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ISSUE PAPER

EXPRESS LANE ELIGIBILITY

How To Enroll Large Groups Of Eligible Children In Medicaid and CHIP

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December 1999

The recent expansions of children's health insurance programs at the federal and state levels offer an unprecedented opportunity to reach out and enroll millions of uninsured children who now qualify for publicly subsidized health coverage. However, even with the infusion of new money and resources to get this job done, states and localities have had limited success reaching the millions of children who are currently eligible but not enrolled for health care coverage.

This strategy brief offers practical suggestions for dramatically boosting enrollment in children's health insurance programs. It suggests an approach called Express Lane Eligibility which accelerates enrollment for the hundreds of thousands of uninsured children already enrolled in other income-comparable publicly funded programs such as Head Start or school lunch. The simple notion is that children who have met the income test for these income-comparable programs should have their eligibility expedited and do not need to provide duplicative income information to qualify for health care coverage. Express Lane Eligibility can cut administrative red tape while streamlining the application process, thereby making health insurance more attractive for eligible families.

While ideas like Express Lane Eligibility have been discussed for a long time and are being tried in a handful of places, this brief suggests ways that the idea can be taken further to enroll far more children more simply, using a variety of income-comparable programs. In addition, with leaders ranging from President Clinton to governors to civic leaders calling for stepped up efforts to enroll children, there is a keener interest in focusing on high leverage strategies that can reach many more children. Finally, Express Lane Eligibility holds added potential for success because it addresses the challenge faced by so many states: families are turned off by the time-consuming, often demeaning steps they must take to enroll their kids.

BACKGROUND

The creation in 1997 of the Children's Health Insurance Program (CHIP) marked an unprecedented moment in children's health in America. Not only did CHIP offer an infusion of federal and state funding to provide health coverage to millions of uninsured low-income children, it induced states to reach out to the millions of other uninsured children who were eligible for health coverage through Medicaid.

Roughly 70 percent of all uninsured children in the US now qualify for public health coverage through Medicaid or CHIP.[1] Finding these children and ensuring they enroll for coverage is one of the greatest challenges facing states today. It is not an easy task, nor is it one for which US health programs have a strong track record. As many as 4.7 million uninsured children are eligible for Medicaid but not enrolled.[2] In addition, while states have moved forward quickly to enroll roughly 1.3 million uninsured children into CHIP, there is still a tremendous amount of work to do to reach the up to 1.8 million remaining eligible children.[3]

The barriers to reaching and enrolling these children are daunting. Recent focus groups with parents of potentially eligible Medicaid children conducted by the Kaiser Family Foundation describe the barriers families encounter, including burdensome application forms and procedures, complex eligibility rules, lack of knowledge, and the families' negative perceptions of the enrollment process.[4] A survey by the Harvard School of Public Health conducted after CHIP was created found that only 29 percent of parents with uninsured children were aware of the new efforts to expand health coverage to children.[5]

While the concept of linking programs has been around for years, the barriers to making it happen have been many, including the numerous and dissimilar program eligibility rules and administrative hurdles. With the increased importance and attention placed on enrolling uninsured children in health programs, we believe there is greater impetus now than ever before for implementing Express Lane Eligibility.

OVERVIEW OF EXPRESS LANE ELIGIBILITY

Literally millions of children are already enrolled in public programs with eligibility rules similar to those used for Medicaid and CHIP. Not only have these families already been certified as income-eligible for the public programs, they have undergone a thorough application process to enroll their children in these programs. Thus, the most efficient and logical strategy a state could implement to reach its eligible uninsured children would be to link its Medicaid and CHIP programs to public programs with comparable income eligibility standards.

A range of programs with income eligibility levels comparable to Medicaid and CHIP could be utilized for this purpose including the Food Stamp Program (Food Stamps), the National School Lunch Program (NSLP), Head Start, and the Supplemental Nutrition Program for Women, Infants and Children (WIC). Other programs that should be considered include the Child Care and Development Block Grant, Section 8 or other Housing Assistance, the Child and Adult Care Food Program, the Low-Income Home Energy Assistance Program, Unemployment Compensation, Temporary Assistance for Needy Families (TANF), and the Earned Income Tax Credit (EITC).

