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# Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come

THE HENRY J. KAISER FAMILY FOUNDATION
THE KAISER COMMISSION ON
Medicaid and the Uninsured

# kaiser commission on medicaid and the uninsured

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# Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come

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## I. Introduction

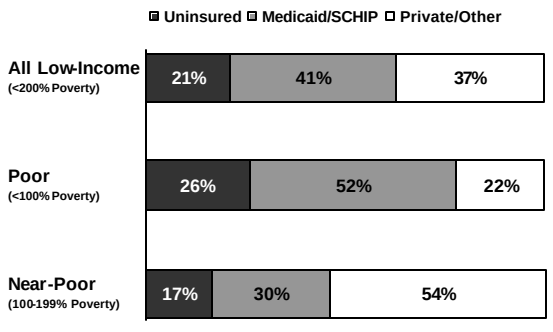
With the enactment of the State Children's Health Insurance Program (SCHIP) came a new resolve at the state and federal levels to find and enroll uninsured low-income children in child health coverage programs. Before SCHIP, little time or resources had been put into strategies to promote participation in Medicaid. States had not always been eager to bear new Medicaid costs, and, in the past, Medicaid operated in tandem with welfare and states had no tradition of encouraging families to enroll in welfare. Once enrollment of uninsured children became a priority, the question on many peoples' minds was whether efforts to enroll eligible children in Medicaid would be successful. Many more children are eligible for Medicaid than for SCHIP, but were families with no ties to welfare willing to sign up for Medicaid?

Enrollment data covering the four years since SCHIP was adopted help answer this important question. Medicaid enrollment among children and their families declined between June 1997 and June 1998, largely as a fall out of welfare reform, but then rose sharply in many states. These enrollment gains followed state-initiated expansions in eligibility, improvements in program operations, and outreach activity prompted by the enactment of SCHIP. While many factors contributed to the enrollment gains, states' success increasing Medicaid enrollment appear to confirm what families have consistently reported: it is not Medicaid per se but restrictive policies, lack of information about Medicaid eligibility, and burdensome and sometimes intrusive enrollment and retention procedures that have kept eligible children and families from enrolling or staying enrolled in the program. As barriers have fallen, enrollment has grown.

The success that has been achieved in many states shows that Medicaid can reach and enroll low-income working families. Forty percent of all low-income children were enrolled in Medicaid and SCHIP in 2000 (Figure 1) and two-thirds of these children live in families with one or two full-time workers. But the job is not done. One fifth of low-income children still lack coverage-- most are eligible for Medicaid but are still not enrolled.

Figure 1

**Health Insurance Status of Low-Income Children, 2000**

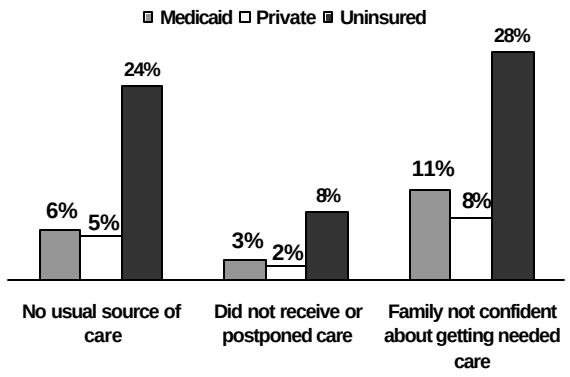



Note: Adults age 19 -64. Federal Poverty Level was $13,738 for a family of three in 2000.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001Current Population Survey, 2001.

Medicaid's recent success among children and their families demonstrates the value of continuing efforts to boost Medicaid participation rates through improved program operations, outreach and family coverage expansions. By linking children to necessary medical care, Medicaid has made a very significant difference in children's lives. Low-income uninsured children have markedly worse access to care than those with Medicaid or private coverage (Figure 2). Medicaid brings children close to the level of access experienced by children with private insurance. Moreover, Medicaid and SCHIP will be needed by a growing number of children as employer-based coverage becomes even scarcer for low-wage workers and their dependents as a result of rising health care costs. As employer coverage contracts, the uninsured rate for children and their families will grow if Medicaid and SCHIP are not available to fill the gap.

Figure 2

**Access to Care Among Low-Income Children by Insurance Status, 1997**




SOURCE: Dubay and Kenney, *Health Affairs*, 2001.

Ironically, however, just when enrollment progress can be shown and the need for publicly-funded coverage is rising, fiscal pressures felt by states across the nation threaten to stall or even reverse the progress that has been made. We now know that if you build it right, they will come, but given state budget pressures, will new enrollees still be welcome?

## II. Modernizing Medicaid—What does it take?

The enactment of SCHIP galvanized state, local, and federal governments, as well as a wide range of public and private organizations, to adopt new strategies to enroll uninsured children. This broad-based effort was unprecedented, but the problem it sought to address was not new. There has long been a gap between the number of children who are eligible for publicly funded coverage and the number of children who are enrolled.[1] By focusing local, state, and national attention on the importance of providing health care coverage to uninsured low-income children, SCHIP prompted a problem-solving approach to a longstanding issue. Through these efforts a blueprint for how to successfully identify, enroll, and retain eligible children began to emerge.

There is now broad consensus that enrollment gains can be achieved when coverage expansions are coupled with program operations that make it simple for eligible families to enroll and stay enrolled and when states and communities let families know that coverage is available and easy to secure. Over the past five years, many state Medicaid programs have made important strides in these areas.[2]

### Expanded Eligibility for Children

A combination of federal requirements and optional state expansions has broadened Medicaid's role for children significantly. According to the most recent census data, one out of five children in the country and a quarter of all children under age six were enrolled in Medicaid in 2000. Children's enrollment has grown from fewer than 10 million children in 1980 to over 21 million children in 1999, the last year for which national administrative data are available. During this time, there also has been a steady decline in the portion of children covered by Medicaid who are receiving welfare.

Medicaid eligibility for children is based on family income, not welfare status. National minimum income eligibility standards for children, which are set by federal law, are well above state welfare eligibility standards in all states.[3]

- Under federal *minimum* requirements, children under age six are eligible for Medicaid if their income is below 133 percent of the federal poverty line ($19,977 for a family of three in 2002).

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[1] T. Selden et al., *Waiting in the Wings: Eligibility and Enrollment in the State Children's Health Insurance Program*, Thomas Selden et al., *Health Affairs*, March/April 1999, 18:2, 125-133.

[2] Except where otherwise noted, findings on the number of states that have taken specified steps to expand eligibility or promote program participation are taken from, D. Cohen Ross, L. Cox, Center on Budget and Policy Priorities *Enrolling Children and Families in Health Coverage: The Promise of Doing More*, for the Kaiser Commission on Medicaid and the Uninsured, June 2002.

[3] The median state eligibility level for welfare, in 2001, was set at 61 percent of the poverty line ($9,162 for a family of three in 2001). Lower eligibility limits apply to families without earnings. KCMU calculation based on the income eligibility levels and the applicable earnings disregards in states' Temporary Assistance to Needy Families (TANF) welfare program as of October 2001.

- Older children are eligible if their income is below the poverty line ($15,020 for a family of three).[4]

Most states have expanded Medicaid coverage for children well above these minimum standards. A number of states had adopted Medicaid expansions for children prior to SCHIP, but the enhanced matching payments available through SCHIP prompted more states to expand Medicaid. Under the SCHIP law, states have the option of using their SCHIP funds to expand coverage for children through Medicaid, to establish or expand a separate child health program, or to undertake a combination of these approaches. Most states have adopted the combination approach: 19 states have separate SCHIP programs and SCHIP-funded Medicaid expansions, 16 states use their SCHIP funds only for separate programs, and 16 states use their SCHIP funds only for Medicaid expansions.[5]

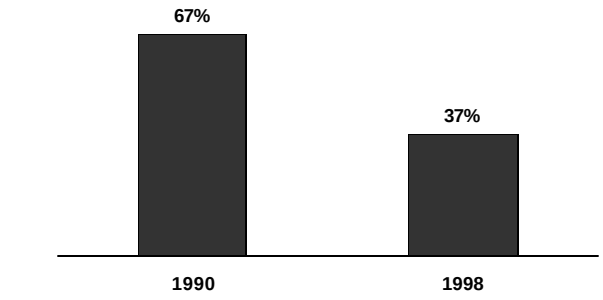
- As of January 2002, state-initiated Medicaid expansions have pushed eligibility for children to levels above federal minimum standards in all but nine states.

- Thirteen states (including the District of Columbia) cover children of all ages in Medicaid with family incomes up to at least twice the poverty level ($30,040 for a family of three).

Despite the expansions in eligibility for children that have been adopted over the last decade, people often refer to SCHIP as the program for children in working families in contrast to Medicaid, which is often still thought of as "the welfare program." The working/welfare line that is commonly drawn to distinguish SCHIP from Medicaid, however, is based on an outdated sense of Medicaid eligibility rules. Medicaid has changed from a program that covered only those who were receiving welfare to a program that primarily serves children in families with earnings whose incomes are too high to qualify for welfare. In 1998, a little more than one-third (37%) of the children enrolled in Medicaid were receiving welfare (Temporary Assistance to Needy Families, or TANF) (Figure 3).

Figure 3

**Most Children Enrolled in Medicaid Do Not Receive Welfare**




SOURCE: Based in HCFC 2082 and HCFA 64 reports for 1998

[4] Coverage of older poor children has been phased in by age; by October 2002, all poor children under age 18 will be eligible for Medicaid. There are additional, nonfinancial eligibility criteria under federal Medicaid rules, most significantly criteria that make certain children who lawfully enter the country on or after August 22, 1996, ineligible for Medicaid for their first five years in the United States.

[5] Center for Medicare and Medicaid Services (CMS) SCHIP website, http://www.hcfa.gov/init/SCHIP-map.htm.

**Expanded Eligibility for Families**

Until 1996, families with children (that is, parents as well as their children) were generally eligible for Medicaid only if they were receiving welfare. In 1996, with the enactment of the federal welfare law (the Personal Responsibility Work Opportunity and Reconciliation Act of 1996), Medicaid eligibility for families with children was delinked from eligibility for welfare, following the change that had been made for children some years before. There is no uniform federal minimum income standard for families with children; the minimum eligibility standards vary by state and generally are quite low compared to the standards in place for children. However, a growing number of states have taken advantage of federal options to expand Medicaid to a broader group of low-income families, prompted in part by a growing body of research showing that family coverage promotes enrollment among children.[6] As of January 2002, 20 states cover families with children (i.e., parents as well as children) at incomes at or above 100 percent of the poverty line.

**Improved Program Operations**

Expansions in Medicaid eligibility and the formal delinking of Medicaid and welfare eligibility fundamentally altered Medicaid's scope and mission with respect to children and their families. Changes in the way Medicaid operated and in the public's perceptions of Medicaid, however, frequently lagged far behind.

For many years the Medicaid eligibility process was the welfare application process for children and their families. When a family was found eligible for welfare, the family automatically received Medicaid, and when the family's welfare payments ended, so did its Medicaid coverage. Even after Medicaid began to cover children with incomes above welfare standards, the welfare office and the combined welfare/Medicaid/Food Stamp application continued to serve as the main route to Medicaid enrollment.

Medicaid's historic link to welfare meant that practices that discouraged reliance on welfare were automatically carried over to Medicaid. Applications were long and complex and in-person interviews at the welfare office were almost universally required. In addition, families had to supply numerous documents to verify eligibility, frequently requiring repeated trips to the welfare office to complete the process. Intrusive questions about paternity and absent parents were part of the application, and sometimes neighbors and employers were contacted by the welfare agency to confirm eligibility. Families had to repeat the entire application process every

[6] J. M. Lambrew, George Washington University, *Health Insurance: A Family Affair*, for the Commonwealth Fund, May 2001; *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms,* Ku and Broaddus, Center on Budget and Policy Priorities, September 5, 2000; L. Dubay, G. Kenney, Urban Institute, *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, for the Kaiser Commission on Medicaid and the Uninsured; A. Davidoff, G. Kenney, L. Dubay, A. Yemane, Urban Institute, *Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions,* November 2001; K. Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Use Revisited," *Inquiry*, 35, 1998.

six or twelve months, and some states also required families to submit written eligibility reports every month or every quarter even when no changes in family circumstances had occurred.

Not surprisingly, research has shown that these application and renewal procedures and other practices discouraged families from enrolling their children in Medicaid.[7] While some families may reject Medicaid (and SCHIP) because it is a publicly funded program, most of the families who stay away from Medicaid do so because they do not know about their eligibility or because they have not been able to get through burdensome enrollment and renewal requirements. A survey of barriers to the application process showed that more than two-thirds (67 percent) of the families with eligible children *had* applied, but only 43 percent had successfully enrolled their child. Other studies have shown high rates of denials for " failure to follow procedures."[8]

The barriers to enrollment in Medicaid originating from Medicaid's historical link to welfare were implicitly, and often explicitly, recognized as states proceeded to implement SCHIP. States that used their SCHIP funds to establish new child health programs almost uniformly rejected the practices that had been carried over to Medicaid from welfare. Streamlined procedures, however, have long been possible in Medicaid. Federal Medicaid rules do not import welfare procedures to Medicaid. Instead, they give states broad flexibility to design their Medicaid enrollment and renewal procedures and to establish the methods they will use to assure program integrity.[9] Virtually every simplification and marketing initiative that has been adopted for separate SCHIP programs can be applied to Medicaid (Figure 4, next page).

[7] J. Stuber, KA, Maloy, S. Rosenbaum, and K. Jones, Center for Health Services Research and Policy, George Washington University, *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-income Families to Enroll in Medicaid?* June 2000; G. Kenney, J. Haley, Urban Institute, *Why Aren't More Children Enrolled in Medicaid and SCHIP?*, May 2001.

[8] M. Perry, S.Kannel, R.B.Valdez, Lake, Snell and Perry, Chang, C. *Medicaid and Children: Overcoming Barriers to Enrollment*, for the Kaiser Commission on Medicaid and the Uninsured, January 2000. There is a long history of procedural denials. For example, a 1988 study examining the reasons for denials of AFDC and Medicaid applications showed that in 11out of 17 southern states, over one-half of all denials were for "failure to comply with procedures." S. Shuptrine, V. Grant, *Study of the AFDC/Medicaid Eligibility Process in the Southern States, for the Southern Regional Project on Infant Mortality*, the Southern Governors' Association and the Southern Legislative Conference, April 1988.

[9] The flexibility to establish simplified procedures has not always been made clear to states, but the enactment of SCHIP prompted the federal agency that oversees Medicaid, the Center for Medicare and Medicaid Services (formerly the Health Care Financing Administration), to clarify the federal requirements and options that give states.

**Figure 4**

# Can Medicaid Application and Renewal Procedures be Simplified?

| Simplified Procedures | Allowed under Federal Medicaid Law? (For children and families with children) |
|---|---|
| **Application** | |
| Short, simplified applications | Yes. |
| Mail-in applications; no in-person interview at the welfare office | Yes. |
| Eliminate questions about assets | Yes. |
| Eliminate questions about paternity and whereabouts of an absent parent | Yes.<br><br>Such information cannot be required as a condition of a child's eligibility and therefore can be dropped completely from a child-only application. Parents must cooperate in obtaining medical support from an absent parent if they are to be covered under Medicaid, but it is sufficient to simply ask whether the parent will agree to cooperate and then pursue medical support as appropriate at a later time. |
| Reduce verification requirements (i.e., requirements that families supply documents to verify eligibility) | Yes.<br><br>The only documentation that federal law requires proof of immigration status for applicants who are not citizens. Self-declaration of all other eligibility factors is permitted under federal law. States are required to assure program integrity through computer-based matches. |
| **Renewal** | |
| Short renewal forms and pre-printed renewal forms | Yes. |
| Mail-in renewal forms; no in-person interview | Yes. |
| Reduce verification requirements at the point of renewal | Yes.<br><br>No documents need be required unless the beneficiary is an immigrant whose status has changed since the time of application or most recent renewal. |
| 12-month eligibility review periods | Yes. |
| Continuous eligibility for children | Yes. |

While every state is unique and faces its own set of challenges, the following operational improvements are widely viewed by program administrators as well as community organizations working with families as important components of a successful effort for improving Medicaid participation rates. Virtually all of these Medicaid program enhancements have been adopted in separate SCHIP-funded child health programs.

☑ ***Simplify and shorten the Medicaid application.***
Since SCHIP was enacted, most states have shortened their Medicaid applications for children (and sometimes for families as well). Compare, for instance, the 26-page Medicaid/TANF/Food stamp application used by Oklahoma to enroll children before 1997 with the 4-page Oklahoma mail-in Medicaid application now in use for children and pregnant women.[10] More recently, some states have been looking to further improve their applications and other forms by eliminating beaurocratic terminology, adopting simpler and more direct language, and improving translations.

☑ ***Limit the number of documents families are required to supply and rely instead on computerized data matches, audits, or other methods of assuring program integrity.***
Many states still require families applying for Medicaid to provide a long list of documents to verify their child's eligibility, even when the same state does not require these documents from families applying for SCHIP.[11] In the past, some states required several weeks or even months of pay stubs, birth certificates, rent receipts, and even school records. Many states have reduced these requirements, and, as of January 2002, 13 states required no documentation for children applying for coverage other than for immigration status. Under federal law (both Medicaid and SCHIP), the only document that individuals must provide in establishing eligibility is proof of immigration status if the person applying for coverage is a noncitizen. States can assure program integrity by conducting computerized data matches and post-eligibility audits or reviews.[12]

**Medicaid Can Work for Families: Reduce Verification Requirements**

*"My first time applying…I was working part time. My job wasn't enough to pay for doctor visits when you're pregnant. So I applied for Medicaid and they wanted a lot of stuff I didn't have like bank statements and all kinds of stuff that you just don't keep or maybe can't get a hold of…So I had to figure out lots of different days of when I did this and that. It was hard…(But this most recent time) I didn't have to have anything but the Social Security number and my ID. That's all they wanted."*

Mother from South Carolina

Lake, Snell, Perry & Associates, December 2001

[10] V. Smith, E. Ellis, Health Management Associates, C. Chang, Kaiser Commission on Medicaid and the Uninsured, *Eliminating the Asset Test for Medicaid: A Review of State Experiences*, Appendix 4, for the Kaiser Commission on Medicaid and the Uninsured, April 2001.

[11] See, for example, *Barriers to Medicaid: Challenges and Opportunities for New York*, prepared by Care for the Homeless in collaboration with Greater Upstate Law Project and Commission on the Public's Health System, March 2001. After September 11, 2001, New York City permitted one-page applications with no verification requirement for a limited period of time.

☑ ***Allow mail-in applications and renewals with no in-person interview requirement.*** The welfare office interview requirement, which was a feature of most state Medicaid programs as recently as five years ago, is a carryover from Medicaid's link to cash assistance. Federal Medicaid law does not require interviews. As of January 2002, all but four states have dropped the interview requirement for children, although 16 states still require an interview at the welfare office when children and parents apply together.

**Medicaid Can Work for Families: Accept Mail-In Applicants**

*"(M)y son was informed by the school system that he needed two hearing aids. At that time he was like 14. I couldn't afford hearing aids, what do I do? The woman (from the) school board gave me an application for SoonerCare (Medicaid) and advised me to fill it out and mail it in. I took it home and I filled it out and mailed it in. I was shocked. I mean, it was very, very simple, easy; fill it out and mail it in. Two weeks later you get a little blue card."*

Mother from Oklahoma

Lake, Snell, Perry & Associates, December 2001

☑ ***Assure that applications and other forms are properly translated and that interpreter services are available at application sites.*** Appropriately translated Medicaid applications, notices, and renewal forms, and interpreters at sites where people apply for Medicaid and health services are, are critical to assuring that all people have an opportunity to apply for and use Medicaid services. While federal civil rights law requires programs relying on federal funds to make translated forms and interpreter services available,[13] children in families with limited English proficiency continue to face additional barriers to enrollment. Low-income Latino children who live in Spanish-speaking families are twice as likely to be uninsured compared to low-income Latino children who live in English-speaking families (43% vs. 21%).[14] Improved communications with families who are not proficient in English can help close this gap.

☑ ***Facilitate opportunities for families to complete applications and renewals by phone or at sites other than the welfare office.*** While welfare offices remain critical entry points for some low-income children and families to enroll in Medicaid, states are increasingly recognizing the importance of providing families help completing the forms at other sites and by phone. In 1990, two provisions were added to federal Medicaid law to require states to establish "outstation" application sites for pregnant women and children at "disproportionate share" hospitals and federally qualified health centers and to develop applications for that were separate

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

[13] The HHS Office of Civil Rights issued guidance regarding services to persons with limited English proficiency; see http://www.hhs.gov/ocr/lep/guide.html. Innovative state and local practices at the point of service are described in, M. Youdelman, J. Perkins, National Health Law Program, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*, for the Commonwealth Fund, May 2002.

[14] L.Ku, Center on Budget and Policy Priorities, forthcoming.

from the welfare applications for use at the outstation sites.[15] There is no federal outstation requirement for family applications.

Several states have expanded beyond the federal minimum outstationing requirements, finding that outstationing is a particularly effective element of their outreach and enrollment strategy. Utah places many of its eligibility workers outside of the welfare office, mostly in clinics and hospitals. Georgia promotes community-based application assistance with its new on-line application, a concept that is spreading to other states. Massachusetts is experimenting with a "rolling" redetermination process that allows outstation sites to help families renew their coverage when they come in for care, and New York contracts with "community facilitators" to assist with applications outside of the welfare office.

☑ ***Assure that Medicaid rules are followed at local welfare offices and that the Medicaid coverage message is carried over to the welfare office.***

While families should be able to apply for Medicaid by mail and at sites other than welfare offices, welfare offices continue to play an important role for Medicaid. In almost all states, welfare agency staff makes the Medicaid eligibility decision for families and often for children applying without their families as well. Welfare offices also continue to be the most convenient place for TANF and Food Stamp applicants to apply for Medicaid.

Despite a new focus on customer service in many state Medicaid programs, there can be a breakdown in protocol and a different manner of proceeding at the local welfare office. Medicaid is often a second-tier concern for welfare administrators who understandably are more attentive to welfare program operations and initiatives. At the same time, because Medicaid eligibility for families had been linked to welfare, Medicaid administrators have not been accustomed to managing the family side of the Medicaid application and renewal process. When the programs were linked, this was the province of the welfare agency. Perhaps just as significant in these days of computerized eligibility determinations and systems-driven processes, is that virtually all states rely on automated eligibility systems to determine Medicaid, TANF and food stamp eligibility for families and sometimes for children as well. One of the primary causes of children and families having lost Medicaid benefits inappropriately following welfare reform was delays in updating these computer systems to reflect the new rules. Medicaid-related computer changes were not a priority for welfare administrators, and Medicaid agency personnel frequently had little control over these systems. States continue to rely on these integrated systems even now when the programs have been delinked.

Recognizing that welfare offices continue to serve as an important entry point to the Medicaid program and that the "welfare message" is often very different than the

[15] State implementation of the outstationing requirement has been uneven. S. Rosenbaum, K.A. Maloy, J. Stuber, J. Darnell, Center for Health Services Research and Policy, George Washington University, *Initial Findings from a Nationwide Study of Outstationed Medicaid Enrollment Programs at Federally Qualified Health Centers*, February 1998, CMS, State Medicaid Director letter, January 18, 2001, http://www.cms.gov/medicaid/letters/smd01181.pdf.

"Medicaid message," some states have taken action to ensure that Medicaid enrollment becomes a focus of welfare office activity. Indiana set county-based enrollment goals. The state held local welfare agencies accountable for those goals as a means of explicitly countering the message that often dominates in the welfare context, which is to keep the rolls down and to divert families from receiving aid. In Alaska, the Medicaid agency helped to assure that welfare workers remembered to consider Medicaid eligibility separate from welfare by posting "Think Delink" signs throughout the welfare offices.

☑ ***Drop questions about paternity and absent parents from child-only applications***. Even states with shortened Medicaid applications for children often ask for information on the application or through a supplemental form about absent fathers, aimed at establishing paternity and pursuing medical support. While many families want to pursue support from an absent parent, families often find these questions intrusive and inappropriate when they are seeking health coverage for their children. Such questions are again carryovers from welfare applications and, in some cases, appear to go beyond what federal law requires or even allows. Under federal law, states may ask but are not permitted to require families to supply information about paternity and an absent parent on a child-only Medicaid application.[16] States have not chosen to pursue paternity or medical support in their separate SCHIP programs.

☑ ***Streamline renewal procedures.***
Until recently, many states required quarterly or semi-annual eligibility reviews, generally consisting of a rehash of the full application process. Federal law requires annual reviews but allows states to conduct more frequent eligibility reviews. Because many states have found that families and children were losing coverage at the redetermination stage, states have been lengthening the time between reviews and streamlining the review/renewal process. As of January 2002, 42 states and the District of Columbia rely on 12-month reviews for children, although fewer (38) states do so for families with children. (Every state with a separate SCHIP-funded child health program reviews eligibility for SCHIP at 12-month intervals, the maximum time between reviews allowed by federal SCHIP law.) Under federal law, states can also guarantee 12 months of Medicaid coverage for children; once enrolled, the child stays enrolled for the 12-month period regardless of changes in income or other family circumstances. Seventeen states have elected this option.

Some states also have adopted streamlined renewal forms, limiting the questions asked to matters that may have changed since the last eligibility review. A few states are drawing on information available from other programs to avoid unnecessary paperwork. In Washington State, the state Medicaid agency relies on the information collected at quarterly food stamp reviews to evaluate whether the family continues to be eligible for

[16] CMS, State Medicaid Director letter, December 19, 2000, http://www.hcfa.gov/medicaid/smd12190.htm. Federal Medicaid law does require parents of children with an absent father to cooperate in establishing paternity and pursuing medical support as a condition of the parent's eligibility. However, federal guidance has clarified that all that is needed during the application process is an agreement from the parent that she or he will cooperate in providing such information at a later point. Thus, significant opportunities to simplify the application exist even for family applications.

Medicaid. If the food stamp program information shows that the child or family is eligible for Medicaid, Medicaid is renewed without additional paperwork for the family or the agency.

☑ ***Coordinate enrollment and renewals between Medicaid and separate SCHIP programs.*** One of the most important challenges facing states with two publicly funded coverage programs for children is to assure that children move easily and automatically between programs, as appropriate. Families typically cannot predict which program their child will be eligible for, and, once enrolled, changes in family income and circumstances often result in children losing eligibility for one program and gaining eligibility for the other program.

States have developed different models for accomplishing coordination at the application stage, and some are continuing to perfect their systems. Most use joint program applications so that families do not have to complete a second application if it is determined that their child is not eligible for the program for which they initially applied. The joint application, however, is only a first step toward effective coordination. The chances of losing children between the cracks of a dual program system are significantly lessened to the extent that the two programs use the same definitions of income, the same deductions and the same verification requirements. In addition, coordination is needed at both the application stage and the renewal stage. While 33 of the 35 states with separate SCHIP programs use joint applications, as of January 2002, only 21 states use joint renewal forms.

The obligation to ensure coordination between programs rests with both the separate SCHIP program and the Medicaid agency.[17] It is also important for coordination to work in both directions so that children who become ineligible for SCHIP are automatically screened and enrolled in Medicaid and children who become ineligible for Medicaid are automatically screened and enrolled in the separate SCHIP program, as appropriate.

☑ ***Simplify notices and other forms of written communications with beneficiaries.*** The style of the notices that families receive about their coverage is often as important as the substance of the notices. Notices sent to families applying for or receiving Medicaid are often very complex, intimidating, and full of legalese. There are some federal notice requirements, and in some states portions of their notices have been written to comply court rulings. By and large, however, the manner in which notices are written is left largely to states. Through a contractor, the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) is providing technical assistance to states interested simplifying notices, making them less impenetrable and more like the kind of notice families might expect to receive with respect to private health insurance coverage.

☑ ***Eliminate asset rules.***
Asset tests are not required but are allowed under federal Medicaid law for children or for families with children. While asset requirements often do not screen out otherwise

[17] SCHIP/Medicaid regulations; 42 CFR section 431.636.

income-eligible persons, they do add complexity to the application process. State agency administrators have commented that dropping the asset test has saved time and resulted in administrative savings.[18] As of January 2002, only seven states still use an asset test for children applying for Medicaid. Thirty-two states still have an asset requirement for parents.

☑ ***Limit age-based eligibility rules for children.*** Enrollment and retention can be particularly challenging in states that continue to use "stair case" eligibility rules where the Medicaid and SCHIP eligibility standards depend on a child's age as well as the child's family income. Age-based eligibility criteria will mean that children in the same family may be eligible for different programs. They also require children to change programs when they reach a certain age even if their family circumstances have not changed.

Several states have taken steps to limit or eliminate age-based eligibility criteria. For example, New York recently changed its Medicaid eligibility rules so that all children age one or older with incomes up to 133 percent of the poverty line are eligible for Medicaid. This change switched coverage for some older children from Child Health Plus (the state's separate SCHIP program) to Medicaid and limited the instances when a family would have children enrolled in two different programs. The state continues to receive SCHIP funding for these Medicaid-eligible children.

**Simplification Pays Off In a Number of Different Ways**

*After Maryland began to accept self-declaration of income for Medicaid and SCHIP, 80 percent of the applications were processed in less than 10 days, as compared to 30 – 50 percent before the change. Self-declaration has meant that outreach and eligibility workers spend less time helping people obtain all the required documents; it "frees up outreach people for outreach."*

Maryland Agency Official

Center on Budget and Policy Priorities, December 2001

☑ ***Use the same providers for Medicaid and SCHIP.*** In states with a separate SCHIP program, a significant number of children will move from one program to the other due to changes in family circumstances (e.g., a new job, the loss of a job, or a new baby) or because of a child "ages" out of Medicaid eligibility (due to age-based eligibility rules). To the extent that children must change programs, it is important to limit the need for them to also have to change providers or health plans.[19] To promote continuity of care, some states require plans as a condition of their contracts to participate in both Medicaid and SCHIP.

[18] V. Smith, E. Ellis, Health Management Associates, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, for the Kaiser Commission on Medicaid and the Uninsured, April 2001.
[19] GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, GAO-01-883, September 2001.

☑ ***Broaden and simplify family coverage.***

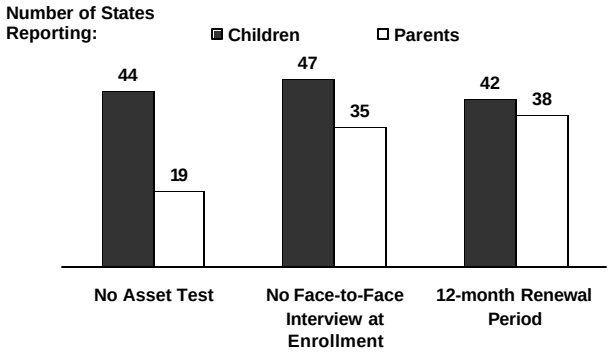
Several studies have recently confirmed the common sense notion that family coverage promotes participation of children in publicly funded health programs and improves children's access to care. As noted above, expanded family coverage is now possible under Medicaid without a waiver, although some states have relied on waivers most often to take advantage of enhanced SCHIP matching funds or to require cost sharing above levels that are permitted without a waiver.

States also have the option under federal Medicaid law to eliminate restrictions in coverage of two-parent families, another carryover from the welfare rules. Under old Aid to Families with Dependent Children (AFDC) rules that applied to Medicaid, Medicaid for families was largely limited to single-parent families. The bias against covering two-parent families, however, was dropped under federal Medicaid rules adopted in August 1998.[20] Eight states continue to limit Medicaid coverage for parents to mostly single parent families.

Even without broadening income eligibility for parents, states can do a great deal to promote enrollment among currently eligible parents and make the program more welcoming to families. States can take virtually all of the simplification steps for families that they have taken for children (Figure 5).

Figure 5

**Children Applying for Medicaid With Their Parents Face More Barriers Than Children Applying On Their Own**




SOURCE: Cohen Ross and Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, May 2002.

☑ ***Strengthen access to providers.***

Access to providers is central to the mission of the Medicaid program. While many of the issues relating to provider access are beyond the scope of this paper, it is important to note the link between having an adequate provider base and enrollment. Some states that established separate SCHIP programs with stronger dental provider participation than in Medicaid (largely because of higher provider payment rates paid under SCHIP) reported that families were particularly attracted to the new SCHIP program because access to dental care under Medicaid had been so limited.

In general, Medicaid coverage has permitted children to access care that they otherwise would not have been able to obtain. Studies have shown that children covered by Medicaid receive care at rates similar to privately insured children.[21] Despite the

[20] CMS, State Medicaid Director letter, August 17, 1998; http://www.hcfa.gov/medicaid/wrdl8178.htm.
[21] Newacheck et al., "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine*, February 19, 1998.

evidence that a Medicaid enrollment card generally does deliver necessary care, access to care for Medicaid beneficiaries is a problem in some parts of the country. Often this is due to a limited provider base in the state or in a particular area of the state. Sometimes it is due to payment rates that are not sufficient to attract providers or to procedures for enrolling providers or processing claims that providers find burdensome and inefficient.[22] While progress has been made in these areas in recent years, rate reductions are often the first place policymakers turn when looking to save costs in Medicaid.

**Marketing "the New Medicaid"**

All states that have expanded coverage to children, either through Medicaid or through separate state health programs, have recognized the importance of outreach. Misconceptions about Medicaid eligibility are widespread. Many families still believe they must be receiving welfare in order to qualify for Medicaid and do not know that children in two-parent families, or children whose families own a car can enroll in Medicaid.[23]

Moreover, even when a state has implemented changes in its Medicaid program, families are often unaware that the improvements have been made. Parents in California who were interviewed about Medicaid and SCHIP (in California, these programs are called Medi-Cal and Healthy Families) believed that they were familiar with Medi-Cal but, in fact, many were unaware that applications had been streamlined and now could be mailed in.[24]

To clear up misconceptions about Medicaid eligibility, some states aired public service announcements specially noting that "you don't have to be on welfare to be eligible for Medicaid." Just as important are strategies that avoid unintentionally perpetuating misunderstandings about Medicaid eligibility. For example, some states, as they were marketing their separate SCHIP programs, emphasized in their advertising that the *new* program (i.e., SCHIP) was not a welfare program, suggesting to some that the *old* program (i.e., Medicaid) was in fact a program

**Medicaid Can Work for Families: Promoting Health Coverage Separate From Welfare**

*"I had a friend tell me (I might be eligible). She asked me why I never got (Medicaid) and I said, 'They had it where you have to either get AFDC or be pregnant and I wasn't either…' And she said, 'It's not like that anymore.' So I went up there and applied."*

Woman from South Carolina

Lake Snell, Perry & Associates, December 2001

[22] A recent GAO report considers Medicaid and SCHIP provider rates and their impact on provider participation. GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, www.aap.org. GAO-01-883, September 2001. See also, B. Yudkowsky et al, *Pediatrician Participation in Medicaid/SCHIP*, Survey of Fellows of the American Academy of Pediatrics, 2000.

[23] M. Perry, S.Kannel, R.B.Valdez, Lake, Snell, Perry & Associates, C.Chang, Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children: Overcoming Barriers to Enrollment*, Kaiser Commission on Medicaid and the Uninsured, January 2000.

[24] M. Perry, Lake Snell Perry & Associates, for the Kaiser Family Foundation, January 2001. *Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Program.*

only for people on welfare.

Similarly, families get mixed messages about Medicaid when the separate SCHIP program, but not Medicaid, is advertised broadly, often with the endorsement of the Governor or other state and local officials, movie stars and sports personalities, or when T-shirts, pens, rulers and other promotional items bearing the SCHIP program name are widely distributed in low-income communities. Even if a state has a joint application process and has taken affirmative steps to improve how Medicaid operates, this kind of selective advertising of one but not both of the state's low-income children's coverage programs can inadvertently reaffirm families' perception that Medicaid is different from, and perhaps not as good as the new SCHIP program.

Many states have avoided these problems by adopting joint outreach and marketing strategies, changing the name used for Medicaid, using one name for both programs, and adopting other strategies so that outreach efforts do not undermine efforts to enroll eligible children in Medicaid. Thirty-five out of 48 states responding to a Kaiser Commission on Medicaid and the Uninsured survey conducted in 2000 reported that they conduct joint outreach campaigns.[25] However, the GAO has found that states may be spending different amounts of funds for Medicaid versus SCHIP outreach. In its survey of ten states, two states reported spending more funds for SCHIP outreach than for Medicaid. Colorado estimated that it was spending $10,000 for Medicaid outreach and about $700,000 for SCHIP, while Pennsylvania reported spending $500,000 for Medicaid outreach compared to $808,250 for SCHIP. Two other states, Utah and New York reported spending more on Medicaid outreach than SCHIP outreach and the other six states were unable to break down their outreach spending by program.[26]

[25] M. Perry, Lake, Snell, Perry & Associates, V. Smith, C. Smith, Health Management Associates, *Marketing Medicaid and SCHIP*, for the Kaiser Commission on Medicaid and the Uninsured, October 2000.
[26] GAO, *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits* HEHS-00-86, April 2000.

## III. Improvements Have Made a Difference: A Look at Enrollment Tends

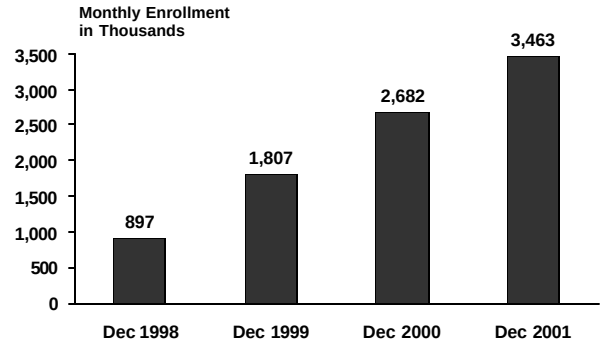
With several years experience since SCHIP was enacted into law, the evidence is mounting that SCHIP and Medicaid are having a significant positive impact on coverage.

### SCHIP Enrollment Has Been Climbing Steadily

SCHIP enrollment has climbed steadily over the past three years, after a slower than anticipated start.[27] Data collected by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured show that SCHIP enrollment (in separate programs and in Medicaid expansions) has risen from 897,000 children enrolled in December 1998, to nearly 3.5 million enrolled in December 2001 (Figure 6). [28]

Figure 6

**Total U.S. SCHIP Enrollment in 50 States and the District of Columbia**




SOURCE: Compiled for the Kaiser Commission on Medicaid and the U ninsured by Health Management Associates from state enrollment reports. SCHIP enrollment includes enrollment in separate CHIP programs and CHIP-funded Medicaid expansions.

### Enrollment Gains In "Regular" Medicaid Drives Overall Enrollment Trends

SCHIP enrollment data, however, tell only part of the story. A more revealing measure of the progress being made to increase coverage among eligible low-income children and their families requires consideration of both SCHIP and "regular" Medicaid. ("Regular" Medicaid refers to coverage under Medicaid eligibility standards for children and families with children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children and families.) When enrollment changes under Medicaid and SCHIP are considered in combination, Medicaid's performance inevitably dominates because Medicaid is a much larger program. As a result, regardless of how well as state might be doing in its SCHIP program, progress in coverage of children and families will be compromised without strong enrollment in regular Medicaid.

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[27] Not all of the SCHIP children had previously been uninsured. A few states, including New York, Florida, and Pennsylvania, had state-funded child health programs that were converted to SCHIP after the federal law was enacted.

[28] Data reported by CMS show similar trends. CMS data show that 4.6 million children were enrolled in SCHIP (either in a separate child health program or a Medicaid expansion) at some point in the federal fiscal year ending September 30, 2001, up from 3.3 million for the previous year. *The State Children's Health Insurance Program Annual Enrollment Report -- Fiscal Year 2001 Annual Enrollment Report*, February 6, 2002. http://www.cms.hhs.gov/schip/schip01.pdf. The CMS data reports the number of children enrolled at any time during the year while the enrollment data collected by the Health Management Associates is "point in time" data—it reports the number of children enrolled in SCHIP-funded programs as of a specified date.

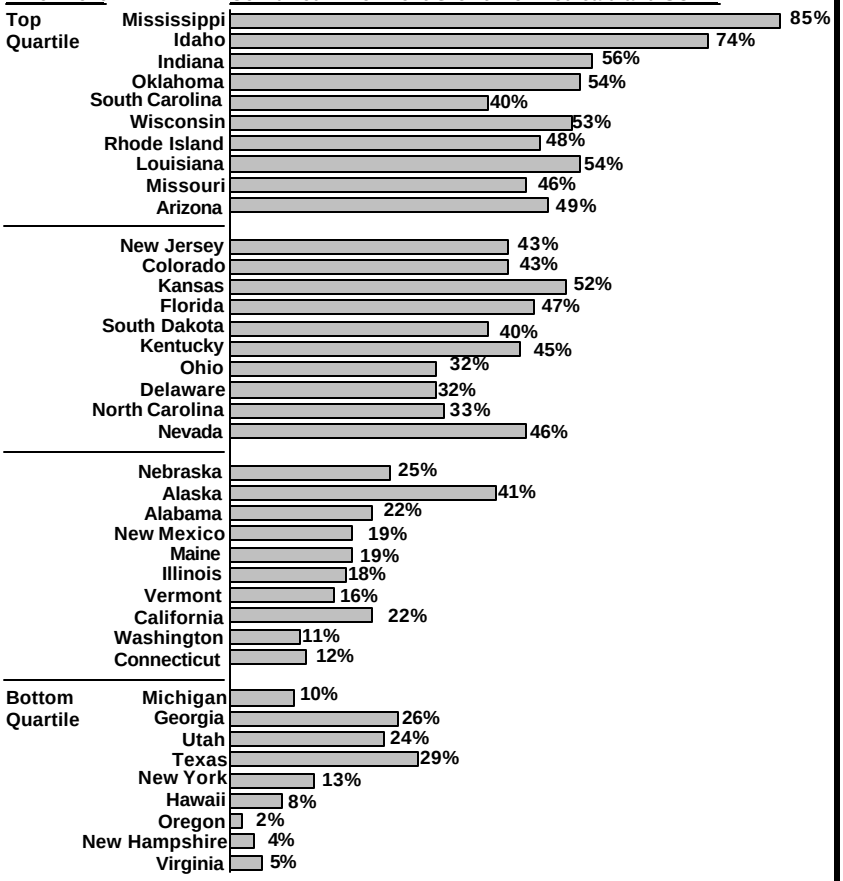
Figure 7 shows the relationship between regular Medicaid enrollment and overall performance for Medicaid and SCHIP for children, families and pregnant women. Enrollment trends are analyzed for the 39 states for which comparable enrollment data were available.[29] The states are ranked based on their performance enrolling children, families and pregnant women in "regular" Medicaid, measured by the percentage change in enrollment between December 1998 and June 2001. The horizontal bars show each state's combined enrollment growth for SCHIP and "regular" Medicaid (for children, families with children, and pregnant women).

The graph shows that the two measures are closely related: states with strong growth in their regular Medicaid enrollment generally had strong combined Medicaid and SCHIP enrollment, and states that had more sluggish growth (or even a drop) in regular Medicaid enrollment were much less likely to show strong overall enrollment gains. (See appendix for year-by-year Medicaid and SCHIP enrollment data.) It is important to note that these data do not look at children's enrollment alone. (Separate enrollment data for children enrollment in Medicaid was not available from states.) They combine enrollment data for children with enrollment data for families with children and pregnant women. Thus, a state's enrollment performance will be influenced by factors relating to its coverage rules and enrollment policies relating to families and pregnant women as well as children applying on their own.

Figure 7

**The Relationship of Medicaid to Overall Enrollment of Children, Families and Pregnant Women**

**December 1998 to June 2001**




* States listed by descending order based on enrollment growth in "regular" (non-SCHIP) Medicaid for children, families with children, and pregnant women. ** Combined enrollment growth in SCHIP and "regular" (non-SCHIP) Medicaid for children, families with children, and pregnant women.

SOURCE: KCMU analysis of state data compiled by Health Mgt. Assoc.

[29] The data has been reported by states to the Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. Only states that had at least one year of SCHIP enrollment as of June 2001 were considered in these analyses.

**Focusing on Medicaid Makes a Difference**

Many factors influence enrollment in regular Medicaid for children and their families, including the scope of a state's TANF program and changes in its TANF caseload, the extent to which a state has expanded coverage for parents as well as children, population changes and the strength of the state's economy. Restrictions in Medicaid eligibility for immigrants and confusion about immigrants' eligibility that resulted from the federal rules adopted in 1996 also have a big impact in enrollment in many communities. Four of the 12 states that had the weakest enrollment gains in regular Medicaid enrollment (Texas, New York, Illinois and California) are states with large numbers of immigrants.

Although a range of factors are inevitably at play in each state, state reports of their enrollment experiences as well as these enrollment data suggest that enrollment growth among eligible children and their families has been strongly affected by state efforts to improve and promote their Medicaid programs. Indiana is an example of a state that links its strong enrollment gains for children and families to outreach and Medicaid program improvements. After SCHIP was adopted at the federal level, Indiana was leaning toward establishing a separate SCHIP program in part because there was strong feeling within the state that the Medicaid program had problems and that newly eligible families might not want to enroll their children in Medicaid. Following considerable debate, however, the state changed its course. It adopted a Medicaid expansion, and aggressively addressed the problems that had been identified. (Indiana later added a separate SCHIP component and is now a "combination" state.)

The data show that beginning in June 1998, states like Indiana, which used their SCHIP funds to adopt broad expansions in their Medicaid programs, generally have had strong overall enrollment gains for children and families. These states did not necessarily do better in their SCHIP enrollment than states with separate SCHIP programs. However, particularly in the early years of SCHIP implementation, Medicaid expansion states generally had stronger enrollment growth with respect to regular Medicaid enrollment for children, families with children and pregnant women than states with separate SCHIP programs. As a result, they generally had stronger overall enrollment gains for Medicaid and SCHIP combined.

The enrollment trends for the 39 states considered in Figure 7 are displayed in Figures 8 and 9 (see following pages), organized by whether a state used its SCHIP funds to expand Medicaid or to create or expand a separate child health program. For purposes of this analysis, a state was considered a Medicaid expansion or a separate SCHIP state if it adopted a relatively

## FIGURE 8

**Children, Families and Pregnant Women in "Regular" Medicaid (Title XIX)** *by Type of SCHIP Expansion*

| | Percent Change in "Regular" Medicaid (Title XIX) Enrollment | | | | |
|---|---|---|---|---|---|
| | June 97 to June 98 | June 98 to June 99 | June 99 to June 00 | June 00 to June 01 | June 97 to June 01 |
| **Medicaid Expansion States** | | | | | |
| **Total** | **-0.6%** | **3.7%** | **11.1%** | **14.4%** | **31.0%** |
| Alaska | 4.6% | 4.9% | 5.4% | 3.0% | 19.0% |
| Hawaii | -2.0% | -3.4% | -7.0% | 8.6% | -4.5% |
| Idaho | 2.1% | -8.0% | 27.3% | 26.9% | 51.7% |
| Indiana* | -5.7% | 24.9% | 12.9% | 15.4% | 53.4% |
| Kentucky* | -4.5% | -3.9% | 13.4% | 10.6% | 15.1% |
| Louisiana | -2.0% | 4.6% | 14.3% | 15.6% | 35.5% |
| Missouri** | -2.0% | 15.5% | 6.7% | 13.4% | 37.0% |
| Nebraska | 6.6% | 12.3% | 6.6% | 8.3% | 38.3% |
| New Mexico | 1.8% | 8.6% | 4.6% | 6.3% | 22.9% |
| Ohio** | -4.4% | -7.8% | 6.9% | 22.3% | 15.2% |
| Oklahoma | 15.5% | 9.1% | 17.8% | 9.9% | 63.1% |
| Rhode Island** | 2.7% | 9.8% | 15.0% | 5.2% | 36.4% |
| South Carolina | 20.6% | 2.1% | 12.9% | 18.2% | 64.4% |
| Wisconsin** | -11.6% | -2.2% | 28.5% | 10.7% | 23.0% |
| **Separate Program States** | | | | | |
| **Total** | **-5.2%** | **-0.7%** | **3.2%** | **9.3%** | **6.2%** |
| Alabama | 1.9% | 0.5% | 3.7% | 10.6% | 17.4% |
| Arizona** | -9.7% | 1.9% | 12.7% | 15.2% | 19.5% |
| California** | -5.3% | 1.2% | -0.8% | 10.4% | 5.0% |
| Colorado | -5.5% | 2.2% | 12.3% | 11.0% | 20.5% |
| Connecticut** | -0.6% | 4.4% | 0.5% | 5.0% | 9.5% |
| Delaware | -0.9% | 19.4% | -2.1% | 18.9% | 37.7% |
| Florida | -6.9% | 0.9% | 13.9% | 13.0% | 20.9% |
| Georgia | -3.9% | -1.8% | -2.3% | 12.0% | 3.2% |
| Illinois | -5.9% | -3.0% | 7.8% | 5.4% | 3.6% |
| Indiana* | -5.7% | 24.9% | 12.9% | 15.4% | 53.4% |
| Kansas | -12.5% | 7.4% | 8.9% | 9.3% | 11.8% |
| Kentucky* | -4.5% | -3.9% | 13.4% | 10.6% | 15.1% |
| Maine** | -1.9% | 2.4% | 3.0% | 10.2% | 14.0% |
| Michigan | -1.5% | -7.3% | -2.1% | 8.5% | -2.9% |
| Mississippi | -11.7% | 9.5% | 18.5% | 34.1% | 53.6% |
| Nevada | 5.5% | -1.4% | 7.6% | 17.3% | 31.1% |
| New Hampshire | -4.5% | 5.7% | -1.1% | -6.8% | -6.9% |
| New Jersey** | -0.3% | -3.1% | 3.2% | 28.6% | 28.4% |
| New York | -5.7% | -4.8% | -1.3% | 5.8% | -6.2% |
| North Carolina | -3.6% | -0.2% | 6.9% | 16.8% | 20.1% |
| Oregon | 0.0% | 5.2% | -1.4% | -4.2% | -0.7% |
| South Dakota | 2.8% | 12.7% | 7.8% | 13.5% | 41.8% |
| Texas | -10.3% | -4.5% | 2.7% | 4.2% | -8.4% |
| Utah | 0.8% | -2.2% | -1.5% | 4.5% | 1.4% |
| Vermont | -0.5% | 4.0% | 4.2% | 3.9% | 12.0% |
| Virginia | -6.2% | -3.5% | -4.2% | -0.7% | -13.9% |
| Washington | -2.8% | -1.8% | 13.8% | -3.9% | 4.3% |

SOURCE: KCMU analysis of data compiled by Health Management Associates from state Medicaid agencies.

* Indiana and Kentucky established broad expansions through SCHIP in Medicaid and through separate SCHIP programs.

** These states implemented Medicaid parent coverage expansions to cover parents with incomes up to 100% of the poverty line or higher at some point between June 1997 and June 2001.

Note: For both sets of states, only states that adopted relatively broad SCHIP-funded expansions were considered. For this purpose, we used the definitions used in the evaluation of the State Children's Health Insurance Program performed by Mathematica Policy Research, Inc. for the Health Care Financing Administration (now CMS) [Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Momentum Is Increasing After a Modest Start, First Annual Report*. Mathematica Policy Research, Inc. for the Health Care Financing Administration, January 2001, available at: http://www.hcfa.gov/stats/schip1.pdf]. States that implemented their broad-based expansion after June 2000 were not included in this analysis. Data for 5 states and the District of Columbia that established broad SCHIP expansions prior to June 2000 were also not considered because these states did not report separate Medicaid data for children, families with children and pregnant women to Health Management Associates.

## FIGURE 9

## Children, Families, and Pregnant Women in "Regular" Medicaid (Title XIX) and SCHIP (Title XXI) *by Type of SCHIP Expansion*

| | Percent Change in "Regular" Medicaid and SCHIP Enrollment | | | | |
|---|---|---|---|---|---|
| | June 97 to June 98 | June 98 to June 99 | June 99 to June 00 | June 00 to June 01 | June 97 to June 01 |
| **Medicaid Expansion States** | | | | | |
| **Total** | **-0.6%** | **10.5%** | **14.2%** | **15.7%** | **45.2%** |
| Alaska | 4.6% | 12.5% | 14.0% | 5.8% | 41.8% |
| Hawaii | -2.0% | -3.4% | -7.0% | 13.5% | -0.2% |
| Idaho | 2.1% | -2.2% | 31.1% | 30.1% | 70.3% |
| Indiana* | -5.7% | 36.0% | 14.9% | 15.7% | 70.5% |
| Kentucky* | -4.5% | -1.4% | 25.3% | 12.7% | 33.1% |
| Louisiana | -2.0% | 10.4% | 18.2% | 19.6% | 52.9% |
| Missouri** | -2.0% | 26.2% | 9.9% | 14.2% | 55.2% |
| Nebraska | 6.6% | 16.7% | 8.0% | 8.4% | 45.8% |
| New Mexico | 1.8% | 9.1% | 6.1% | 7.2% | 26.3% |
| Ohio** | -4.4% | -2.5% | 7.7% | 25.0% | 25.5% |
| Oklahoma | 15.5% | 21.6% | 19.8% | 9.7% | 84.6% |
| Rhode Island** | 2.7% | 16.0% | 19.5% | 6.7% | 52.1% |
| South Carolina | 20.6% | 18.4% | 11.7% | 15.6% | 84.5% |
| Wisconsin** | -11.6% | -0.8% | 36.2% | 11.3% | 33.0% |
| **Separate Program States** | | | | | |
| **Total** | **-5.2%** | **6.3%** | **7.4%** | **12.6%** | **21.8%** |
| Alabama | 1.9% | 11.4% | 5.0% | 10.9% | 32.3% |
| Arizona** | -9.7% | 7.2% | 18.7% | 18.4% | 36.1% |
| California** | -5.3% | 5.3% | 3.7% | 13.4% | 17.3% |
| Colorado | -5.5% | 14.0% | 14.9% | 14.4% | 41.6% |
| Connecticut** | -0.6% | 8.3% | 1.0% | 5.3% | 14.5% |
| Delaware | -0.9% | 22.5% | -0.4% | 18.9% | 43.8% |
| Florida | -6.9% | 12.6% | 18.6% | 16.5% | 44.8% |
| Georgia | -3.9% | 3.1% | 6.0% | 17.2% | 23.0% |
| Illinois | -5.9% | 0.9% | 9.5% | 6.0% | 10.1% |
| Indiana* | -5.7% | 36.0% | 14.9% | 15.7% | 70.5% |
| Kansas | -12.5% | 17.9% | 13.0% | 11.7% | 30.2% |
| Kentucky* | -4.5% | -1.4% | 25.3% | 12.7% | 33.1% |
| Maine** | -1.9% | 9.1% | 5.5% | 9.7% | 23.9% |
| Michigan | -1.5% | -3.7% | -1.1% | 10.1% | 3.3% |
| Mississippi | -11.7% | 13.4% | 23.6% | 39.7% | 72.9% |
| Nevada | 5.5% | 8.5% | 13.3% | 24.3% | 61.1% |
| New Hampshire | -4.5% | 8.5% | 0.9% | -5.0% | -0.7% |
| New Jersey** | -0.3% | 5.4% | 9.9% | 26.8% | 46.5% |
| New York | -5.7% | 13.6% | 6.7% | 3.0% | 17.6% |
| North Carolina | -3.6% | 8.5% | 10.2% | 14.1% | 31.6% |
| Oregon | 0.0% | 10.4% | -0.2% | -3.4% | 6.5% |
| South Dakota | 2.8% | 17.8% | 11.0% | 18.3% | 59.1% |
| Texas | -10.3% | -1.9% | 2.9% | 29.3% | 17.1% |
| Utah | 0.8% | 8.0% | 5.5% | 10.1% | 26.5% |
| Vermont | -0.5% | 5.7% | 5.4% | 4.8% | 16.1% |
| Virginia | -6.2% | 0.5% | 0.0% | 2.0% | -3.9% |
| Washington | -2.8% | -1.8% | 14.0% | -3.5% | 5.0% |

SOURCE: KCMU analysis of data compiled by Health Management Associates from state agencies.

* Indiana and Kentucky established broad expansions through SCHIP in Medicaid and through separate SCHIP programs.

** These states implemented Medicaid parent coverage expansions to cover parents with incomes up to 100% of the poverty line or higher at some point between June 1997 and June 2001.

See Note on Figure 8

broad Medicaid or separate program expansion, using the definitions adopted by the federal SCHIP evaluation.[30] In this way roughly comparable expansions were considered. States that used SCHIP funds in Medicaid only to accelerate the phase-in coverage of older poor children were not considered Medicaid expansion states for purposes of this analysis because their Medicaid expansion was so narrow.

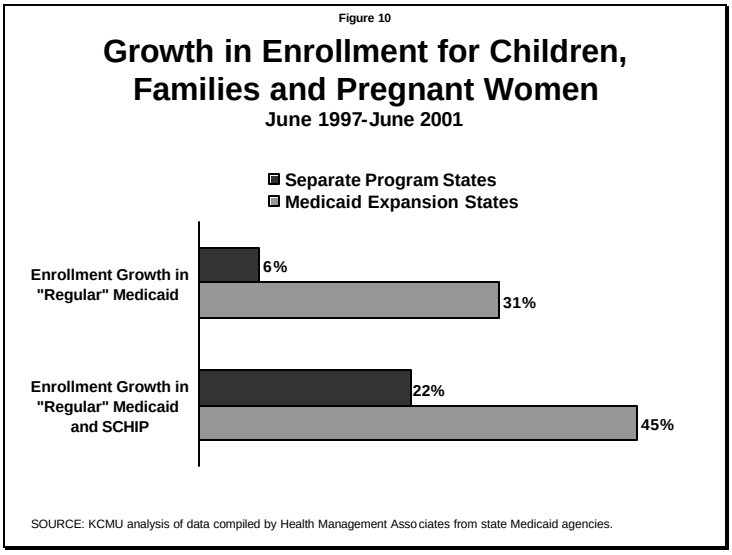
With some exceptions, among this group of 39 states, the 14 states that implemented Medicaid expansions under SCHIP had much stronger regular (nonSCHIP) Medicaid enrollment growth, and stronger enrollment growth overall (Medicaid and SCHIP) for children, families with children and pregnant women than the 27 states that expanded coverage through separate SCHIP programs (Indiana and Kentucky are in both groups) (Figure 8).

- Over the four-year period, regular Medicaid enrollment for children, families and pregnant women grew by an average of 31 percent in the Medicaid expansion states compared to 6.2 percent in the separate program states.

- In eight out of the 14 Medicaid expansion states, enrollment in regular Medicaid grew by more than one third (33%). By comparison, only four of the 27 states with separate programs (including Indiana, a combination state) saw enrollment growth in regular Medicaid that was as high.

The differences, on average, between Medicaid expansion states and separate SCHIP program states with respect to regular Medicaid enrollment contributed to significant differences in combined Medicaid and SCHIP enrollment for children and their families (Figure 9). For Medicaid expansion states, Medicaid and SCHIP enrollment for children, families with children, and pregnant women grew by 45.2 percent, and for separate SCHIP program states, combined enrollment grew by an average of 21.8 percent (Figure 10).

Figure 10



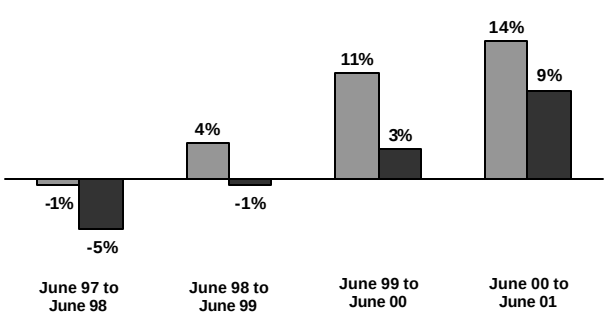

These data do not suggest that states with separate SCHIP programs have not made important progress covering uninsured children or that these states did not or cannot improve their Medicaid programs. Separate SCHIP programs generally have been very successful enrolling eligible children in SCHIP, and these data show that several states with separate programs have had strong enrollment gains for children and their families in Medicaid as well as SCHIP.

[30] Rosenbach, et al. Mathematica Policy Research, Inc., *Implementation of the State Children's Health Insurance Program: Momentum is Increasing After a Modest Start, First Annual Report*. January 2001,for the Health Care Finance Administration, http://www.cms.gov/states/SCHIP1.pdf.

Additionally, while many states with separate SCHIP programs may have been more focused on their new programs when they first implemented SCHIP, most states did turn their attention to Medicaid and saw marked improvements in regular Medicaid enrollment during this period. The year-by-year data show that most states with separate SCHIP programs had stronger enrollment gains in regular Medicaid for children, families with children, and pregnant women toward the latter part of the period studied. The gap between Medicaid expansion states and separate SCHIP program states with respect to "regular" Medicaid enrollment gains for children, families, and pregnant women narrowed significantly over the four years (Figure 11).

Figure 11

**Enrollment Growth in "Regular" Medicaid for Children, Families and Pregnant Women**




SOURCE: KCMU analysis of data compiled by Health Management Associates from state Medicaid agencies.

Some of regular Medicaid enrollment gains in states with separate SCHIP programs came about because when children applied for SCHIP, Medicaid-eligible children were identified and enrolled in Medicaid. Some of these gains occurred because once states implemented their separate SCHIP program, they began to take steps to improve their Medicaid programs and the coordination between the two programs. In Arizona, Florida, and Mississippi, for example, enrollment for children, families and pregnant women in regular Medicaid grew strongly between June 1998 and June 2001 following efforts to simplify their enrollment procedures, market their Medicaid programs, improve coordination between Medicaid and SCHIP, and assure that families leaving welfare were properly evaluated for Medicaid.[31]

Many states have reported that the steps they have taken to improve Medicaid program operations, marketing, and coverage for families strongly contributed to their enrollment gains.

- Michigan (a state with a separate SCHIP program) reduced its verification requirements and adopted self-declaration of income in Medicaid and SCHIP in 2000. Michigan reports that before it streamlined its verification requirements, three-fourths of the Medicaid applications received on behalf of children were deemed incomplete and could not be acted upon. After the change, fewer than 20 percent of the applications needed follow-up because they were incomplete and less than three percent of applications were denied for incomplete information.[32] After three years of decline, Michigan's regular

[31] Year-by-year regular Medicaid and SCHIP enrollment data for children, families with children and pregnant women are included in the Appendix.

[32] General Accounting Office, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, September 2001, GAO-01-883. Michigan also reports that the change in verification roles did not result in a high error rate.

Medicaid enrollment for children, families, and pregnant women grew by 8.5 percent between June 2000 and June 2001.

- New Jersey (another state with a separate SCHIP program) adopted a number of improvements in its Medicaid and SCHIP programs, including, in the fall of 2000, a broad expansion of coverage for parents and a new family coverage application. It also addressed problems it had identified in the area of retention. After modest enrollment gains in regular Medicaid for children, families with children and pregnant women between 1997 and 2000, New Jersey saw a 28.6 percent rise in enrollment for this group between June 2000 and June 2001.

- Ohio is a Medicaid expansion state whose regular Medicaid enrollment for children, families with children and pregnant women declined between June 1997 and June 1999, and then rose modestly between June 1999 and June 2000. In 2000, the state made a number of changes to its Medicaid program: it adopted relatively narrow expansions in coverage for parents and pregnant women, expanded eligibility (funded through SCHIP) for children, simplified verification, revised its family application, and improved systems to assure that families leaving welfare did not lose Medicaid coverage inappropriately. Between June 2000 and June 2001, enrollment for children, families with children, and pregnant women in regular Medicaid jumped by 22 percent and combined Medicaid and SCHIP enrollment grew by 25 percent.

- After September 11th, New York created a special procedure, called "Disaster Relief Medicaid" easing the application requirements for Medicaid and SCHIP in New York City. The application was cut to one page and documentation was limited to proof of identity. Enrollment cards were issued to eligible people the day of application. According to press reports, in six weeks, 75,000 families applied for Medicaid, compared to the normal application rate of 8,000 applicants a month. In four months, 380,000 New Yorkers enrolled.[33]

Whatever specific measures may have been responsible for improvements in Medicaid participation across the states, these enrollment data and other studies show that Medicaid performance is central to overall enrollment gains and strongly suggest that improvements in Medicaid program operations and marketing can result in significant coverage gains for children and their families.[34]

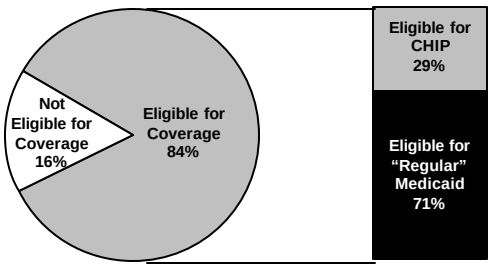
[33] Testimony of James R. Tallon, Jr., President, United Hospital Fund, New York State Assembly Standing Committee on Health, December 3, 2001; *Currents, United Hospital Fund*, Vol. 6, No. 4, Spring 2002.
[34] L. Dubay, J. Haley, G. Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*, New Federalism, Urban Institute, March 2002.

## IV. Modernizing Medicaid—The Next Steps

While many states have made much progress expanding coverage and promoting enrollment among eligible children and their families, more needs to be done. Most (84%) low-income uninsured children are now eligible for coverage, and more than two-thirds (71%) of the uninsured children who qualify for public coverage are eligible for "regular" Medicaid, not SCHIP (Figure 12).[35] Many families continue to be unaware that their children may be eligible for coverage and several states still have simpler procedures for children applying for SCHIP than Medicaid (Figure 13). A substantial number of states that have adopted improvements in Medicaid for children rely on their old welfare-linked procedures when a child applies for coverage along with his or her parents.

Figure 12

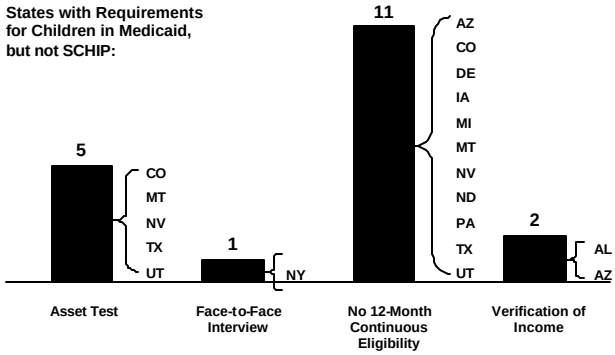
**Most Uninsured Low-Income Children are Eligible for "Regular" Medicaid (1999)**




Note: Low-income refers to families with incomes below 200% of the federal poverty level. Estimates include children who are not eligible for Medicaid or SCHIP because of their immigration status. Children eligible for SCHIP include those eligible either under a SCHIP-funded separate child health program or SCHIP-funded Medicaid expansion. "Regular" Medicaid refers to coverage under pre-SCHIP Medicaid eligibility standards.
SOURCE: Urban Institute simulations using 1999 data based on July 2000 eligibility rules.

Figure 13

**States That Have Not Simplified the Process for Children in Medicaid to the Same Extent as in SCHIP**




Note: Thirty-five states have separate SCHIP programs.
SOURCE: Center on Budget and Policy Priorities Survey for the Kaiser Commission on Medicaid and the Uninsured, January 2002.

Further improvements in the following areas could help boost Medicaid participation rates:

- Extending Medicaid program improvements adopted for children to families;
- Strengthening provider networks to assure access to care and engaging providers, as appropriate, in efforts to retain eligible children and families in coverage;
- Making further progress reducing documentation requirements and relying on data systems and other methods to ensure program integrity;
- Assuring that the renewal process is as simple as it can be and well coordinated between Medicaid and the separate SCHIP program;
- Using more direct and easier to understand language in applications, renewal forms, and program notices, and assuring that materials are available in all appropriate languages;
- Improving integrated computer eligibility systems to ensure that eligibility is determined properly, particularly as families move in and out of the welfare system. Improved coordination across information systems can also help avoid circumstances where

[35] Ibid

enrollment is denied or terminated when information needed to establish or renew eligibility is available through other programs (such as the School Lunch program, child care subsidies and child support collections);

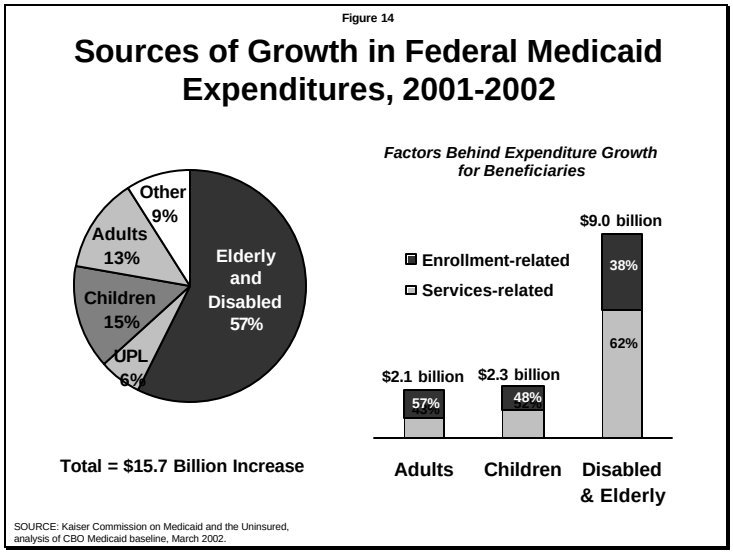
- Letting families know that Medicaid has changed and that new eligibility rules and new procedures make affordable coverage readily available to low-income families with earnings.

## V. Where There Is Will – and the Commitment of Resources – There Is A Way

As state economies falter and health care costs rise, it is now more clear than ever that a certain degree of "political will" is needed to accomplish and maintain real change. The states and local communities that have had the most success in improving their Medicaid programs have been explicit about their mission and have had strong backing from elected officials in the executive and legislative branches. They have embraced changes that have gone beyond adopting a new name for the program or shortening the application form. These initiatives often have been developed with community input after careful examination of the program from many different vantage points to identify how Medicaid program operations may have discouraged rather than encouraged enrollment.

Figure 14

**Sources of Growth in Federal Medicaid Expenditures, 2001-2002**




SOURCE: Kaiser Commission on Medicaid and the Uninsured, analysis of CBO Medicaid baseline, March 2002.

Continued commitment to eliminating barriers to coverage and improving Medicaid policies and procedures in ways that have been proven to work is being put to the test as the economic downturn and rising healthcare costs take their toll on state budgets. Neither children nor nondisabled adults are the major contributors to rising Medicaid costs (Figure 14).[36] Regardless of the source of the higher costs, however, states facing budget shortfalls are forced to make difficult decisions. In the past, enrollment barriers have helped to limit the cost of Medicaid at least in the short run. But these barriers have come at the expense of coverage and, to some degree, the program's reputation. Medicaid enrollment has made and continues to make a major difference in children's lives. The challenge now is to continue the progress that has been made and to not let barriers creep back into the system as a hidden cost saving mechanism.

[36] KCMU calculations based on the Congressional Budget Office's Medicaid baseline, January 2002 and CBO, *The President's Fiscal Year 2003 Budget: An Overview of the Health Programs*, March 2002.

## Table 1

## Combined Enrollment for Children, Families, and Pregnant Women in "Regular" Medicaid (Title XIX) and SCHIP (Title XXI)

| | Monthly Enrollment in Thousands | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Jun-97 | Dec-97 | Jun-98 | Dec-98 | Jun-99 | Dec-99 | Jun-00 | Dec-00 | Jun-01 | Sep-01 | Change, Jun 97 to Jun 01 |
| Alabama | 282 | 276 | 287 | 305 | 320 | 323 | 336 | 344 | 373 | 389 | 91 |
| Alaska | 50 | 47 | 52 | 50 | 59 | 62 | 67 | 65 | 71 | 69 | 21 |
| Arizona | 311 | 297 | 281 | 284 | 302 | 339 | 358 | 396 | 424 | 476 | 112 |
| California | 3,879 | 3,676 | 3,674 | 3,729 | 3,870 | 3,916 | 4,012 | 4,113 | 4,550 | 4,692 | 672 |
| Colorado | 166 | 160 | 157 | 165 | 179 | 193 | 206 | 220 | 236 | 242 | 69 |
| Connecticut | 220 | 216 | 219 | 226 | 237 | 238 | 239 | 243 | 252 | 264 | 32 |
| Delaware | 57 | 58 | 57 | 62 | 69 | 71 | 69 | 72 | 82 | 85 | 25 |
| Florida | 927 | 920 | 863 | 916 | 972 | 1,046 | 1,153 | 1,263 | 1,343 | 1,382 | 416 |
| Georgia | 669 | 661 | 643 | 654 | 662 | 672 | 702 | 731 | 823 | 826 | 154 |
| Hawaii | 130 | 129 | 127 | 120 | 123 | 119 | 114 | 128 | 129 | 130 | 0 |
| Idaho | 60 | 59 | 61 | 59 | 60 | 64 | 78 | 91 | 102 | 105 | 42 |
| Illinois | 949 | 937 | 892 | 884 | 900 | 950 | 985 | 1,013 | 1,045 | 1,099 | 96 |
| Indiana* | 276 | 277 | 261 | 301 | 355 | 383 | 407 | 440 | 472 | 487 | 195 |
| Kansas | 120 | 112 | 105 | 103 | 123 | 137 | 140 | 145 | 156 | 159 | 36 |
| Kentucky | 302 | 293 | 288 | 277 | 284 | 292 | 356 | 392 | 402 | 399 | 100 |
| Louisiana | 311 | 311 | 305 | 310 | 337 | 384 | 398 | 434 | 476 | 501 | 165 |
| Maine | 99 | 95 | 97 | 103 | 106 | 109 | 112 | 115 | 123 | 125 | 24 |
| Michigan | 796 | 786 | 784 | 745 | 755 | 745 | 747 | 771 | 822 | 846 | 27 |
| Mississippi | 224 | 210 | 198 | 213 | 224 | 242 | 277 | 318 | 387 | 391 | 163 |
| Missouri | 404 | 406 | 396 | 428 | 499 | 531 | 549 | 583 | 627 | 640 | 223 |
| Nebraska | 104 | 107 | 111 | 122 | 130 | 136 | 140 | 145 | 152 | 155 | 48 |
| Nevada | 63 | 67 | 66 | 69 | 72 | 73 | 81 | 92 | 101 | 109 | 38 |
| New Hampshire | 60 | 58 | 57 | 57 | 62 | 62 | 63 | 58 | 59 | 61 | 0 |
| New Jersey | 437 | 429 | 436 | 448 | 460 | 487 | 505 | 560 | 641 | 660 | 204 |
| New Mexico | 195 | 188 | 198 | 207 | 216 | 221 | 229 | 238 | 246 | 254 | 51 |
| New York | 2,037 | 1,980 | 1,921 | 2,122 | 2,181 | 2,239 | 2,327 | 2,363 | 2,397 | 2,399 | 359 |
| North Carolina | 523 | 514 | 504 | 517 | 547 | 572 | 603 | 636 | 688 | 672 | 165 |
| Ohio | 761 | 720 | 728 | 723 | 709 | 729 | 764 | 883 | 955 | 993 | 194 |
| Oklahoma | 176 | 185 | 204 | 211 | 248 | 285 | 297 | 312 | 326 | 336 | 149 |
| Oregon | 245 | 241 | 245 | 256 | 270 | 262 | 270 | 266 | 261 | 258 | 16 |
| Rhode Island | 73 | 75 | 75 | 75 | 87 | 95 | 104 | 107 | 111 | 114 | 38 |
| South Carolina | 232 | 252 | 279 | 306 | 331 | 349 | 370 | 394 | 427 | 456 | 196 |
| South Dakota | 39 | 39 | 40 | 44 | 47 | 49 | 52 | 56 | 62 | 64 | 23 |
| Texas | 1,447 | 1,394 | 1,298 | 1,316 | 1,274 | 1,288 | 1,311 | 1,513 | 1,695 | 1,799 | 248 |
| Utah | 95 | 93 | 95 | 97 | 103 | 104 | 109 | 113 | 120 | 124 | 25 |
| Vermont | 64 | 64 | 64 | 64 | 67 | 70 | 71 | 73 | 75 | 75 | 10 |
| Virginia | 337 | 322 | 316 | 308 | 317 | 322 | 317 | 318 | 323 | 329 | -13 |
| Wisconsin | 266 | 243 | 235 | 232 | 233 | 276 | 318 | 331 | 354 | 372 | 88 |

* Monthly enrollment reports for this state represent the average monthly enrollment for the quarter ending in the month indicated.
SOURCE: KCMU analysis of data compiled by Health Management Associates from state agencies.

## Table 2

## Enrollment for Children, Families, and Pregnant Women in "Regular" Medicaid (Title XIX)

| | Monthly Enrollment in Thousands | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Jun-97 | Dec-97 | Jun-98 | Dec-98 | Jun-99 | Dec-99 | Jun-00 | Dec-00 | Jun-01 | Sep-01 | Change, Jun 97 to Jun 01 |
| Alabama | 282 | 276 | 287 | 283 | 289 | 289 | 300 | 311 | 331 | 343 | 49 |
| Alaska | 50 | 47 | 52 | 50 | 55 | 55 | 58 | 56 | 59 | 58 | 9 |
| Arizona | 311 | 297 | 281 | 280 | 287 | 311 | 323 | 354 | 372 | 422 | 61 |
| California | 3,879 | 3,676 | 3,674 | 3,662 | 3,718 | 3,685 | 3,689 | 3,723 | 4,071 | 4,178 | 192 |
| Colorado | 166 | 160 | 157 | 153 | 161 | 170 | 181 | 192 | 201 | 205 | 34 |
| Connecticut | 220 | 216 | 219 | 220 | 228 | 229 | 229 | 232 | 241 | 252 | 21 |
| Delaware | 57 | 58 | 57 | 62 | 68 | 68 | 66 | 69 | 79 | 81 | 22 |
| Florida | 927 | 920 | 863 | 860 | 871 | 921 | 993 | 1,074 | 1,121 | 1,151 | 194 |
| Georgia | 669 | 661 | 643 | 654 | 631 | 615 | 616 | 625 | 690 | 682 | 21 |
| Hawaii | 130 | 129 | 127 | 120 | 123 | 119 | 114 | 125 | 124 | 123 | -6 |
| Idaho | 60 | 59 | 61 | 56 | 56 | 60 | 71 | 82 | 91 | 93 | 31 |
| Illinois | 949 | 937 | 892 | 859 | 865 | 903 | 932 | 952 | 982 | 1,030 | 34 |
| Indiana* | 276 | 277 | 261 | 276 | 326 | 348 | 368 | 394 | 424 | 440 | 148 |
| Kansas | 120 | 112 | 105 | 103 | 112 | 122 | 122 | 126 | 134 | 136 | 14 |
| Kentucky | 302 | 293 | 288 | 272 | 277 | 264 | 314 | 339 | 347 | 347 | 45 |
| Louisiana | 311 | 311 | 305 | 306 | 319 | 357 | 365 | 393 | 422 | 438 | 110 |
| Maine | 99 | 95 | 97 | 98 | 100 | 100 | 103 | 106 | 113 | 115 | 14 |
| Michigan | 796 | 786 | 784 | 729 | 727 | 712 | 712 | 728 | 773 | 793 | -23 |
| Mississippi | 224 | 210 | 198 | 204 | 217 | 231 | 257 | 288 | 344 | 344 | 120 |
| Missouri | 404 v | | 396 | 404 | 457 | 476 | 488 | 513 | 553 | 564 | 149 |
| Nebraska | 104 | 107 | 111 | 118 | 125 | 130 | 133 | 139 | 144 | 146 | 40 |
| Nevada | 63 | 67 | 66 | 67 | 65 | 66 | 70 | 78 | 82 | 88 | 20 |
| New Hampshire | 60 | 58 | 57 | 57 | 60 | 59 | 60 | 54 | 56 | 57 | -4 |
| New Jersey | 437 | 429 | 436 | 426 | 423 | 431 | 436 | 484 | 561 | 581 | 124 |
| New Mexico | 195 | 188 | 198 | 207 | 215 | 218 | 225 | 232 | 239 | 246 | 45 |
| New York | 2,037 | 1,980 | 1,921 | 1,852 | 1,829 | 1,814 | 1,805 | 1,834 | 1,910 | 1,919 | -127 |
| North Carolina | 523 | 514 | 504 | 499 | 503 | 517 | 538 | 564 | 628 | 621 | 105 |
| Ohio | 761 | 720 | 728 | 688 | 671 | 684 | 717 | 816 | 877 | 912 | 116 |
| Oklahoma | 176 | 185 | 204 | 196 | 222 | 252 | 262 | 275 | 288 | 298 | 111 |
| Oregon | 245 | 241 | 245 | 245 | 258 | 248 | 254 | 250 | 243 | 241 | -2 |
| Rhode Island | 73 | 75 | 75 | 72 | 82 | 88 | 95 | 96 | 100 | 102 | 27 |
| South Carolina | 232 | 252 | 279 | 268 | 285 | 305 | 322 | 350 | 381 | 409 | 149 |
| South Dakota | 39 | 39 | 40 | 43 | 45 | 46 | 49 | 51 | 55 | 57 | 16 |
| Texas | 1,447 | 1,394 | 1,298 | 1,281 | 1,239 | 1,260 | 1,272 | 1,313 | 1,326 | 1,357 | -121 |
| Utah | 95 | 93 | 95 | 92 | 93 | 91 | 92 | 92 | 96 | 98 | 1 |
| Vermont | 64 | 64 | 64 | 64 | 66 | 68 | 69 | 70 | 72 | 73 | 8 |
| Virginia | 337 | 322 | 316 | 307 | 305 | 303 | 292 | 288 | 290 | 295 | -47 |
| Wisconsin | 266 | 243 | 235 | 232 | 230 | 259 | 295 | 305 | 327 | 344 | 61 |

* Monthly enrollment reports for this state represent the average monthly enrollment for the quarter ending in the month indicated.
SOURCE: KCMU analysis of data compiled by Health Management Associates from state agencies.

## Table 3

## Enrollment in SCHIP (Title XXI)

| State | Dec-98 | Jun-99 | Dec-99 | Jun-00 | Dec-00 | Jun-01 | Sep-01 | Change, