverage eligibility determination is collected when a family applies for other programs, states need to take

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[12] U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition and Evaluation, *Characteristics of Food Stamp Households: Fiscal Year 2000*, U.S. Department of Agriculture, Food and Nutrition Service, October 2001. U.S. Department of Agriculture, Food and Nutrition Service Program Data, http://www.fns.usda.gov/pd/.

affirmative steps to ensure that, for example, families are enrolled in both food stamps and Medicaid at the same time.

- **Implementing easy renewal procedures.** During an economic downturn it is particularly important to help families retain Medicaid and SCHIP for as long as they are eligible, since they are less likely to be leaving the program because they have found private coverage through an employer. Families should be able to complete the renewal process by mail without having to produce verification of information that has not changed since initial application.

Although states may be under pressure to dispense with the public education and media campaigns that have been popular and effective over the past several years, outreach also will continue to be crucial during hard economic times. A recent Urban Institute analysis found that more than half of low-income parents — 53 percent — are either not aware of any child health insurance program in their state or do not know that enrollment in welfare is not a precondition for participation.[13] More families are likely to be unaware of available coverage if they have had a longstanding stable work history, employer-based coverage, or have not interacted with public assistance programs in the past. Outreach will be of special importance for this "new audience" to alert them to the availability of Medicaid and SCHIP for their children and to the possibility of obtaining coverage for parents.

In addition, workers recently laid off from low-wage jobs, including individuals whose families received public assistance in the past, may be aware of health coverage programs, but may not realize that they or their children can qualify. Families that are now compelled to seek cash assistance because they have lost their jobs and have little or no other income also need to understand that eligibility for cash assistance and health coverage are "delinked." This means they can apply for health coverage even if their application for cash assistance is delayed until they comply with job search or other requirements. Also, in the event the family is denied cash assistance, its Medicaid application should go forward.

What More Can Be Done to Simplify?

To further advance efforts to facilitate Medicaid and SCHIP enrollment and retention states have continued to scrutinize their programs' procedures to identify remaining barriers to coverage. Strategies aimed at removing these enduring obstacles include: eliminating unnecessary verification requirements, adopting presumptive eligibility, enabling all children in a family to qualify for the same program, using information already known to the state to renew a family's health coverage and approving a full 12 months of coverage regardless of changes in family circumstances. Although still a minority, the number of states that have adopted these approaches grew in 2001.

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[13] Genevieve Kenney, Jennifer Haley and Lisa Dubay, *How Familiar Are Low-Income Parents with Medicaid and SCHIP?*, Urban Institute, May 2001.

Steps States Can Take to Further Simplify Enrollment

Remove unnecessary verification requirements. Reducing verification requirements lifts the paperwork burden on families and makes programs easier to administer. Families are required to provide proof of the immigration status of a non-citizen applying for Medicaid coverage. Under federal law, families do not have to supply verification of any other information they report on their applications.[14] Yet, states historically have imposed additional verification requirements on families, most often requiring them to submit a series of pay stubs or other documentation, mirroring the requirements for cash assistance applicants.

While many states have taken steps to pare back the number of pay stubs they require from families applying for health coverage and to eliminate the need to prove residency or a child's age, various studies indicate that families continue to have difficulty gathering all the required documents and this can delay or deny coverage to otherwise eligible children.[15]

Thirteen (13) states are currently implementing self-declaration policies, meaning they do not require families to produce verification of their income and most other information. In these states verification is generally accomplished by cross-checking the information reported on Medicaid and SCHIP applications with data from other government agencies, such as the Social Security Administration and state Departments of Labor. States using such methods have found that data-matching results in reliable and efficient eligibility determinations and upholds program accountability. For example:

- Between December 1999 and December 2000, a review of 543 approved children's Medicaid cases in **Idaho** reflected an accuracy rate of more than 99 percent.

- An ongoing monthly audit of the income reported on children's health insurance applications in **Michigan** has shown that self-declaration has not led to high error rates in children's Medicaid and SCHIP, and the state saw the proportion of applications placed in the "pending" category — due in large part to missing verification — decline from 75 percent to below 20 percent.[16]

- A project run by the Baltimore City Health Department, in which eligibility workers enroll children in the **Maryland** Children's Health Program, found processing time to

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[14]U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Families and Children in Health Care Coverage*, August 2001.

[15] *See* Perry, et.al. (January 2000); Kenney and Haley (May 2000); and Cox (December 2001)

[16] U.S. General Accounting Office, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, (GAO-01-883), September 2001.

be significantly reduced after the implementation of self-declaration. Outreach workers who previously spent a great deal of time helping families gather necessary documentation are now able to spend more time recruiting new families through door-to-door canvassing and identifying eligible children in Head Start programs and schools.[17]

Adopt presumptive eligibility for children. Presumptive eligibility can increase entry points into the children's health coverage system, speed enrollment and eliminate gaps in coverage. Under federal law, states may authorize "qualified entities" to conduct presumptive eligibility determinations, enrolling children temporarily in Medicaid and separate SCHIP programs if they appear eligible, while their families complete the formal application process. In the meantime, children can receive prompt attention to their medical needs and providers can be reimbursed for delivering needed care. Qualified entities may include health care providers, schools, WIC agencies, Head Start programs, certain emergency food and shelter programs, agencies that determine eligibility for subsidized child care, federal housing assistance, and child support enforcement, as well as the agencies administering Medicaid, SCHIP, and TANF, and other entities the U.S. Secretary of Health and Human Services deems appropriate.

In 2001, Mississippi adopted presumptive eligibility, joining eight other states that allow the procedure in their children's health coverage programs. In a news release announcing HHS approval, Secretary Tommy Thompson said: "Getting medical care to children as quickly as possible makes sense for Mississippi's children ... We are committed to giving states the flexibility they need to make this kind of change to improve health care for children and families alike." [18] A number of states report that systematic training for staff of qualified entities and the ability to track the disposition of presumptively approved applications are key features of an effective system. Qualified entities in a number of states have reported high rates of continued eligibility for children entering Medicaid or SCHIP through the presumptive eligibility process.[19]

One important advantage of presumptive eligibility is that it conveys a strong message that the enrollment process is likely to be successful and is worth pursuing. Agencies and advocates in New York City found this to be a significant motivator for families seeking coverage under Disaster Relief

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[17] Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*, Center on Budget and Policy Priorities, December 2001.

[18] U.S. Department of Health and Human Services Press Release, *HHS Approves Mississippi Plan to Speed Up SCHIP Enrollment*, October 5, 2001.

[19] Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2000. Donna Cohen Ross, *Enrolling Children In Health Coverage: It Can Start With School Lunch*, Center on Budget and Policy Priorities for Covering Kids, January 2001.

Medicaid (DRM) procedures initiated to assist New Yorkers in obtaining health coverage after the city's computer systems were damaged in the September 11th tragedy. Under the DRM procedures, families and individuals could obtain four months of temporary health coverage by completing a one-page application and attesting that their income fell within the guidelines for the state's Family Health Plus (Medicaid and SCHIP) guidelines. Children and parents found to be eligible received coverage the same day or the next day.

Presumptive eligibility also could be used to help make program administration more efficient. For example, since agencies that administer SCHIP can be authorized as "qualified entities," they could use presumptive eligibility to facilitate the federally required "screen and enroll" procedure. The SCHIP agency could presumptively enroll in Medicaid a child who has applied to the separate SCHIP program, but who has been found eligible for Medicaid. This direct route to Medicaid could avert any delays or gaps in coverage that could arise in states where children's applications must be transferred from the SCHIP agency to the Medicaid agency for final processing. States developing methods to enroll children in health coverage when they apply for other public benefits also may find presumptive eligibility to be a useful tool for quickly linking children to health coverage through schools or the subsidized child care agency, which are examples of qualified entities. California has been exploring the use of presumptive eligibility under both these scenarios.

Steps States Can Take to Further Simplify Renewal

Keeping eligible children from losing Medicaid and SCHIP is an important tactic for sustaining the progress states are making on reducing the number of uninsured children. The reported high degree of "churning" in Medicaid and high loss of Medicaid and SCHIP at the end of the enrollment period when it is time to renew coverage suggest a range of strategies are needed to prevent any unwarranted drop in coverage.[20] These include taking steps to ensure families know when and how to renew their coverage and adopting options for simplifying renewal procedures.

Incorporating renewal into outreach messages. A critical step toward improving retention in Medicaid and SCHIP is to inform families about the need to renew coverage. Recent research in Rhode Island revealed that many families that failed to renew their Medicaid eligibility did not know about the program's annual renewal cycle and thus could not navigate their first renewal successfully.[21] Half the families in a recent study of children whose SCHIP coverage had lapsed

[20] John Czajka and Cara Olsen, *The Effects of Trigger Events on Changes in Children's Health Insurance Coverage*, Mathematica Policy Research, Inc., March 2000.

[21] E. Cahow, *Analysis of Eligibility Loss at Recertification*, Neighborhood Health Plan of Rhode Island, February 2001.

reported that they had not been told or did not recall being told that they would have to renew their child's coverage. [22]

State protocols vary with respect to how families are alerted to the need to renew their child's health coverage and how that process is explained. Some combination of forms and notices is usually sent to families prior to the renewal date. Sometimes families also receive personalized follow-up contact via mail or telephone. Whatever the process, it appears that such state efforts could be enhanced by clarifying language on notices and forms and by integrating messages advising families of the need to renew their coverage into all promotional flyers, ads, application forms, member brochures, and other materials.

In addition, a comprehensive approach to ensuring that eligible children do not lose coverage at renewal also should include activities conducted by community-based organizations. In many states, community groups and institutions have played an instrumental role in helping families obtain coverage for their children. Many organizations have become involved with renewal as well, urging families to seek their help if they need assistance interpreting notices or completing forms. A number of states that have actively supported the development of community-based application assistance have added renewal assistance to the services application assistors perform. For example, in New York, staff of community groups, trained as "facilitated enrollers," help families renew their coverage when the initial enrollment period is up; in New Mexico community-based assistance also is provided for renewal. In Hamilton County, Ohio, contracted staff at the CHIP helpline are able to check the county database to identify children whose eligibility period is ending and call their families to offer them renewal assistance. A pilot project in Massachusetts is testing the effectiveness of allowing families to renew their children's coverage when they visit a community clinic, WIC office or other neighborhood site.

Simplifying Renewal Procedures. Despite increased attention to simplifying the renewal process, to date the majority of states have not taken full advantage of all the options that are available for simplifying renewal procedures. Moreover, while states have made significant progress in coordinating Medicaid and SCHIP enrollment procedures, they have not demonstrated the same attentiveness in coordinating renewal procedures. For example, many states with a joint application form for their Medicaid and SCHIP programs have not developed such a form for the renewal process. In addition, while most states have made it easier for children to apply or renew coverage, fewer states have adopted similar simplifications for parents' coverage. For example, all but three states have eliminated the face-to-face interview requirement for the renewal of children's coverage and permit renewals by mail or telephone, but 16 states still require that parents seeking renewal come in for a face-to-face interview.

Procedural reforms are as essential to improving retention as they are to facilitating initial enrollment. Easy renewal procedures instill families with the confidence that their child can receive

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[22]Cynthia Pernice, Trish Riley, Michael Perry, and Susan Kannel, *Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment*, National Academy for State Health Policy, February 2002.

ongoing consistent care. Simplifying renewal helps states avoid the administrative costs incurred by continually enrolling and reenrolling the same people. The Centers for Medicare and Medicaid Services (CMS) have offered states an array of options for simplifying renewal, which include many of the strategies they have used to simplify enrollment, such as issuing joint Medicaid/SCHIP renewal forms and eliminating face-to-face interview requirements.

"Member Express Renewal" Helps Families Retain Coverage in Massachusetts

Through its outreach mini-grant program, Massachusetts has supported intensive efforts on the part of community organizations to help get children enrolled in the state's Medicaid and SCHIP programs, known as MassHealth. Considering the investment in outreach, state officials and advocates were disappointed to learn that a large proportion of families — about 20 percent — were not responding to renewal notices at the end of the 12-month coverage period, presumably because they did not understand what is required of them or needed help completing the form. As a result, large numbers of children were losing coverage even though they were likely to still qualify. The decision was made to apply the advantages of community-based assistance to the renewal process. With funding from CMS, a procedure termed "Member Express Renewal" was developed in which some families can opt to renew their coverage "off-cycle," that is, before their scheduled redetermination date, when they visit a community clinic or other community location. So, for example, if a child were determined eligible on January 1, 2002 she would not be due to renew her coverage until January 1, 2003. But, if the child were scheduled for a pediatric care visit on September 1, 2002, her parent could fill out a simple form in the clinic waiting room and the child's eligibility could be extended until September 1, 2003. Thus far, the results have been encouraging. Recent data show that of all the families permitted to renew via the "Member Express" process (some beneficiaries, such as those also on food stamps, are not permitted to do so), 100 percent received continued coverage.

* Correspondence with Joshua Greenberg, Health Care for All, Boston, Massachusetts, February 6, 2002

In addition, states are exploring a range of strategies aimed at reducing the deterrent effect of imposing burdensome paperwork on families when it is time to renew health coverage.[23] New York,

[23]U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Families and Children in Health Care Coverage*, August 2001. CMS clarified that states can employ the same simplification

(continued...)

for instance, passed legislation in January 2002 to streamline procedures for Medicaid and its separate SCHIP program, Child Health Plus. Among the streamlining provisions was the elimination of the income verification requirement for families renewing Child Health Plus. New York's legislation indicates the state may verify the family's information by matching it against the state wage reporting system and other databases. Other strategies include:

- **Adopting 12-month continuous eligibility.** Although most states have lengthened health coverage enrollment periods for children to 12 months, families still are required to report changes in income that occur in the interim. However, because income fluctuations are common (especially for families with workers who earn hourly wages, work overtime, or work irregularly), such policies have caused many families to cycle on and off health coverage from month to month.

  To provide a solution, the Balanced Budget Act of 1997 gave states the option of enrolling children in Medicaid for 12 months, regardless of fluctuations in family income, assets, or other circumstances, thereby eliminating the need for cumbersome reporting during the 12 months. (States may adopt this procedure in their separate SCHIP programs, as well.) Minimizing reporting requirements also has advantages for eligibility agencies. A study by Mathematica Policy Research found that extending children's coverage through the use of 12-month continuous eligibility could reduce Medicaid administrative costs between 2 and 12 percent.[24] Calculations performed by the Center on Budget and Policy Priorities estimate that the second six months of Medicaid coverage costs about 30 percent less than the first six months of coverage in a year,

[23](...continued)
techniques at renewal that have proved useful at enrollment, and suggested reasons states might consider instituting self-declaration policies at renewal, even if they have not adopted the practice at enrollment. According to CMS guidance, "By the time of renewal, the state will have been able to verify the family's income through IEVS [the income eligibility verification system] or other computer matches. Even if the information available through such matches is not current, it should be recent enough to allow the state to assess whether the family has reported information accurately in the past." The agency also emphasizes that a signature is not required on a renewal form, indicating that paperwork does not necessarily need to be returned to the state agency in order for coverage to continue.

[24]Carol Irvin, D. Peikes, C. Trenholm and N. Khan, *Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children*, Mathematica Policy Research, Cambridge, MA., October 24, 2001.

further supporting the advantages of adopting the 12-month continuous eligibility option.[25]

- **Using preprinted renewal forms**. Some states, including Alaska, Mississippi and New Jersey, send families a renewal form preprinted with some or all of the information the family supplied on the original application. Generally, families are asked to note changes, sign the form and return it to the agency. Sometimes a state's preprinted renewal form is actually a filled-in version of an initial application; others use an abbreviated form that resembles the application in style. Still other states send computer-generated forms or letters that may be difficult to read and may not appear to be related to the health coverage program. The state may or may not require the family also to supply verification of its current income.

- **Implementing "passive renewal."** Taking the advantages of a preprinted form a step further, some states have implemented a procedure, termed "passive renewal," under which families are sent the preprinted form and are instructed to return it with any changes noted. If the family's circumstances have remained the same, the form does not need to be returned. In Florida and Georgia, a "passive renewal" procedure is used in the separate SCHIP program, which requires families to pay a monthly premium. If the renewal form is not returned, but the premium payment is received, coverage is continued. Utah has a passive renewal procedure in its separate SCHIP program, which does not require a monthly premium, and South Carolina allows passive renewal in its Medicaid program.

- **Using eligibility data from other benefit programs to renew health coverage.** Health coverage can be renewed automatically if current information about the family is available from another agency or program. In Washington State, county community service offices (CSOs) automatically perform a Medicaid eligibility review at the same time a family comes in for a food stamp review. If the new food stamp information indicates the child still qualifies for health coverage, the child's Medicaid is extended for 12 months from that date, even if the family is not up for renewal. This process provides additional months of health coverage and reduces administrative burdens on the family and the state agency. Illinois is implementing a similar procedure.

Steps States Can Take to Achieve Better Coordination Between Medicaid and SCHIP

In states that maintain age-based income eligibility rules in Medicaid — under which younger children can qualify at higher income levels than their older siblings — children in the same family may

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[25]Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families,* Commonwealth Fund, forthcoming.

be eligible for different programs. Procedural differences between Medicaid and SCHIP create a particularly vexing situation for these families. To enroll their children, families may have to navigate two sets of program rules and procedures to obtain coverage for *all* their children, a complication that can override the advantages of having a common application. Families could be faced with having to deal with the confusion of paperwork being processed by two separate agencies at the same time. If they ultimately have children enrolled in each of the programs, they may have to abide by two sets of reporting requirements and respond to correspondence from two different agencies. Different enrollment dates and enrollment periods of different durations are likely to trigger different renewal schedules for each child.

Menu of Strategies Improves Retention in Louisiana

In Louisiana, improving retention started with the development of systems to track the reasons children were losing coverage. Computer codes were initially vague, indicating that cases were closed for "failure to cooperate." New codes were established to provide more explicit information, such as "failed to return form," "failed to return verification," or "mail not delivered." Another beginning step was to change the vocabulary used on forms, in manuals and in conversation with program participants. "The word 'redetermination' is welfare-speak," said one state official. "The term, 'renewal' makes more sense to families and is a lot friendlier."

The state piloted a host of new strategies, which now have become part of the renewal process. Caseworkers first search the computer to see if the child is receiving another benefit, such as food stamps. If so, the family's income is automatically verified and health coverage is continued. For families whose health coverage cannot be continued automatically, the state created a new, simple renewal form. Although families are asked to return proof of income with the form, if the form is returned without it, coverage will not be terminated if the wage information on the Department of Labor database verifies that the child still qualifies. Finally, the state is taking steps to track the performance of local Medicaid offices to ensure caseworkers understand and follow the new procedures. This concerted effort to assure children retain health coverage for as long as they remain eligible is showing success. According to state data, case closures for procedural reasons have declined from around 25 percent to less than 10 percent.

* Correspondence with Ruth Kennedy, Louisiana Department of Health and Hospitals, February 2, 2002.

The procedural imbalances between Medicaid and separate SCHIP programs that still persist in many states generally impose greater difficulty when children appear to be eligible for Medicaid.

These families — the lower-income families — often have to take extra steps, provide additional information and undergo greater scrutiny in order to obtain coverage for their children. Considering that the majority of uninsured children who are eligible for an existing health coverage program qualify for Medicaid, this situation could be a major obstacle to reducing the number of uninsured children.

Bringing all children in a family into the same health insurance program should help prevent such complications and should substantially improve the degree to which children in the family receive uninterrupted health care. States can accomplish this by using the authority they have under Medicaid law or by using SCHIP funds to expand Medicaid beyond the minimum thresholds to establish a uniform Medicaid income eligibility limit for all children through age 18. Age-based eligibility in Medicaid still exists in the majority of states. Since October 2000, when only 18 states had removed the age-based standards in Medicaid, two additional states have followed this path. Most recently, in April 2002, New York implemented Medicaid income eligibility guidelines for all children ages one through 18 with family income at or below 133 percent of the federal poverty line; Virginia will follow suit for children birth through age 18 starting in September 2002.

Sometimes even slight procedural disparities between Medicaid and separate SCHIP programs can make a critical difference to enrollment or renewal, and because the differences are subtle they may be overlooked. A recent experience in Connecticut illustrates how this can happen. Outreach workers observed that while most major coordination issues had been addressed, a "behind the scenes" difference between the state's Medicaid and separate SCHIP programs (HUSKY A and HUSKY B, respectively) may have been responsible, in part, for deterring renewal for some families. Although all families are oriented to the HUSKY "brand," families with children enrolled in HUSKY A received their renewal notices in an envelope from the Department of Social Services (DSS) and families with children enrolled in HUSKY B got their notices directly from the HUSKY B contractor.

Since families with children in HUSKY would not necessarily make the connection between their children's health coverage and DSS, they may have been confused by the envelope or may have assumed its contents did not apply to them. The renewal envelope for the HUSKY A families was changed so that it now bears the program's name and logo. This change was made at the same time other significant procedural changes were made, so it is not possible to isolate the effect of the new envelope, however, this easy "fix" seems to have made a difference. In November 2000, 25 percent of renewals were "not initiated," meaning families did not respond to the renewal notice. In November of 2001, after introduction of the HUSKY envelope, the percentage of renewals "not initiated" dropped to 18 percent. A month later, the non-response at renewal was only 16 percent.[26]

[26] Correspondence with Judith Solomon, Executive Director, Children's Health Council, Hartford, CT, February 22, 2002.

II. State Efforts to Expand and Simplify Health Coverage in 2001: The National Survey

The Center on Budget and Policy Priorities completed the second in a series of surveys for the Kaiser Commission on Medicaid and the Uninsured on enrollment and renewal procedures used by states in their health coverage programs for children and families. The survey was conducted via telephone interviews with Medicaid and SCHIP officials in the 50 states and the District of Columbia; in some states, health advocates were interviewed as well. While the Center's 2000 survey focused solely on enrollment and renewal procedures in children's coverage programs, the survey completed in 2001 also explored these aspects of health coverage programs for families with children. The tables and narrative prepared for this report reflect eligibility and procedural changes implemented in states as of January 2002. Information on procedures for children was collected for 51 Medicaid programs and 35 separate SCHIP programs. With respect to procedures for enrolling and renewing coverage for families with children, the survey examined 51 "regular" Medicaid programs and 20 programs that have expanded health coverage to parents with income up to 100 percent of the federal poverty line or higher. Information on the following program elements was collected:

Eligibility criteria

- income eligibility guidelines in Medicaid for children and parents and in separate SCHIP programs for children;
- use of asset tests in determining eligibility for children and parents; and
- length of waiting periods in Medicaid and separate SCHIP programs.

Application procedures

- use of a joint Medicaid/SCHIP application for children; use of a single family coverage application for children and parents;
- face-to-face interview requirements at initial application for children and parents;
- presumptive eligibility for children; and
- selected verification requirements (income, age, residency).

Renewal procedures

- length of enrollment periods for children and parents;
- face-to-face interview requirements at renewal for children and parents;
- 12-month continuous eligibility for children; and
- use of a joint Medicaid/SCHIP renewal form for children; use of a single renewal form for families.

Survey Findings

Children's Health Coverage Programs

Despite fiscal pressure in the states, the survey found that in 2001 states continued to expand eligibility and simplify enrollment and renewal procedures in their children's health coverage programs. Since the Center reported on these issues in 2000, nearly all states maintained the simplified procedures they had adopted in their children's Medicaid and SCHIP programs, and many states further advanced their efforts to simplify.

States have continued to expand eligibility for children's health coverage.

Income eligibility guidelines

During 2001, nine (9) states expanded income-eligibility for children in either their Medicaid or separate SCHIP programs. These eligibility expansions included major steps forward in some states and more modest adjustments in others. **Louisiana** extended Medicaid to children in families with income from 150 percent to 200 percent of the federal poverty line. **West Virginia** expanded eligibility in its separate SCHIP program from 150 percent of the federal poverty line to 200 percent. Both **Maryland** and **South Dakota** built upon their previous Medicaid expansions by further expanding coverage to children through newly created separate SCHIP programs. Maryland boosted eligibility from 200 percent of the federal poverty line to 300 percent. South Dakota's SCHIP-funded Medicaid expansion previously covered children with family income up to 140 percent of the federal poverty line; the state's separate SCHIP program now covers children with family income between 141 percent and 200 percent of the federal poverty line. **Virginia** changed the way income is counted to determine eligibility, a revision that amounts to a slight coverage expansion.

In addition to the significant expansions noted above, **Delaware** and **New Jersey** increased Medicaid coverage for infants from 185 percent of the federal poverty line to 200 percent. Such infants were previously covered under those states' separate SCHIP programs. Both **Arizona** and **Wyoming** increased coverage for 18-year-olds to 100 percent of the federal poverty line from 50 percent of the federal poverty line and 67 percent, respectively.

In 2002, forty (40) states, including the District of Columbia, make health coverage available to children in families with income up to 200 percent of the federal poverty line or higher.

Asset tests

During 2001, two (2) states eliminated asset tests in their children's health coverage programs, making it easier for some children to qualify. **Arkansas**, which expanded Medicaid under a Section 1115 waiver, eliminated the asset test for children who qualify for "regular" Medicaid under the state's pre-expansion income guidelines, a rule that already applied to children who qualify under the

expansion guidelines. **North Dakota** enacted legislation to drop the asset test for Medicaid, a step it already had taken in its separate SCHIP program. The state implemented this change in January 2002.

In 2002, forty-four (44) states, including the District of Columbia, disregard assets in determining eligibility for children in Medicaid and in their separate SCHIP programs.

Waiting periods

Several states recently reduced or eliminated the length of time they require children to be uninsured before they can be enrolled in the state's SCHIP program. Under the federal SCHIP law, states are required to include in their state plans a description of reasonable procedures to ensure that health coverage provided under SCHIP does not substitute for (or "crowd out") private coverage. Some 38 states responded by designing their SCHIP-funded Medicaid expansion or separate programs to include waiting periods, during which a child had to be uninsured before he or she could enroll. These waiting periods ranged in length from one month to 12 months. In part because the states were seeing little evidence of "crowd-out," the SCHIP regulations clarified that monitoring potential substitution is sufficient and states do not have to impose waiting periods, which can be detrimental to children needing care. Moreover, waiting periods in SCHIP-funded Medicaid expansion programs are not permitted without a waiver. Prior to 2001, one state — Mississippi — had eliminated its waiting period.

During 2001, seven of the 37 states that continued to impose waiting periods in their children's health coverage programs reduced or eliminated them. **Virginia** reduced its waiting period from 12 months to six months; **Arizona** from six months to three months; and **Connecticut** from six months to two months. In addition, **Kansas, Louisiana, New Mexico,** and **Rhode Island** eliminated their waiting periods.

In 2002, eighteen (18) states — including 11 SCHIP-funded Medicaid expansions and seven (7) SCHIP-funded separate programs — do not impose waiting periods in their SCHIP-funded programs.

States have continued to simplify enrollment procedures in children's health coverage programs.

During 2001, despite the weakening economy, states took steps to further simplify enrollment procedures in their children's health coverage programs. The strategies implemented included allowing families to apply for coverage for their children using a joint application for Medicaid and separate SCHIP programs and allowing applications to be submitted by mail without requiring a face-to-face interview. Several states reduced verification requirements, with a growing number of states adopting a "self-declaration of income" policy. One state adopted presumptive eligibility, and a few others expanded or revised presumptive eligibility systems already in place.

Joint Medicaid/SCHIP applications

During 2001, **Nevada, North Dakota** and **Texas** adopted new procedures to allow families to use a joint Medicaid/SCHIP application to apply for children's health coverage.

In 2002, of the 35 states with separate SCHIP programs, 33 allow families to use a joint application to apply for Medicaid for children and the separate SCHIP program.

Face-to-face interviews

During 2001, seven (7) states including **Georgia, Montana, New Mexico, Texas, West Virginia, Wisconsin** and **Wyoming** eliminated the face-to-face interview that was previously required of families applying for Medicaid for their children.

In 2002, forty-seven (47) states, including the District of Columbia, do not require families to have a face-to-face interview when they apply for Medicaid and the separate SCHIP program for their children.

Self-declaration of income

States recently have made noteworthy efforts to simplify application procedures by reducing the amount of verification they require families to submit to document the information they provide on their application. Although federal law requires families to prove only the immigration status of a non-citizen applying for coverage, most states require families to submit income documents and verify other information they report on the application. States may adopt "self-declaration" policies, relieving families of the need to supply numerous documents. To verify a family's financial eligibility for the health coverage program, states with self-declaration policies generally match reported income with other government databases or use other methods.

During 2001, five (5) states adopted policies allowing families to self-declare income when applying for children's health coverage. **Connecticut** and **Mississippi** adopted the policy for both children's Medicaid and the separate SCHIP program. **Wisconsin** began allowing families applying for coverage in BadgerCare, including "regular" Medicaid and the Medicaid expansion component, to self-declare their income. **Wyoming** dropped the requirement that families verify the income reported on their child's application for Medicaid, a practice already in place in the state's separate SCHIP program. **Arizona** dropped the requirement in its separate SCHIP program, but continues to impose verification requirements on families with children eligible for Medicaid. Although they did not implement self-declaration of income, several additional states eliminated other verification requirements. For example, Alabama and Texas no longer require families to verify the ages of their children when applying for Medicaid or SCHIP**,** and Louisiana reduced the amount of income documentation it requires, from two months to one month.

In 2002, 13 states allow families to self-declare their income when applying for Medicaid for children and the separate SCHIP program.

Presumptive eligibility

Presumptive eligibility has not been widely adopted. During 2001, one state, **Mississippi**, adopted presumptive eligibility. Some states that already were using the option modified their programs. For example, Connecticut expanded the list of qualified entities to include all those authorized under federal law and New Hampshire began efforts to redesign its training program for qualified entities and to revise its procedures to improve their effectiveness.

In 2002, nine (9) states have adopted the presumptive eligibility option in their children's Medicaid programs; five (5) states allow the option in their separate SCHIP programs. Six (6) states have adopted the option in both their Medicaid and separate SCHIP programs. Some of these states have not yet implemented procedures.

Most states paid increased attention to simplifying the renewal process in their children's health coverage programs, but additional steps could aid retention of health coverage.

Concern about the large number of children that lose coverage at the point their families must renew their eligibility for Medicaid or SCHIP has focused attention on procedural barriers that make it difficult for children to retain coverage even though they continue to be eligible. As states were making aggressive efforts to facilitate enrollment in children's health coverage programs, the fact that children were being lost to the system at the same time was not being addressed as vigorously. Now, the concept that there are two simultaneous routes to reducing the number if uninsured — enrollment and retention — is receiving considerable attention.

In 2001, at least 12 states made one or more changes to their renewal procedures — including lengthening enrollment periods, eliminating face-to-face interviews, allowing families to use joint Medicaid/SCHIP renewal forms and adopting 12-month continuous eligibility — but, in general, states have yet to take full advantage of the options available to them. A number of states are experimenting with innovative techniques to improve the renewal process, discussed elsewhere in this report, including the use of preprinted renewal forms, implementing so-called "passive renewal" procedures and using recent information other benefit programs have collected from families to renew health coverage.

Longer enrollment periods

During 2001, **Maine** and **Vermont** increased the length of the enrollment periods in both Medicaid and SCHIP from six months to 12 months; **Wyoming** did so in its Medicaid program.

In 2002, forty-two (42) states, including the District of Columbia, allow families to renew coverage for their children under Medicaid and the separate SCHIP program every 12

months, as opposed to the remaining states that require families to renew children's health coverage more frequently.

Face-to-face interview

During 2001, **Alabama, Georgia, Montana, South Carolina, Texas** and **Wisconsin** stopped requiring families to have a face-to-face interview when they renew Medicaid coverage for their children. (In Alabama, Georgia, Montana and Texas the separate SCHIP programs already allowed renewal without an interview.)

In 2002, forty-eight (48) states including the District of Columbia, do not require families to have a face-to-face interview when they renew their child's coverage under Medicaid or the separate SCHIP program.

Joint Medicaid/SCHIP renewal forms

In 2001, **Alabama, Connecticut, Georgia, West Virginia** and **Wyoming** began allowing families to use a joint form to renew their children's coverage under Medicaid and the separate SCHIP program. **Maryland** and **South Dakota** created new separate SCHIP programs and designed them with the joint application feature. A joint renewal form is especially helpful to families that may have children enrolled in both programs, precluding the need for them to complete different forms to maintain coverage for all children in the family. A joint renewal form also can make it easier for program administrators to switch children from the separate SCHIP program to Medicaid or vice versa, if a change in family circumstances warrants a transfer.

In 2002, only 21 out of 35 separate SCHIP programs allow families to use a joint form to renew coverage in both Medicaid and the separate SCHIP programs, as opposed to 33 states that allow families to use a joint Medicaid/SCHIP form at enrollment.

12- month continuous eligibility

During 2001, **California, West Virginia** and **Wyoming** adopted the 12-month continuous eligibility option in their Medicaid programs for children, a procedure that already was in place for the separate SCHIP programs in those states. **Maine** adopted the 12-month continuous eligibility option for both programs. This option allows states to guarantee a full year of health coverage to children regardless of fluctuations in their family income or other changes in their family's circumstances. Under 12-month continuous eligibility, families are not required to report changes in income or family circumstances that may occur during the 12-month period, as they generally are required to do under the typical 12-month enrollment period.

In 2002, seventeen (17) states have adopted 12-month continuous eligibility option for children in Medicaid and the separate SCHIP programs. Eleven (11) states have the 12-month continuous eligibility option only for children in their separate SCHIP programs and

two (2) states have the option only for children in their Medicaid programs.[27]

Many states have imported eligibility and procedural simplifications from their separate SCHIP programs into their children's Medicaid programs, resulting in closer alignment of some, but not all, aspects of Medicaid and separate SCHIP programs.

Eligibility and procedural imbalances between Medicaid and separate SCHIP programs still persist in many states and impose greater difficulty for families applying for health coverage who appear eligible for Medicaid. Ironically, in a majority of states (33), Medicaid eligibility guidelines for children are still "age-based," meaning in a single family one child could qualify for Medicaid and the child's older sibling could qualify for the separate SCHIP program. If procedures in the two programs are not aligned, families in this situation may be forced to navigate two systems to enroll and renew health coverage for all their children.

During 2001, a number of procedural discrepancies between state Medicaid and separate SCHIP programs were resolved. For example, **North Dakota** removed the asset test for children in Medicaid, bringing the program in alignment with the state's separate SCHIP program. **Georgia, Montana, Texas, West Virginia** and **Wyoming** stopped requiring face-to-face interviews for children applying for Medicaid, a condition not imposed on children applying for the separate SCHIP program. **Wyoming** lengthened the Medicaid enrollment period to 12 months, so that families with Medicaid no longer have to renew coverage more frequently than families with SCHIP.

Although during 2001 no additional states restructured their children's health coverage programs so that all children in a family are covered under the same program, in April 2002, New York implemented Medicaid income eligibility guidelines for all children ages one through 18 with family income at or below 133 percent of the federal poverty line; Virginia will follow suit for children birth through age 18 starting in September 2002.

In 2002, eighteen (18) states have removed the age-based standards in Medicaid — using their authority under Medicaid or SCHIP funds — so that all children in a particular family are eligible for the same program. About two-thirds of the states (33) maintain age-based eligibility standards in their Medicaid and SCHIP programs.[28]

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[27]Florida is one of the states that allows 12-month continuous eligibility for children in Medicaid, but this option is available only to children under age five.

[28] Arkansas and Tennessee operate Medicaid Section 1115 expansion programs. In both states, the eligibility guidelines for "regular" Medicaid – in place prior to the expansion – are based on the child's age.

Parent Coverage Programs

States have begun to expand coverage to parents, but not to the same extent to which they have expanded eligibility for children.

- More than one in three states (20 states, including the District of Columbia) have expanded coverage to parents with income up to the federal poverty line or higher. This has been accomplished either by using the authority they have under federal law to expand Medicaid or by securing Medicaid 1115 waivers or SCHIP 1115 waivers. One state, Washington, has a parent coverage program funded exclusively with state funds.

- Nineteen (19) states, including the District of Columbia, have eliminated the asset test in determining eligibility for parents, as compared with 44 states that have done so for children.

While some states are beginning to tackle the challenge of simplifying the enrollment and renewal procedures used for families, it remains more difficult for parents and children to enroll in health coverage when they apply as a family unit, than it is to enroll children without other family members.

Enrollment procedures

- Twenty-three (23) states including the District of Columbia, allow children and parents to apply for health coverage using a single application. (In all states, families can apply as one unit if they use the combined TANF, Food Stamp and Medicaid application. The applications referred to here generally are for health coverage only, covering both Medicaid and SCHIP.)

  In six (6) states — California, Hawaii, Idaho, Mississippi, North Carolina and Utah — the same application form can be used to request coverage for children and parents, however, additional forms related to assets or medical support also must be submitted before an eligibility determination will be made for the parent.

  In Arkansas, Louisiana and South Carolina, the joint Medicaid/SCHIP application for children can not be used to apply for parents, but the application provides a place for parents to indicate that they also are interested in coverage for themselves. Arkansas and Louisiana send interested parents a Medicaid application, and South Carolina sends families the combined program application for Medicaid, Food Stamps and TANF.

- Thirty-five (35) states no longer require families to have a face-to-face interview when applying for coverage for a parent, as compared with 47 states that have dropped this requirement when applying for a child.

- Of the 13 states that allow families to self-declare their income when they apply for health coverage for their children, seven (7) also allow self-declaration of income when parents apply.

Renewal procedures

It is more difficult for families to renew their health coverage when parents and their children are enrolled as a family unit, than it is for children who receive coverage without other family members.

Parents may be subject to more frequent renewal schedules, more onerous reporting requirements and may not be able to renew their coverage using the same renewal form as the one used for their children. Under such circumstances, all family members are at risk of not retaining their coverage.

- Thirty-eight (38) states, including the District of Columbia, allow parents to renew their health coverage every 12 months, as compared with 42 states that allow children to renew every 12 months.

  In states that require parents to renew their coverage more than once a year, the length of the enrollment period varies from state to state; thus, the number of times a parent must submit reports to retain coverage varies, as well. The length of the enrollment period for the parent may or may not be in alignment with the length of the enrollmnet period for the child.

  — In **North Dakota**, parents are subject to a monthly reporting requirement.

  — In **Nebraska** parents must renew their coverage every four months; in **Utah** parents may be required to renew their coverage every four to six months if their income fluctuates. If their income is routinely stable, they may be allowed to renew coverage every 12 months.

  — In **Alaska, Georgia, Minnesota ("regular" Medicaid), North Carolina, Ohio, Oklahoma, Oregon, Texas** and **Vermont** parents are required to renew their coverage every six months.

- Thirty-five (35) states have dropped the face-to-face interview requirement for parents at renewal time, as compared with 48 states that have done so for children in Medicaid and separate SCHIP programs.

In a few states that expanded Medicaid coverage for parents, eligibility rules and procedures have been simplified for parents who qualify under the expansion, but not for parents who qualify under the pre-expansion, "regular" Medicaid guidelines. As a result, moderate-income parents have an easier time obtaining and retaining coverage than do lower-income parents.

- In **Minnesota, Tennessee, New York,** and **Vermont** the asset test has been removed for parents who qualify under the Medicaid expansion program, but not for parents eligible for

"regular" Medicaid, meaning it is harder for a lower-income parent to qualify for coverage than it is for a moderate-income parent. Parents eligible for Washington's state-funded expansion program do not have to meet an asset test, but they do have to meet an asset test to qualify for Medicaid.

Of the 25 states that continue to count assets for parents but not for children, four (4) states — Idaho, Louisiana, New York and Vermont — allow families to self-declare the value of their assets, averting the need to ask for more documentation if a parent applies for coverage along with a child. A few additional states may not require verification of assets if the family's declared assets are significantly below the state's asset limit.

- In **Minnesota** and **Tennessee** (states that have expanded Medicaid coverage for children and parents under Section 1115 waivers) parents and children eligible under the expansion guidelines renew their coverage every 12 months, while parents and children eligible for "regular" Medicaid (under pre-expansion guidelines) are required to renew their coverage every 6 months.

Despite widespread concern among the states about a weakening economy and state budget shortfalls, only two states rescinded simplification strategies in 2001.

During 2001, **Kentucky** retracted its policy to allow families to self-declare their income on children's health insurance applications, and now requires them to provide pay stubs or other documentation. The state also reinstated the face-to-face interview at the time health coverage is renewed.[29] **Virginia** no longer has joint forms families can use to apply for and renew coverage in Medicaid and the separate SCHIP program.[30] Applicants to the separate SCHIP program who appear to qualify for Medicaid must complete a separate Medicaid application. Children who apply for Medicaid are subject to more rigorous verification requirements than SCHIP applicants.

During at least some portion of 2001, three states stopped enrolling children in their separate SCHIP programs, due to state budget concerns.

North Carolina had closed enrollment in its separate SCHIP program during 2001, but has now re-opened the program. **Utah** plans to re-open enrollment for a short period in June 2002. SCHIP enrollment in **Montana** remains closed.

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[29]Kentucky reportedly plans to go back to allowing families to renew coverage without a face-to-face interview, but will reinstate the interview requirement at initial enrollment.

[30]Virginia plans to reinstate the joint application for children's Medicaid and the state's separate SCHIP program, FAMIS, in September 2002.

Although the Center's survey did not address the issue, news accounts and discussions with state officials and advocates indicate that some states are reducing or eliminating their outreach campaigns aimed at educating families about the availability of coverage.

III. Conclusion

Over the past four years states have made impressive strides to reduce the number of uninsured children. Their aggressive efforts to design health coverage programs that feature simple eligibility rules and enrollment procedures — as well as efforts to import the most prominent simplification features into their existing Medicaid programs — have contributed significantly to the progress achieved in this relatively short period of time. To a great extent, states continued to advance the level of simplification and coordination in their children's health coverage programs during 2001, even as a weakening economy began to exert pressure on state budgets.

The national survey discussed in this report found that most states have implemented critical simplification strategies that include eliminating asset tests, allowing families to use a single application to apply for Medicaid and separate SCHIP for their children, removing face-to-face interview requirements at enrollment and renewal, and lengthening the enrollment period so families do not have to renew their children's coverage more than once a year. But, despite these concerted efforts, the survey also found that persistent procedural barriers continue to make it difficult for eligible children to obtain and retain their health coverage.

States are gradually incorporating additional strategies into their programs to address remaining problems, including reducing the amount of documentation families must submit with their applications and relying more heavily on matches conducted with state databases to verify income and other information. However, while states have paid increased attention to simplifying renewal procedures, the majority of states have not taken full advantage of options available to facilitate retention of coverage, such as implementation of 12-month continuous eligibility. Applying the principles of simplification to parent coverage programs also is critical. In most states it is more difficult for an income-eligible parent to enroll in coverage than it is for her child. Rectifying this disparity has advantages for parents and their children — a growing body of evidence indicates that providing health coverage to parents helps enroll more children.

The challenge now is to sustain the progress achieved and to continue to advance efforts to ensure that eligible children and parents are able to obtain health coverage. This challenge has become more daunting in light of the serious economic conditions with which states are grappling. Yet, staying focused on facilitating the enrollment of eligible children and parents is as important now as ever. As state officials contemplate possible responses to the dilemma they face, it is important to avoid the dangers of cutting back eligibility or reinstating barriers to coverage. In addition to reversing the celebrated progress achieved in reducing the number of uninsured children, such efforts would increase the health and financial risks families face at a time when many are already suffering the effects of the economic downturn.

Table 1

State Income Eligibility Guidelines for Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs[1]

(Percent of Federal Poverty Line)
January 2002

		Medicaid Infants (0-1)[2]	Medicaid Children (1-5)[2]	Medicaid Children (6-17)[3]	Medicaid Children (18-19)[3,4]	Separate State Program[5]
Alabama		133	133	100	100	200
Alaska		200	200	200	200	
Arizona	Z	140	133	100	100	200
Arkansas		200	200	200	200	
California		200	133	100	100	250
Colorado		133	133	100	43	185
Connecticut		185	185	185	185	300
Delaware	Z	200	133	100	100	200
District of Columbia		200	200	200	200	
Florida[6]		200	133	100	100	200
Georgia[7]		235	133	100	100	235
Hawaii		200	200	200	200	
Idaho		150	150	150	150	
Illinois[7]		200	133	133	133	185
Indiana		150	150	150	150	200
Iowa		200	133	133	133	200
Kansas		150	133	100	100	200
Kentucky		185	150	150	150	200
Louisiana	Z	200	200	200	200	
Maine[7]		200	150	150	150	200
Maryland	Z	200	200	200	200	300
Massachusetts[8,9]		200	150	150	150	200 (400+)
Michigan		185	150	150	150	200
Minnesota		280	275	275	275	
Mississippi		185	133	100	100	200
Missouri		300	300	300	300	
Montana		133	133	100	71	150
Nebraska		185	185	185	185	
Nevada		133	133	100	78	200
New Hampshire		300	185	185	185	300
New Jersey	Z	200	133	133	133	350
New Mexico		235	235	235	235	
New York[10]		200	133	133	133	250
North Carolina		185	133	100	100	200
North Dakota		133	133	100	100	140
Ohio		200	200	200	200	
Oklahoma		185	185	185	185	
Oregon		133	133	100	100	170
Pennsylvania[8]		185	133	100	46	200 (235)
Rhode Island		250	250	250	250	
South Carolina		185	150	150	150	
South Dakota	Z	140	140	140	140	200
Tennessee[8]		N/A	N/A	N/A	N/A	
Texas		185	133	100	100	200
Utah		133	133	100	100	200
Vermont[11]		300	300	300	300	300
Virginia	Z	133	133	100	100	200
Washington		200	200	200	200	250
West Virginia	Z	150	150	100	100	200
Wisconsin		185	185	185	185	
Wyoming	Z	133	133	100	100	133

Z Indicates that a state has expanded eligibility in at least one of its children's health insurance programs since October 2000.

Notes for Table 1

1. The income eligibility guideline noted may refer to gross or net income depending on the state.

2. To be eligible in the infant category, a child has not yet reached his or her first birthday. To be eligible in the 1-5 category, the child is age 1 or older, but has not yet reached his or her sixth birthday. Minnesota covers children under age 2 in the infant category.

3. As required by federal law, states provide Medicaid to children age six or older who were born after September 30, 1983 and who have family incomes below 100 percent of the poverty line. By October 1, 2002 all poor children under age 19 will be covered. If the state covers children in this age group who have family incomes higher than 100 percent of the poverty line, or the state covers children born before September 30, 1983, thereby accelerating the phase-in period, it is noted in this column. States that have taken such steps have done so either through Medicaid statutory options or Medicaid waivers.

4. To be eligible in this category, a child is born before September 30, 1983 and has not yet reached his or her 19tth birthday. States are required to provide Medicaid coverage to these children if their family's income and resources are below AFDC standards in effect in their state in July 1996. States can modify those standards and expand eligibility under various statutory options.

5. The states listed use federal State Children's Health Insurance Program (SCHIP) funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children.

6. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings of enrolled children in some areas. Medi-Kids covers children birth through age 4.

7. Illinois and Maine covers infants in families with income at or below 200 percent of the federal poverty line who are born to mothers enrolled in Medicaid. Illinois covers other infants in families with income at or below 133 percent of the federal poverty line. Maine covers other infants in families with income at or below 185 percent of the federal poverty line. Georgia covers infants in families with income at or below 235 percent of the federal poverty line who are born to mothers enrolled in Medicaid. Georgia covers other infants in families with income at or below 185 percent of the federal poverty line.

8. Massachusetts and Pennsylvania provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parentheses. Eligibility under the Tennessee waiver is based on the child's lack of insurance; there is no upper income limit.

9. Children between ages 1 and 19 in families with income between 150 and 200 percent of the federal poverty line will receive either slightly reduced MassHealth (Medicaid) benefits or assistance paying premiums for employer-based plans.

10. New York expanded Medicaid income eligibility guidelines to cover all children age 1 though 19 with family income at or below 133 percent of the federal poverty line. This change was implemented in April 2002.

11. Under Medicaid, uninsured children are covered up to 225 percent of the federal poverty line, and underinsured children are covered up to 300 percent of the federal poverty line. The expansion of coverage for underinsured children was achieved through an amendment to the state's Section 1115 waiver. Vermont covers uninsured children in families with income between 225 and 300 percent of the federal poverty line under a separate SCHIP program.

Table 2

Selected Simplified Enrollment Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

		Program	Joint Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility[2]
Total		Medicaid (51)*	N/A	47	45	9
		SCHIP (35) **	N/A	34	34	5
		Aligned Medicaid and Separate SCHIP ***	33	47	44	6
Alabama		Medicaid for Children[3]	U		U	
		Separate SCHIP		U	U	
Alaska		Medicaid for Children	N/A	U	U	
Arizona		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Arkansas	Z	Medicaid for Children	N/A	U	U	
California		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Colorado		Medicaid for Children	U	U		
		Separate SCHIP		U	U	
Connecticut		Medicaid for Children	U	U	U	U
		Separate SCHIP		U	U	
Delaware		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
District of Columbia		Medicaid for Children	N/A	U	U	
Florida		Medicaid for Children[2,4]	U	U	U	U
		Separate SCHIP		U	U	
Georgia	Z	Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Hawaii		Medicaid for Children	N/A	U	U	
Idaho		Medicaid for Children	N/A	U		
Illinois		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Indiana		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Iowa		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Kansas		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Kentucky		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Louisiana		Medicaid for Children	N/A	U	U	
Maine		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Maryland		Medicaid for Children	U	U	U	
	Z	Separate SCHIP		U	U	
Massachusetts		Medicaid for Children	U	U	U	U
		Separate SCHIP		U	U	U
Michigan		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	U
Minnesota		Medicaid for Children	N/A	U	U	
Mississippi	Z	Medicaid for Children[2]	U	U	U	U
	Z	Separate SCHIP[2]		U	U	U
Missouri		Medicaid for Children[5]	N/A	U	U	
Montana	Z	Medicaid for Children	U	U		
		Separate SCHIP		U	U	
Nebraska		Medicaid for Children	N/A	U	U	U
Nevada	Z	Medicaid for Children	U	U		
	Z	Separate SCHIP		U	U	
New Hampshire		Medicaid for Children	U	U	U	U
		Separate SCHIP		U	U	
New Jersey		Medicaid for Children	U	U	U	U
		Separate SCHIP		U	U	U
New Mexico	Z	Medicaid for Children	N/A	U	U	U
New York		Medicaid for Children[2,6]	U		U	U
		Separate SCHIP		U	U	U
North Carolina		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
North Dakota	Z	Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Ohio		Medicaid for Children	N/A	U	U	
Oklahoma		Medicaid for Children	N/A	U	U	

		Program	Joint Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility[2]
Oregon		Medicaid for Children	U	U	U	
		Separate SCHIP		U		
Pennsylvania		Medicaid for Children[6]	U	U	U	
		Separate SCHIP		U	U	
Rhode Island		Medicaid for Children	N/A	U	U	
South Carolina		Medicaid for Children	N/A	U	U	
South Dakota		Medicaid for Children	U	U	U	
	Z	Separate SCHIP		U	U	
Tennessee		Medicaid for Children	N/A		U	
Texas	Z	Medicaid for Children	U	U		
		Separate SCHIP		U	U	
Utah		Medicaid for Children[3,7]				
		Separate SCHIP			U	
Vermont		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Virginia	,	Medicaid for Children		U	U	
	,	Separate SCHIP		U	U	
Washington		Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
West Virginia	Z	Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	
Wisconsin	Z	Medicaid for Children	N/A	U	U	
Wyoming	Z	Medicaid for Children	U	U	U	
		Separate SCHIP		U	U	

Z Indicates that a state has simplified one or more of its procedures or implemented a new program since October 2000.
, Indicates that a state has rescinded one or more simplified procedures since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

1. This column indicates whether a single application is used for children's Medicaid and the SCHIP-funded separate program, if the state operates one.

2. Under federal law, states may implement presumptive eligibility procedures in Medicaid and SCHIP-funded separate programs. Florida, Mississippi and New York (Medicaid) have yet to implement presumptive eligibility procedures. Presumptive eligibility procedures have been implemented in New York's SCHIP-funded separate program. In Michigan, a presumptive eligibility procedure has been developed for the state's SCHIP-funded separate program, however the procedure is optional and no health plan has chosen to use it.

3. These states require an interview for families applying for Medicaid for their children, however the interview may be conducted by telephone. In Alabama, the interview is usually done by telephone. In Utah, a face-to-face interview is required, but families are permitted to do the interview by telephone. In Utah, an interview also is required for the SCHIP-funded separate program.

4. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings of enrolled children in some areas. Medi-Kids covers children birth through age 4.

5. Missouri has eliminated the asset test for children's "regular" Medicaid. Children in the Medicaid expansion group are subject to a "net worth" test of $250,000.

6. Pennsylvania uses Medicaid and SCHIP applications that solicit "common data elements" in collecting information for Medicaid and SCHIP, thus making Medicaid and SCHIP applications interchangeable.

7. Utah still counts assets in determining Medicaid eligibility for children over the age of 6.

Table 3

Selected Simplified Renewal Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

	Program	Frequency^ (months)	12-Month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Renewal Form[1]
Total	Medicaid (51)*	42^	18	48	N/A
	SCHIP (35) **	33^	23	34	N/A
	Aligned Medicaid and Separate SCHIP ***	42^	17	48	21
Alabama	Z Medicaid for Children	12	U	U	U
	Z Separate SCHIP	12	U	U	
Alaska	Medicaid for Children	6		U	N/A
Arizona	Medicaid for Children[2]	12		U	
	Separate SCHIP	12	U	U	
Arkansas	Medicaid for Children[3]	12		U	N/A
California	Z Medicaid for Children	12	U	U	
	Separate SCHIP	12	U	U	
Colorado	Medicaid for Children[4]	12		U	
	Separate SCHIP	12	U	U	
Connecticut	Z Medicaid for Children	12	U	U	U
	Z Separate SCHIP	12	U	U	
Delaware	Medicaid for Children	12		U	U
	Separate SCHIP	12	U	U	
District of Columbia	Medicaid for Children	12		U	N/A
Florida	Medicaid for Children	12	U (under age 5)	U	
	Separate SCHIP[5]	6		U	
Georgia	Z Medicaid for Children[6]	6		U	U
	Z Separate SCHIP	12		U	
Hawaii	Medicaid for Children	12		U	N/A
Idaho	Medicaid for Children	12	U	U	N/A
Illinois	Medicaid for Children	12	U	U	
	Separate SCHIP	12	U	U	
Indiana	Medicaid for Children	12	U	U	U
	Separate SCHIP	12	U	U	
Iowa	Medicaid for Children	12		U	
	Separate SCHIP	12	U	U	
Kansas	Medicaid for Children	12	U	U	U
	Separate SCHIP	12	U	U	
Kentucky	, Medicaid for Children	12			U
	, Separate SCHIP	12			
Louisiana	Medicaid for Children	12	U	U	N/A
Maine	Z Medicaid for Children	12	U	U	U
	Z Separate SCHIP	12	U	U	
Maryland	Medicaid for Children	12		U	U
	Z Separate SCHIP	12		U	
Massachusetts	Medicaid for Children	12		U	U
	Separate SCHIP	12		U	
Michigan	Medicaid for Children	12		U	
	Separate SCHIP	12	U	U	
Minnesota	Medicaid for Children[3]	6		U	N/A
Mississippi	Medicaid for Children	12	U	U	U
	Separate SCHIP	12	U	U	
Missouri	Medicaid for Children	12		U	N/A
Montana	Z Medicaid for Children	12		U	
	Separate SCHIP	12	U	U	
Nebraska	Medicaid for Children	12	U	U	N/A
Nevada	Medicaid for Children	12		U	
	Separate SCHIP	12	U	U	
New Hampshire	Medicaid for Children	12		U	U
	Separate SCHIP	12		U	
New Jersey	Medicaid for Children[7]	12		U	U
	Separate SCHIP[7]	12		U	
New Mexico	Medicaid for Children	12	U	U	N/A
New York	Medicaid for Children[8]	12	U		U
	Separate SCHIP	12		U	
North Carolina	Medicaid for Children	12	U	U	U
	Separate SCHIP	12	U	U	
North Dakota	Medicaid for Children[9]	1 month		U	
	Separate SCHIP	12	U	U	
Ohio	Medicaid for Children[3]	12		U	N/A
Oklahoma	Medicaid for Children	6		U	N/A

		Program	Frequency^ (months)	12-Month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Renewal Form[1]
Oregon		Medicaid for Children	6		U	U
		Separate SCHIP	6		U	
Pennsylvania		Medicaid for Children	12		U	
		Separate SCHIP[10]	12	U	U	
Rhode Island		Medicaid for Children	12		U	N/A
South Carolina	Z	Medicaid for Children	12	U	U	N/A
South Dakota		Medicaid for Children	12		U	U
	Z	Separate SCHIP	12		U	
Tennessee		Medicaid for Children[3]	6			N/A
Texas	Z	Medicaid for Children	6		U	
		Separate SCHIP	12	U	U	
Utah		Medicaid for Children	12		U	
		Separate SCHIP	12	U	U	
Vermont	Z	Medicaid for Children	12		U	U
		Separate SCHIP	12		U	
Virginia	,	Medicaid for Children	12		U	
	,	Separate SCHIP	12		U	
Washington		Medicaid for Children	12	U	U	U
		Separate SCHIP	12	U	U	
West Virginia	Z	Medicaid for Children	12	U	U	U
	Z	Separate SCHIP	12	U	U	
Wisconsin	Z	Medicaid for Children[4]	12		U	N/A
Wyoming	Z	Medicaid for Children	12	U	U	U
	Z	Separate SCHIP	12	U	U	

Z Indicates that a state has simplified one or more of its procedures or implemented a new program since October 2000.

, Indicates that a state has rescinded one or more simplified procedures since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

^ If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for purposes of this table.

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1. This column indicates whether a single renewal form is used for children's Medicaid and the SCHIP-funded separate program, if the state operates one.

2. In Arizona, local offices may require families with children enrolled in Medicaid to complete a telephone interview at renewal.

3. In Arkansas, Minnesota, Ohio and Tennessee renewal procedures differ for families with children enrolled in Medicaid, depending on whether they are eligible under "regular" Medicaid or under expansions pursuant to Medicaid Section 1115 waivers or SCHIP-funded Medicaid expansions. In Minnesota and Tennessee, children who qualify under waiver programs can renew eligibility every 12 months, as opposed to every 6 months under "regular" Medicaid. In Arkansas and Ohio, children who qualify under expansion rules receive 12 months of continuous eligibility, as opposed to a 12 month renewal period in "regular" Medicaid. In Ohio, a waiver to continue this practice is pending.

4. In Colorado and Wisconsin, renewal procedures vary by county. In Wisconsin, county offices may require a face-to-face interview. Wisconsin has recently released a one-page renewal form that counties may use. If this form is used, no interview is required.

5. In Florida, all children covered under "regular" Medicaid have a 12 month renewal period. All children under age 5 enrolled in Medicaid receive 12 months of continuous eligibility. All children age 5 and older enrolled in Medicaid receive 6 months of continuous eligibility.

6. In Georgia, all families that apply for coverage using the joint Medicaid/SCHIP application receive a joint renewal form. Families that apply at the Medicaid office for Medicaid only receive a renewal form used to redetermine eligibility for TANF, Medicaid and food stamps.

7. In New Jersey, families of children who receive Medicaid or SCHIP can renew coverage using a joint renewal form issued by the central office. Families that qualify for other benefit programs, such as TANF or food stamps, must renew their children's coverage through their county office. County renewal procedures vary.

8. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement. A joint application can be used with the "facilitated enroller" at renewal.

9. In North Dakota, families with children enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

10. In Pennsylvania, renewal procedures for the SCHIP-funded separate program vary by health plan.

Table 4

Selected Verification Procedures: Self-Declaration of Income, Residency or Age in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

Program		Income	Residency	Child's Age
Total	Medicaid (51)*	13	43	45
	SCHIP (35) **	11	31	32
	Aligned Medicaid and Separate SCHIP ***	13	43	45
Alabama	Medicaid for Children		U	U
	Separate SCHIP	U	U	U
Alaska	Medicaid for Children		U	U
Arizona	Medicaid for Children		U	U
Z	Separate SCHIP	U	U	U
Arkansas	Medicaid for Children	U	U	
California	Medicaid for Children			U
	Separate SCHIP[1]			U
Colorado	Medicaid for Children		U	U
	Separate SCHIP		U	U
Connecticut	Z Medicaid for Children	U	U	U
	Z Separate SCHIP	U	U	U
Delaware	Medicaid for Children[2]		U	U
	Separate SCHIP[2]		U	U
District of Columbia	Medicaid for Children			U
Florida	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
Georgia	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
Hawaii	Medicaid for Children		U	U
Idaho	Medicaid for Children	U	U	U
Illinois	Medicaid for Children		U	U
	Separate SCHIP		U	U
Indiana	Medicaid for Children		U	U
	Separate SCHIP		U	U
Iowa	Medicaid for Children		U	U
	Separate SCHIP		U	U
Kansas	Medicaid for Children		U	U
	Separate SCHIP		U	U
Kentucky ,	Medicaid for Children		U	U
,	Separate SCHIP		U	U
Louisiana	Medicaid for Children		U	U
Maine	Medicaid for Children		U	U
	Separate SCHIP		U	U
Maryland	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
Massachusetts	Medicaid for Children		U	U
	Separate SCHIP		U	U
Michigan	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
Minnesota	Medicaid for Children[3]		U	U
Mississippi	Z Medicaid for Children[4]	U	U	U
	Z Separate SCHIP[4]	U	U	U
Missouri	Medicaid for Children[5]		U	U
Montana	Medicaid for Children[1]		U	U
	Separate SCHIP		U	U
Nebraska	Medicaid for Children		U	U
Nevada	Medicaid for Children			U
	Separate SCHIP		U	U
New Hampshire	Medicaid for Children			
	Separate SCHIP			
New Jersey	Medicaid for Children		U	
	Separate SCHIP		U	
New Mexico	Medicaid for Children		U	
New York	Medicaid for Children			
	Separate SCHIP			
North Carolina	Medicaid for Children		U	U
	Separate SCHIP		U	U
North Dakota	Medicaid for Children		U	U
	Separate SCHIP		U	U
Ohio	Medicaid for Children		U	U
Oklahoma	Medicaid for Children	U	U	U
Oregon	Medicaid for Children			U
	Separate SCHIP			U

Program		Income	Residency	Child's Age
Pennsylvania	Medicaid for Children		U	U
	Separate SCHIP		U	U
Rhode Island	Medicaid for Children		U	U
South Carolina	Medicaid for Children		U	U
South Dakota	Medicaid for Children		U	U
	Separate SCHIP		U	U
Tennessee	Medicaid for Children[6]			U
Texas	Medicaid for Children			U
	Separate SCHIP		U	U
Utah	Medicaid for Children		U	U
	Separate SCHIP		U	U
Vermont	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
Virginia	Medicaid for Children		U	
	Separate SCHIP		U	U
Washington	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U
West Virginia	Medicaid for Children		U	U
	Separate SCHIP		U	U
Wisconsin Z	Medicaid for Children	U	U	U
Wyoming Z	Medicaid for Children	U	U	U
	Separate SCHIP	U	U	U

Z Indicates that a state has implemented self-declaration of income since October 2000.

, Indicates that a state has eliminated self-declaration of income since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

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1. In California, families must submit birth certificates for children applying for SCHIP. In Montana, families must submit birth certificates for children applying for Medicaid. In both states, birth certificates are used to verify citizenship.

2. In Delaware, families must verify the birth dates of newborns.

3. Minnesota has adopted self-declaration of income for its Medicaid and Medicaid expansion programs, but procedures have not yet been implemented.

4. Mississippi requires families to provide either a parent's Social Security number or verification of income.

5. In Missouri, income verification is requested only when this information is not available from other sources, such as employment security or the food stamp program.

6. In Tennessee, applicants for the expansion program may self-declare all family information. No verification is required.

Table 5

Presumptive Eligibility in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs
January 2002

State	Presumptive Eligibility in Medicaid	Presumptive Eligibility in Separate SCHIP Program	One-step Application[1]	Qualified Entities
Connecticut	Yes	No	No	Community health centers, school-based health centers and Head Start programs
Florida[2]	Yes	No	Not yet determined	Not yet determined
Massachusetts[3]	Yes	Yes	Yes	MassHealth Enrollment Center
Michigan[4]	No	Yes	Yes	Health plans
Mississippi[5]	Yes	Yes	Yes (slightly modified)	Community health centers, disproportionate share hospitals and health departments
Nebraska	Yes	N/A	Yes	Community health centers and outpatient hospitals
New Hampshire[6]	Yes	No	Yes	Health care providers, WIC, Head Start programs, agencies that determine eligibility for subsidized child care, community-based organizations, Title V programs and Title X programs
New Jersey	Yes	Yes, for children in families with income below 200 percent of the federal poverty line	No	Health departments, community health centers and hospitals
New Mexico	Yes	N/A	Yes	Health departments, Indian Health Service programs, Head Start programs, schools and agencies that determine eligibility for subsidized child care
New York[2]	Yes	Yes	Yes (SCHIP) Not yet determined (Medicaid)	Health plans (SCHIP) Not yet determined (Medicaid)

1. This column indicates whether the application used to determine presumptive eligibility also can be used to make a final eligibility determination.

2. In Florida and New York, presumptive eligibility procedures have not yet been implemented in Medicaid.

3. Presumptive eligibility in Massachusetts differs from the process elsewhere, pursuant to the state's Section 1115 waiver. Under this procedure, all applications received at the central enrollment center that do not include the necessary verification are reviewed for presumptive eligibility. If a family's declared income is at or below 200 percent of the federal poverty line, and the child for whom the family is seeking coverage does not have other health insurance coverage, the child is determined to be presumptively eligible.

4. In Michigan, a presumptive eligibility procedure has been developed for the state's SCHIP-funded separate program, however the procedure is optional and no health plan has chosen to use it.

5. In Mississippi, presumptive eligibility procedures have not yet been implemented.

6. New Hampshire plans to revise its presumptive eligibility procedures to make the process more efficient. Under the new procedures, which will allow the state to track presumptive eligibility approval rates, community health centers and hospitals will be permitted to be qualified entities. Other entities that may have done presumptive eligibility determinations in the past may be designated as application assistance sites.

Table 6

Length of Time a Child is Required to Be Uninsured Prior to Enrolling in Children's Health Coverage*

	Length of Waiting Period[1] (in months)	
	At Implementation	**January 2002**
Alabama[2]	3	3
Alaska	12	12
Arizona	6	3
Arkansas	12	6
California	3	3
Colorado	3	3
Connecticut	6	2
Delaware	6	6
District of Columbia	*None*	*None*
Florida	*None*	*None*
Georgia	3	3
Hawaii	*None*	*None*
Idaho	*None*	*None*
Illinois	3	3
Indiana	3	3
Iowa	6	6
Kansas	6	*None*
Kentucky[3]	6	6
Louisiana	3	*None*
Maine	3	3
Maryland[3]	6	6
Massachusetts	*None*	*None*
Michigan	6	6
Minnesota	4	4
Mississippi	6	*None*
Missouri	6	6
Montana	3	3
Nebraska	*None*	*None*
Nevada	6	6
New Hampshire	6	6
New Jersey	12	6
New Mexico	12	*None*
New York	*None*	*None*
North Carolina	2	2
North Dakota	6	6
Ohio	*None*	*None*
Oklahoma	*None*	*None*
Oregon	6	6
Pennsylvania	*None*	*None*
Rhode Island	4	*None*
South Carolina	*None*	*None*
South Dakota	3	3
Tennessee	*None*	*None*
Texas[2]	3	3
Utah	3	3
Vermont	*None*	*None*
Virginia	12	6
Washington	4	4
West Virginia	6	6
Wisconsin	3	3
Wyoming	1	1

* **States in bold** have SCHIP-funded separate programs and may operate SCHIP-funded Medicaid expansions as well. States not in bold are SCHIP-funded Medicaid expansions.

1. These columns indicate the length of time a child is required to be uninsured before he or she is able to enroll in the SCHIP-funded program.

2. In Alabama and Texas, the waiting period is 90 days.

3. In Kentucky and Maryland, the waiting periods noted are used in both the SCHIP-funded Medicaid expansion and the SCHIP-funded separate program.

Table 7

Income Threshold for Parents Applying for Medicaid (Based on a Family of Three as of June 2001)

State	Income threshold for unemployed parents			Income threshold for employed parents		
	Monthly Dollar ($) Amount	Annual Dollar ($) Amount	As a percent (%) of poverty line	Monthly Dollar ($) Amount	Annual Dollar ($) Amount	As a percent (%) of poverty line
US Median	**$544**	**$6,528**	**45%**	**$836**	**$10,032**	**69%**
AL	$164	$1,968	13%	$254	$3,048	21%
AK	$1,118	$13,416	73%	$1,208	$14,496	79%
AZ *	$1,219	$14,630	100%	$1,309	$15,710	107%
AR	$204	$2,448	17%	$255	$3,060	21%
CA	$1,219	$14,630	100%	$1,309	$15,710	107%
CO	$421	$5,052	35%	$511	$6,132	42%
CT	$1,829	$21,945	150%	$1,919	$23,025	157%
DE	$1,219	$14,630	100%	$1,491	$17,892	122%
DC	$2,438	$29,260	200%	$2,438	$29,256	200%
FL	$303	$3,636	25%	$806	$9,672	66%
GA	$424	$5,088	35%	$756	$9,072	62%
HI *	$1,403	$16,830	100%	$1,403	$16,830	100%
ID	$317	$3,804	26%	$407	$4,884	33%
IL	$377	$4,524	31%	$686	$8,232	56%
IN	$288	$3,456	24%	$378	$4,536	31%
IA	$426	$5,112	35%	$1,065	$12,780	87%
KS	$403	$4,836	33%	$493	$5,916	40%
KY	$526	$6,312	43%	$909	$10,908	75%
LA	$174	$2,088	14%	$264	$3,168	22%
ME	$1,829	$21,945	150%	$1,919	$23,025	157%
MD	$418	$5,016	34%	$523	$6,276	43%
MA	$1,621	$19,458	133%	$1,621	$19,458	133%
MI	$459	$5,508	38%	$774	$9,288	63%
MN *	$3,353	$40,233	275%	$3,353	$40,233	275%
MS	$368	$4,416	30%	$458	$5,496	38%
MO	$1,219	$14,630	100%	$1,309	$15,710	107%
MT	$478	$5,736	39%	$836	$10,032	69%
NE	$535	$6,420	44%	$669	$8,028	55%
NV	$348	$4,176	29%	$1,097	$13,164	90%
NH	$600	$7,200	49%	$750	$9,000	62%
NJ *	$2,438	$29,260	200%	$2,438	$29,260	200%
NM	$389	$4,668	32%	$704	$8,448	58%
NY *	$1,621	$19,458	133%	$1,621	$19,458	133%
NC	$544	$6,528	45%	$750	$9,000	62%
ND	$488	$5,856	40%	$1,336	$16,032	110%
OH	$1,219	$14,630	100%	$1,219	$14,630	100%
OK	$471	$5,652	39%	$591	$7,092	48%
OR *	$1,219	$14,630	100%	$1,219	$14,630	100%
PA	$403	$4,836	33%	$677	$8,124	56%
RI *	$2,255	$27,066	185%	$2,345	$28,146	192%
SC	$610	$7,315	50%	$1,219	$14,630	100%
SD	$796	$9,552	65%	$796	$9,552	65%
TN	$840	$10,080	69%	$990	$11,880	81%
TX	$275	$3,300	23%	$395	$4,740	32%
UT	$583	$6,996	48%	$673	$8,076	55%
VT *	$2,255	$27,066	185%	$2,345	$28,146	192%
VA	$291	$3,492	24%	$381	$4,572	31%
WA	$2,438	$29,260	200%	$2,438	$29,260	200%
WV	$253	$3,036	21%	$343	$4,116	28%
WI *	$2,255	$27,066	185%	$2,255	$27,066	185%
WY	$590	$7,080	48%	$790	$9,480	65%

Notes: (1) These tables take earnings disregards into account when determining income thresholds for working parents. In some cases, these disregards may be time limited. States may also use additional disregards in determining eligibility. (2) States marked with (*) have expanded coverage for parents under an 1115 waiver using Medicaid and/or SCHIP funds, while Washington State has used state funds to expand coverage for parents. Some states, such as Arizona, California, and New York have secured waivers to expand coverage beyond the levels shown in this table, but have not yet implemented their expansions. Tennessee has a waiver to cover parents up to 400% of poverty, but the state currently is not accepting most new applicants unless they have income below the thresholds presented above.

SOURCE: KCMU analysis of "Can Medicaid Work for Working Families" by Maloy et al and "Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000" by Broaddus et al. The Commission conducted its analysis of these two studies in conjunction with Elizabeth Schott, consultant to Mathematica Policy Research, Inc., and Matthew Broaddus with the Center on Budget and Policy Priorities.

Table 8
Selected Simplified Enrollment Procedures in Medicaid for Parents and Children's Health Coverage Programs, January 2002

	Program	Family Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test
Total	Aligned Medicaid for Children and Separate SCHIP *	N/A	47	44
	Total Medicaid for Parents (51)**	23	35	19
Alabama	Medicaid for Children[3]			U
	Separate SCHIP		U	U
	Medicaid for Parents			
Alaska	Medicaid for Children		U	U
	Medicaid for Parents			
Arizona	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
Arkansas	Medicaid for Children		U	U
	Medicaid for Parents[4]			
California	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents[2]		U	
	Expanded Medicaid for Parents[2]		U	
Colorado	Medicaid for Children		U	
	Separate SCHIP	U	U	U
	Medicaid for Parents		U	
Connecticut	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Delaware	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
D.C.	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Florida	Medicaid for Children		U	U
	Separate SCHIP[5]		U	U
	Medicaid for Parents			
Georgia	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			
Hawaii	Medicaid for Children		U	U
	Medicaid for Parents		U	
	Expanded Medicaid for Parents[2]		U	
Idaho	Medicaid for Children		U	
	Medicaid for Parents[2]		U	
Illinois	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
Indiana	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents[6]			
Iowa	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			
Kansas	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
Kentucky	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			
Louisiana	Medicaid for Children		U	U
	Medicaid for Parents[4]		U	
Maine	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	
	Expanded Medicaid for Parents		U	
Maryland	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			

	Program	Family Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test
Massachusetts	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Michigan	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	
Minnesota	Medicaid for Children	U	U	U
	Medicaid for Parents		U	
	Expanded Medicaid for Parents		U	U
Mississippi	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents[2]		U	U
Missouri	Medicaid for Children[7]	U	U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Montana	Medicaid for Children		U	
	Separate SCHIP		U	U
	Medicaid for Parents		U	
Nebraska	Medicaid for Children		U	U
	Medicaid for Parents			
Nevada	Medicaid for Children		U	
	Separate SCHIP		U	U
	Medicaid for Parents		U	
New Hampshire	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			
New Jersey	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
New Mexico	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
New York	Medicaid for Children[8]	U		U
	Separate SCHIP[8]		U	U
	Medicaid for Parents[8]			
	Expanded Medicaid for Parents[8]			U
North Carolina	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents[2]		U	
North Dakota	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Ohio	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Oklahoma	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
Oregon	Medicaid for Children	U	U	U
	Separate SCHIP		U	
	Medicaid for Parents		U	
	Expanded Medicaid for Parents		U	
Pennsylvania	Medicaid for Children[9]	U	U	U
	Separate SCHIP[9]		U	U
	Medicaid for Parents[9]		U	U
Rhode Island	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
South Carolina	Medicaid for Children		U	U
	Medicaid for Parents[4]		U	U
	Expanded Medicaid for Parents[4]		U	U
South Dakota	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	
Tennessee	Medicaid for Children[10]			U
	Medicaid for Parents[10]			
Texas	Medicaid for Children		U	
	Separate SCHIP		U	U
	Medicaid for Parents			

Program		Family Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test
Utah	Medicaid for Children[3, 11]			
	Separate SCHIP[3]			U
	Medicaid for Parents[2]			
Vermont	Medicaid for Children[12]	U	U	U
	Separate SCHIP[12]		U	U
	Medicaid for Parents[12]		U	
	Expanded Medicaid for Parents[12]		U	U
Virginia	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	
Washington	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	
	Expanded Medicaid for Parents		U	U
West Virginia	Medicaid for Children		U	U
	Separate SCHIP		U	U
	Medicaid for Parents			
Wisconsin	Medicaid for Children	U	U	U
	Medicaid for Parents		U	U
	Expanded Medicaid for Parents		U	U
Wyoming	Medicaid for Children	U	U	U
	Separate SCHIP		U	U
	Medicaid for Parents		U	U

* "Aligned Medicaid for Children & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively, are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

** "Total Medicaid for Parents" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both "regular" Medicaid for parents and expanded Medicaid coverage for parents, if the state has expanded coverage for parents. All 50 states and the District of Columbia operate Medicaid programs.

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1. This column indicates whether a single application can be used to apply for coverage for children and parents. In states with "family" applications, parents are not required to complete additional forms in order to obtain coverage for themselves.

2. In California, Hawaii, Idaho, Mississippi, North Carolina and Utah, the same application can be used to apply for coverage for children and parents. However, parents must also complete additional forms to obtain coverage for themselves.

3. These states require an interview for families applying for Medicaid for their children, however the interview may be conducted by telephone. In Alabama, the interview is usually done by telephone. In Utah, a face-to-face interview is required, but families are permitted to do the interview by telephone for children's and parent coverage. In Utah, an interview also is required for the SCHIP-funded separate program.

4. The joint Medicaid/SCHIP applications in Arkansas, Louisiana, and South Carolina have a place for parents to indicate they are interested in health coverage for themselves. In Arkansas and Louisiana, parents are required to complete a Medicaid application. In South Carolina, parents are sent a combined program application for Medicaid, food stamps and TANF.

5. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings of enrolled children in some areas. Medi-Kids covers children birth through age 4.

6. In Indiana, parents are permitted to do the interview by telephone.

7. Missouri has eliminated the asset test for children eligible under "regular" Medicaid. Children in the Medicaid expansion program are subject to a "net worth" test of $250,000. Parents are not subject to an asset test.

8. In New York families may apply for health coverage for their children using one of two possible applications. One application can be used to apply for children's coverage (Medicaid and the separate SCHIP program) and Medicaid for pregnant women. The other application may be used to apply for coverage for these groups as well as parents. A contact with a community-based "facilitated enroller" will meet the Medicaid face-to-face interview requirement.

9. Pennsylvania uses Medicaid and SCHIP applications that solicit "common data elements" in collecting information for Medicaid and SCHIP, thus making Medicaid and SCHIP applications interchangeable.

10. In Tennessee, different applications are used based on whether the children and parents qualify under "regular" Medicaid or the state's Section 1115 expanded coverage. Parents who qualify under "regular" Medicaid rules must meet an asset test. Parents who qualify under the state's Section 1115 expansion do not have to meet an asset test.

11. Utah still counts assets in determining Medicaid eligibility for children over age 6.

12. In Vermont, there is an application that can be used to apply for coverage for all children and parents. There is another application that can be used to apply for coverage for all children and some parents.

Table 9
Selected Simplified Renewal Procedures in Medicaid for Parents and Children's Health Coverage Programs, January 2002

	Program	Frequency (months)	Eliminated Face-to-Face Interview	Family Renewal Form[1]
Total	Aligned Medicaid for Children and Separate SCHIP *	42^	48	N/A
	Total Medicaid for Parents (51)**	38^	35	24
Alabama	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[2]	12		
Alaska	Medicaid for Children	6	U	
	Medicaid for Parents	6	U	
Arizona	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[2]	12	Unknown	
Arkansas	Medicaid for Children	12	U	
	Medicaid for Parents	12	U	
California	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
	Expanded Medicaid for Parents	12	U	
Colorado	Medicaid for Children[3]	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[3]	12	U	
Connecticut	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	U
	Expanded Medicaid for Parents	12	U	
Delaware	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	U
	Expanded Medicaid for Parents	12	U	
D.C.	Medicaid for Children	12	U	
	Medicaid for Parents	12	U	U
	Expanded Medicaid for Parents	12	U	
Florida	Medicaid for Children[4]	12	U	
	Separate SCHIP	6	U	
	Medicaid for Parents	12		
Georgia	Medicaid for Children[5]	6	U	
	Separate SCHIP[5]	12	U	
	Medicaid for Parents[5]	6		
Hawaii	Medicaid for Children	12	U	
	Medicaid for Parents	12	U	U
	Expanded Medicaid for Parents	12	U	
Idaho	Medicaid for Children	12	U	
	Medicaid for Parents	12	U	U
Illinois	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Indiana	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[2]	12		
Iowa	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12		
Kansas	Medicaid for Children	12	U	
	Separate SCHIP	12	U	U
	Medicaid for Parents	12	U	
Kentucky	Medicaid for Children	12		
	Separate SCHIP	12		U
	Medicaid for Parents	12		
Louisiana	Medicaid for Children	12	U	U
	Medicaid for Parents	12	U	
Maine	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	U
	Expanded Medicaid for Parents	12	U	
Maryland	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[6]	12		

	Program	Frequency (months)	Eliminated Face-to-Face Interview	Family Renewal Form[1]
Massachusetts	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
	Expanded Medicaid for Parents	12	U	
Michigan	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Minnesota	Medicaid for Children[7]	6	U	
	Medicaid for Parents[7]	6	U	
	Expanded Medicaid for Parents[7]	12	U	
Mississippi	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Missouri	Medicaid for Children	12	U	U
	Medicaid for Parents	12	U	
	Expanded Medicaid for Parents	12	U	
Montana	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Nebraska	Medicaid for Children	12	U	
	Medicaid for Parents[6]	3		
Nevada	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
New Hampshire	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12		
New Jersey	Medicaid for Children[8]	12	U	U
	Separate SCHIP[8]	12	U	
	Medicaid for Parents[8]	12	U	
	Expanded Medicaid for Parents[8]	12	U	
New Mexico	Medicaid for Children	12	U	U
	Medicaid for Parents	12	U	
New York	Medicaid for Children[9]	12		Unknown
	Separate SCHIP	12	U	
	Medicaid for Parents[9]	12		
	Expanded Medicaid for Parents	12	U	
North Carolina	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents[2]	6		
North Dakota	Medicaid for Children[10]	1	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[10]	1	U	
	Expanded Medicaid for Parents[10]	1	U	
Ohio	Medicaid for Children	12	U	U
	Medicaid for Parents	6	U	
	Expanded Medicaid for Parents	6	U	
Oklahoma	Medicaid for Children	6	U	U
	Medicaid for Parents	6	U	
Oregon	Medicaid for Children	6	U	U
	Separate SCHIP	6	U	
	Medicaid for Parents	6	U	
	Expanded Medicaid for Parents	6	U	
Pennsylvania	Medicaid for Children	12	U	
	Separate SCHIP[11]	12	U	
	Medicaid for Parents	12	U	
Rhode Island	Medicaid for Children	12	U	U
	Medicaid for Parents	12	U	
	Expanded Medicaid for Parents	12	U	
South Carolina	Medicaid for Children	12	U	
	Medicaid for Parents	12	U	
	Expanded Medicaid for Parents	12	U	
South Dakota	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Tennessee	Medicaid for Children[7]	6		
	Medicaid for Parents[7]	6		

	Program	Frequency (months)	Eliminated Face-to-Face Interview	Family Renewal Form[1]
Texas	Medicaid for Children	6	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	6		
Utah	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents[2,12]	4-12		
Vermont	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents	6	U	
	Expanded Medicaid for Parents	6	U	
Virginia	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	
Washington	Medicaid for Children[13]	12	U	U
	Separate SCHIP[13]	12	U	
	Medicaid for Parents[13]	12	U	
	Expanded Medicaid for Parents[13]	N/A	U	
West Virginia	Medicaid for Children	12	U	
	Separate SCHIP	12	U	
	Medicaid for Parents	12		
Wisconsin	Medicaid for Children[3]	12	U	U
	Medicaid for Parents[3]	12	U	
	Expanded Medicaid for Parents[3]	12	U	
Wyoming	Medicaid for Children	12	U	U
	Separate SCHIP	12	U	
	Medicaid for Parents	12	U	

* "Aligned Medicaid for Children & Separate SCHIP" indicates the number of states that have adopted a particular simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively, are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

** "Total Medicaid for Parents" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both "regular" Medicaid for parents and expanded Medicaid coverage for parents, if the state has expanded coverage for parents. All 50 states and the District of Columbia operate Medicaid programs.

^ If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for purposes of this table.

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1. This column indicates whether a single application can be used to renew coverage for children and parents.

2. These states require an interview for parents renewing Medicaid coverage, however the interview may be conducted by telephone. In Alabama, the interview is usually done by telephone. In Indiana, parents are required to do either a face-to-face or telephone interview. In North Carolina, a telephone interview is required of parents. In Utah, a face-to-face interview is required, but parents are permitted to do the interview by telephone.

3. In Colorado and Wisconsin, renewal procedures vary by county. In Wisconsin, county offices may require a face-to-face interview. Wisconsin has recently released a one-page renewal form that counties may use. If this form is used, no interview is required.

4. In Florida, all children covered under "regular" Medicaid have a 12 month renewal period. All children under age 5 enrolled in Medicaid receive 12 months of continuous eligibility. All children age 5 and older enrolled in Medicaid receive 6 months of continuous eligibility. Parents who are enrolled in Medicaid, and do not receive other benefits such as food stamps or TANF, have a 12 month renewal period.

5. In Georgia, all families that apply for coverage using the joint Medicaid/SCHIP application receive a joint renewal form. Families that apply at the Medicaid office for Medicaid only receive a renewal form used to redetermine eligibility for TANF, Medicaid and food stamps. Parents must complete a face-to-face interview at every other renewal.

6. In Maryland and Nebraska, county offices determine whether a face-to-face interview is required of parents.

7. In Minnesota and Tennessee, children and parents who qualify under waiver programs can renew eligibility every 12 months, as opposed to every 6 months under "regular" Medicaid. In Tennessee, children and parents who qualify under waiver programs can renew eligibility every 12 months, as opposed to every 6 months under "regular" Medicaid.

8. In New Jersey, children and parents who receive Medicaid and children who receive SCHIP can renew coverage using a joint renewal form issued by the central office. Families that qualify for other benefit programs, such as TANF or food stamps, must renew their children's coverage through their county office. County renewal procedures vary.

(continued)

Table 9 Endnotes
(continued)

9. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement. A joint application can be used with the "facilitated enroller" at renewal.

10. In North Dakota, children and parents enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

11. In Pennsylvania, renewal procedures for the SCHIP-funded separate program vary by health plan.

12. In Utah, renewal periods for parent coverage vary from 4 months to 12 months, based on income fluctuation.

13. In Washington, the same renewal form is used for the state's SCHIP-funded separate program and Medicaid for children and parents. Washington Basic Health Plan, the state-funded program which provides expanded coverage for parents, reviews the income of adults who have been enrolled in the program for 12 months. This review is generally done without contacting the family, by accessing other state databases. If the income reported by the family does not match the income found through the database check, the family may be contacted and asked to provide verification of income and Washington State residency.

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