Because states have established varying income guidelines for these programs, states will need to determine which programs work best for them. However, by reviewing four programs that have federal income guidelines that are relatively close to most states' Medicaid and CHIP programs, it is apparent that Express Lane Eligibility has the capacity to reach a large number of eligible children. (See Chart A)

Food Stamps has the potential for reaching over 1 million children who are enrolled in the program but are uninsured. The net income eligibility standard for Food Stamps is 100% of the federal poverty level (FPL), with the gross income standard being 130% FPL. Since many states have extended their Medicaid programs to serve children up to 130% FPL or higher, and Food Stamps' immigration guidelines are similar to Medicaid's, many of these uninsured children are eligible for Medicaid.

Other programs also hold great promise as vehicles for identifying and reaching uninsured children. Substantial numbers of low-income uninsured children are estimated to be participating in the National School Lunch Program and the WIC program.[6] Some programs, like WIC, are relatively easy to link to Medicaid and CHIP. Others, however, require more effort to ensure compliance with additional Medicaid and CHIP eligibility requirements.

CHART A
Children Enrolled Nationally in Food Stamps, Head Start, the National School Lunch Program and WIC

PROGRAM	FEDERAL INCOME GUIDELINES	TOTAL CHILDREN ENROLLED	HEALTH INSURANCE STATUS
Food Stamps	· gross income up to 130% of the Federal Poverty Level (FPL)	· 10,005,000[1]	· 1,062,000 uninsured[1]
Head Start	· up to 100% FPL · allows up to 10% of enrollees to be over the income limit	· 822,316[2]	· 37% not receiving Medicaid[3]
National School Lunch Program (NSLP)	· up to 130% FPL for free lunch · 130-185% FPL for reduced price lunch	· 15.3 million[4]	N/A
Supplemental Nutrition Program for Women, Infants and Children (WIC)	· up to 185% FPL	· 5,600,252[5]	N/A

[1] US Census Bureau, March 1998 Current Population Survey. Enrollment and insurance figures refer to 1997.
[2] Communication with Rita Schwartz, Analyst, Head Start Bureau, May 1999. Figure refers to the 1998-99 academic year.
[3] Head Start Bureau, "Program and Information Report," June 1999. Figure refers to the 1998-1999 academic year, data is self-reported by families.
[4] Communication with Jeff Derr, Analyst, Food and Nutrition Service, USDA, September 1999. Enrollment figure refers to FY98.
[5] Enrollment figure obtained from Food and Nutrition Service, Supplemental Food Programs Division, Program Analysis and Monitoring Branch, "WIC Program: State Agency Participation and Expenditure Report, Fiscal Year 1999," February 1999, p. 3.

Express Lane Eligibility In Practice

There are different levels of implementing Express Lane Eligibility, including strategies that can be implemented immediately and those that would require further federal guidance. What model a local or state entity uses will depend on a number of different program variables including eligibility guidelines, program administration, and the technological ability to link between programs. The following is a review of the different models, along with examples of the few places that are already putting Express Lane Eligibility into practice.

Create the Same Application for Multiple Programs: Perhaps the most common approach used by states to link children's health programs with other public programs has been through the development of integrated program applications. With a single application, families are only required to fill out and submit information once. A number of states including Illinois, Maryland, Michigan, California, and Ohio use joint applications for their TANF, Medicaid, and Food Stamp programs. Other states use the same application for their WIC and Medicaid programs. For instance, Vermont has a joint application for WIC and its

Medicaid program (Dr. Dynasaur) that has successfully resulted in 97 percent of Vermont children in WIC having health insurance.[7]

However, simply combining a number of applications into one packet without trying to streamline the programs' eligibility criteria can lead to a longer and more cumbersome form. For example, Colorado's "single purpose application," which allows applicants to apply for a number of state-run programs including Medicaid, Food Stamps, Supplemental Security Income (SSI), nursing home care, etc., is 18 pages long and requires extensive income information to meet each program's requirements. As a result, families applying for Medicaid or CHIP often prefer to use the state's Medicaid and CHIP short-form application.

Targeted Outreach to Children in Income-Comparable Public Programs: Another way states can utilize other public programs to reach children eligible for Medicaid and CHIP is to create a referral system between programs. A state can implement this model in a number of ways:

- A state agency administering a program that reaches families with incomes similar to Medicaid or CHIP can send all enrolled parents and caretakers, or all enrollees if it is not possible to identify applicants with children, an application, application instructions, and a letter informing them about health coverage available for children.

- When applying for benefits through an income-comparable program, applicants can authorize the sharing of their names and addresses with Medicaid and CHIP, so that the health program staff can contact them and provide them with applications and assistance in applying. Authorization can be accomplished through a check-off box on the application or through a separate consent form attached to the application. Guidance released by the United States Department of Agriculture (USDA) in the fall of 1998 on ways states and school officials can use the National School Lunch Program as a referral mechanism for Medicaid or CHIP is a good example of this model. The USDA created prototype applications for schools, which ask parents whether they want to waive confidentiality for the limited purpose of permitting the school to share information from the NSLP application with children's health insurance programs.

In the Field: The Chicago Public School System conducted an extensive effort to enroll uninsured children eligible for its free or reduced price school lunch program into KidCare, Illinois' Medicaid and CHIP program. Over 200,000 uninsured children in Chicago are estimated to be eligible for KidCare, which covers children ages 1 -18 with family incomes up to 185% FPL and pregnant women and children up to age 1 with incomes up to 200% FPL.

Under a data exchange agreement with the state, the school system conducted a computer match to identify children who were eligible for the school lunch program but not enrolled in KidCare. In the fall and spring of the last school year, these families were sent a KidCare information packet and application along with an invitation to receive help filling out the application at a Report Card Pick-Up Day, an event parents are required to attend. All school children were also sent home with letters about KidCare and the Report Card Pick-Up Day. The state's Medicaid agency reimbursed the school system for about 75 percent of the costs of this effort, excluding staff time. An extensive follow-up system has also been implemented and includes six regional walk-in centers and a toll-free hotline available to help people with ongoing questions. The fall effort generated about 5,000 applications. Immediately following the spring campaign, KidCare received between 11,000 and 13,000 applications from the Chicago area -- many of which were generated by the campaign.

In addition, the school system modified its school lunch application in 1998 to give parents the opportunity to consent to the release of information to the Medicaid agency for purposes of applying for KidCare. In 1999, the consent clause was modified to also allow the release of names to community outreach groups, so that they can do application follow-up. Over 98,000 families signed the consent form -- families whose children were eligible for free or reduced price lunches but who were not currently enrolled in KidCare. Officials are currently working on a system to track what happens with families who sign the consent form.

Streamline the Enrollment for Children Already Connected to Income-Comparable Public Programs: One step beyond a simple outreach and referral process is for a state to simplify the Medicaid and CHIP enrollment process for children who are already enrolled in other public programs with comparable income and/or eligibility guidelines. Thus, a child who is enrolled in an income-comparable program would not be required to fill out the full Medicaid and CHIP application(s) because the family has already provided relevant information. This process can work in several ways:

- When an application is submitted to an income-comparable program, the agency can ask the applicant to authorize the release of any relevant information to Medicaid or CHIP for the purpose of an eligibility determination. Authorization can be accomplished through a check-off box or a separate consent form. The consent form can also ask for any additional information needed by the health programs, such as the child's health insurance or immigration status. Again, the USDA has created prototypes that enable school lunch officials to establish such a system.

- For families already enrolled in an income-comparable program, the agency can notify them of their child's potential eligibility for Medicaid or CHIP. With that notification, the agency can ask the family's permission to forward their information to the health care agency while at the same time asking the family to provide remaining information needed to complete a Medicaid or CHIP application, such as immigration status.

In the Field: Los Angeles County's Department of Public Social Services (DPSS) recently sent out a notice of potential Medi-Cal (California's Medicaid program) eligibility to almost 28,000 food stamp households with children who are not enrolled in TANF.[8] The information about family composition and TANF enrollment was obtained from the DPSS database, a feasible process since Food Stamps, TANF and Medi-Cal are all administered by DPSS. With the notice, DPSS included a card that the family could sign and return in a pre-stamped envelope giving authorization for Medi-Cal to access data in the family's Food Stamp case file to determine their children's eligibility for Medi-Cal. A phone number was also provided for those families with questions.

In the month after these notices were sent out, DPSS received over 1,700 responses, 94 percent of which were cards authorizing them to proceed with the eligibility determination. Among these respondents, 659 were not receiving Medi-Cal and their applications are currently being processed.

Upon receipt of the authorization cards, eligibility workers complete full eligibility determinations. Face-to-face interviews and additional signatures are not required. When there is not enough information in the Food Stamp file, eligibility workers contact applicants for missing data (for instance, current insurance status is unlikely to be in the file). Families found eligible will be informed of this determination and then asked to pick health care providers. Families that are not eligible for Medi-Cal but potentially eligible for the state's CHIP program (Healthy Families) are referred to that program. DPSS plans to follow-up with another mailing to those families that did not respond to its initial mailing.

Define Groups of Kids Already Enrolled in Income-Comparable Public Programs as Automatically Eligible for Medicaid and CHIP: The strategy that holds the greatest potential for reaching large numbers of eligible children most simply is to allow eligibility for one program to be used to fulfill some or all of the eligibility requirements for health care. The June 1998 Interagency Task Force on Children's Health Insurance Outreach described this process as a "way to shorten the Medicaid and/or CHIP application and speed up eligibility determinations."[9]

This full Express Lane Eligibility model has already been utilized to link Medicaid with the SSI program. Currently, federal law authorizes that enrollment in SSI automatically grants a person eligibility for Medicaid.[10] Most states allow for a simultaneous application for SSI and Medicaid, although some require that an applicant first get SSI approval and then apply for Medicaid.

There are a number of strategies for how a state could implement the full Express Lane Eligibility model. The following is a brief outline of some of these avenues.

Under CHIP, the federal statute (Title XXI of the Social Security Act) provides states with significant flexibility in setting the income methodology used to define eligibility for their children's health programs. Thus, a state could opt to grant automatic income eligibility for CHIP to groups of children already found by income-comparable public programs to have low family incomes. However, since most children enrolled in other public programs will be eligible for Medicaid and not CHIP, Medicaid rules might be more relevant to a state.

Under Medicaid law (Title XIX of the Social Security Act), a state also has some flexibility in implementing a full Express Lane Eligibility model. A state would start by taking inventory

of its public programs to determine which programs do, and do not, fall within the income guidelines and methodology of its Medicaid program.[11] Eligibility could then be expedited for children in programs determined to fall within the income guidelines of Medicaid.

More specifically, for a public program to align with a state's Medicaid methodology, the Medicaid eligibility rules must be liberal enough so that no child could qualify for the income-comparable public program and be ineligible for Medicaid. Under this scenario, a state would still need to meet Medicaid's regulatory provisions such as immigration and verification requirements, but a child enrolled in the income-comparable program could be considered automatically income-eligible for Medicaid. In addition, under this Express Lane Eligibility model, a state should not have to worry about being sanctioned for any Medicaid Eligibility Quality Control (MEQC) errors if the Medicaid agency properly applied the income determinations made by the non-health agencies.

In instances where an income-comparable public program does not fit within the Medicaid eligibility rules, a state could still implement full Express Lane Eligibility by using Section 1902(r)(2)[12] of the Social Security Act to make its Medicaid rules less restrictive, thus aligning them with the rules of the income-comparable program. Another alternative is to obtain passage of federal legislation that would authorize Medicaid and CHIP agencies to accept a child's documented participation in designated public programs as evidence of income eligibility for Medicaid and CHIP.

In the Field: The WIC Program. Implementation of a full Express Lane Eligibility model is demonstrated by the WIC program's use of what it refers to as "adjunctive eligibility." In 1989, Congress authorized WIC agencies to accept an applicant's documented participation in Medicaid, Food Stamps and AFDC (today known as TANF) as evidence of income eligibility for WIC. However, this process does not currently work in the other direction, i.e. Medicaid cannot accept an applicant's documented participation in WIC as evidence of income eligibility for Medicaid. An applicant must also be found nutritionally at-risk and meet residency requirements to actually be enrolled in WIC. Today, fully two-thirds of WIC participants are enrolled through an Express Lane Eligibility model.[13]

Congress authorized this process to reduce the administrative burden on WIC staff, expedite an applicant's entry into the program, remove potential barriers to program participation, and increase referrals between WIC and other health and social service programs. Many WIC staff believe "adjunctive eligibility" has met these goals, and today the process is so fully incorporated into the WIC system that it is taken for granted.

ISSUES TO CONSIDER

States and counties should anticipate and be ready to address several implementation issues that arise around Express Lane Eligibility.

Different Eligibility Guidelines Between Programs
While certain public programs may have income limits that are comparable to a state's Medicaid and CHIP programs, in many cases each program will have different ways of counting that income, such as using different definitions for allowable income, income deductions, or household composition. Therefore, when linking a program with Medicaid or CHIP, additional income information may be needed from the family to finalize the eligibility determination process.

In addition, while Medicaid and CHIP restrict eligibility to US citizens and certain "qualified aliens," some public programs do not. Again, additional immigration information may need to be obtained from a family to determine a child's eligibility for Medicaid or CHIP. A system for obtaining this information should be created that would not in any way discourage a family from applying to an income-comparable program that does not require immigration information.

Resources and Collaboration
Implementing any of the Express Lane Eligibility models requires a sustained collaborative effort among different program agencies, administrations, and computer systems. It is therefore vital to get support from all of the key persons and entities who potentially have a role to play in Express Lane Eligibility. In addition, when implementing Express Lane Eligibility care should be taken to limit the additional work demands placed on administering agencies or program staff or to find ways to reimburse for them. One option is for states to pay the administrative costs associated with Express Lane Eligibility, especially those undertaken by bodies other than the health agency, through federal Medicaid administrative payments.

The impact such issues can have on whether Express Lane Eligibility is successful or not is demonstrated by the National School Lunch Program, where there are many legitimate sensitivities about adding new work for the school personnel who administer the local school lunch programs and whose time is already spread thin. Washington state attempted to link school lunch applicants to health coverage by including a check-off box on its school lunch application allowing families to request information about health programs. In two years of operation, the state has received only about 200 referrals. Part of the problem stemmed from the fact that school staff did not forward these families' names to the health department either because of confidentiality concerns or because their workload did not allow them to devote sufficient time to implement the new procedure.

Confidentiality
Each public program has distinct confidentiality and disclosure rules, designed to protect a family's privacy. Some programs, like Food Stamps, provide a federally defined, clear policy for sharing information with other federal and state programs serving low-income persons. Others may have different confidentiality guidelines at the state, local, or even the program (e.g., Head Start) level. In any case, interagency agreements are likely to be required to ensure that the information obtained will be used only for outreach and/or enrollment purposes.

Screen and Enroll
Federal law requires that prior to enrolling a child in a state's separate CHIP program, the child must first be screened for and, if eligible, enrolled in Medicaid. For the 25 states that simply expanded their Medicaid programs to implement CHIP, this requirement is already fulfilled. In addition, if the income-comparable public program has income guidelines that fall squarely within Medicaid's income guidelines, there is no screening or enrollment problem. Food Stamps may be one such program, since its income guidelines are at or below Medicaid guidelines in most states. Any child enrolled through Express Lane Eligibility would appropriately be enrolled in Medicaid. However, since states receive an enhanced federal match for children newly eligible for health coverage under the CHIP statute, even if the coverage is Medicaid, states may need to obtain additional income information from families to receive the appropriate matching rate.

In states with a separate CHIP plan, there will also be instances in which enrollees in income-comparable programs (WIC, in many states) will be either CHIP- or Medicaid-eligible. Under such circumstances, the state will need to ensure that all Medicaid-eligible children get enrolled in Medicaid, not CHIP, and that the state receives its appropriate federal matching rate. This should not be a difficult process for states that have the ability to share information between different programs and agencies via computer. Those without the information sharing capability between programs can consider allowing a family to self-certify their income, but not require documentation, so the Medicaid/CHIP agency can easily determine whether the child is eligible for Medicaid or CHIP.

HOW TO GET STARTED

There are a number of concrete steps a state or county can take now to implement Express Lane Eligibility.

√ **Review the guidelines and administrative structures of all potential public programs to determine which will best accommodate the different Express Lane Eligibility models in your state or local community.**
- Determine which programs best align with your state's Medicaid and CHIP guidelines.
- Examine the programs' administrative structures to decide which guidelines allow Express Lane Eligibility to be implemented most efficiently and effectively. For instance, in states where Medicaid and Food Stamps are administered by the same agency, it may be easier to coordinate efforts and transfer information.
- Determine whether the program would be implemented on a state-wide basis or at a county/local level, based on administrative structures and authorities.

√ **Form an Interagency Task Force with the agencies that will be involved in structuring Express Lane Eligibility.**
- Acquire the support of each Agency Director and/or Commissioner. If possible, obtain the support of the Governor or other high-level state administrator.
- Involve information systems and eligibility specialists from relevant agencies.

√ **Tackle some of the key hurdles early on. For instance:**

- Begin trying to work out confidentiality agreements and procedures. For ideas, look at the USDA's recent model school lunch program application designed to get necessary authorizations for information sharing.
- Discuss the possibility of amending the eligibility guidelines of income-comparable public programs to align them more closely with Medicaid -- or determine exactly how Medicaid guidelines need to be changed to match the public programs.
- Examine the possibilities for information sharing and verification offered by a state-wide database.

√ **Develop and work for legislative changes to streamline Medicaid and CHIP enrollment processes and improve the potential success of Express Lane Eligibility.**

- Implement 12 months of continuous eligibility, as allowed under federal law.
- Allow families to self-certify their income, as allowed under federal law.
- Implement presumptive eligibility, as allowed under federal law.
- If your state has separate Medicaid and CHIP programs, work to streamline or combine the eligibility and application process.

CONCLUSION

There is important new ground to break in the health insurance field as states and local communities face the tough challenge of enrolling eligible children in programs often not liked by families because of a perceived "welfare stigma" or because their enrollment processes are overly complex. All of the resources in the world directed at outreach will not succeed at bringing children into health care unless steps are taken to dramatically simplify enrollment and destigmatize the programs.

Amidst many experiments states are trying, Express Lane Eligibility holds the potential to address the core problems that keep families away and, at the same time, provide a high leverage solution by reaching up to several million children.

The Children's Partnership with support from the Kaiser Commission on Medicaid and the Uninsured is committed to providing the research and development to move this idea into reality. We hope interested leaders in the field will share their successes and challenges with us as we continue to study the feasibility of Express Lane Eligibility and document best practices.

This paper was prepared by The Children's Partnership with support from the Kaiser Commission on Medicaid and the Uninsured. Special thanks goes to Gloria Bryngelson, Stan Dorn, Chris Linville, Ann Rosewater, Donna Cohen Ross, Andy Schneider, Sandra Shewry, Sarah Shuptrine and Denise Taylor for their input and expertise, and to Barbara Lyons and Christina Chang with the Henry J. Kaiser Family Foundation.

The Children's Partnership is a national nonprofit organization founded to advance the interest of America's children and families in the 21st century. In particular, we advocate to ensure underserved children have access to the resources they need to thrive; we set out a children's agenda in areas where none exists; and we build support for children's issues among leaders and the American public.

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NOTES

[1] US Census Bureau, March 1998 Current Population Survey. 68 percent of all uninsured children are in families with incomes below 200 percent of the poverty level ($33,400 for a family of 4). CHIP, established as Title XXI of the Social Security Act, was created to allow states to provide health coverage to uninsured children in families with incomes up to 200 percent of the poverty level who were not already eligible for Medicaid, the health insurance program for lower income families. This figure does not reflect states that have provided coverage to children in families with incomes above 200 percent of the poverty level. This number also holds true if we estimate that 4.7 million uninsured children are eligible for Medicaid (see Footnote 2) and that 2.6 - 3.1 million uninsured children are eligible for CHIP (see Footnote 3). With an estimated 10.7 million uninsured children, that would make 68% to 72% of uninsured children eligible for health coverage.

[2] Thomas Selden, Jessica Banthin, and Joel Cohen, "Medicaid's Problem Children: Eligible but not Enrolled," *Health Affairs*. May/June 1998: 192-200. The estimate of 4.7 million unenrolled but Medicaid eligible children is for the year 1996.

[3] Health Management Associates, "Enrollment Increases in State CHIP Programs, December 1998 to June 1999," The Kaiser Commission on Medicaid and the Uninsured, July 1999; Thomas Selden, Jessica Banthin, and Joel Cohen, "Waiting in the Wings: Eligibility and Enrollment in the State Children's Health Insurance Program," *Health Affairs*. March/April 1999: 126-133. Using the federal maximum CHIP income thresholds, estimates that in 1999 3.1 million uninsured children were eligible for CHIP. When examining state plans approved or submitted as of August 1998, that number falls to 2.6 million. However, these numbers do not take into account any of the recent state CHIP expansions, many covering children in families with incomes above 200 percent of the poverty level.

[4] Lake Snell Perry & Associates, "Barriers to Medicaid and Medi-Cal Enrollment," The Henry J. Kaiser Family Foundation, presentation at the National Academy of State Health Policy Annual Conference, Cincinnati, Ohio, August 1999.

[5] University of Maryland Survey Research Center, "American Attitudes Toward Children's Health Care Issues," Harvard School of Pubic Health, December 1997.

[6] Genevieve M. Kenny, Jennifer M. Haley, and Frank C. Ullman, "Most Uninsured Children are in Families Served by Government Programs," The Urban Institute, Assessing the New Federalism, Series B, no. B-4, December 1999.

[7] Communication with Donna Bister, state WIC Director, Vermont Department of Social Welfare, August 1999.

[8] DPSS officials originally intended to compare Food Stamp households with children against Medi-Cal enrollment but due to an administrative error the households were compared against TANF enrollment, thereby yielding a less precise list of potential Medi-Cal eligible children.

[9] Report to the President, Interagency Task Force on Children's Health Insurance Outreach, submitted by the Secretary of Health and Human Services, Washington, D.C., June 1998, p. 109.

[10] While most states take advantage of this federal regulation, there are 12 states (referred to as Section 209(b) states) that have opted, when determining a child's Medicaid eligibility, to use a more stringent definition of childhood disability than the SSI program's definition. Thus, some children enrolled in SSI in these states are not eligible for Medicaid. Note: Section 209(b) of the Public Law 92-603 later became Section 1902(f) of the Social Security Act.

[11] The few states where a resource test is imposed on poverty-level children applying for Medicaid would also have to line up Medicaid's resource standards and methodologies against those of the income-comparable programs.

[12] Section 1902(r)(2) of the Social Security Act allows states to expand Medicaid coverage to certain groups, including children, by liberalizing Medicaid income and resource methodologies.

[13] Food and Nutrition Service, Office of Analysis and Evaluation, "Study of WIC Participant and Program Characteristics 1996: Final Report," p. 47.

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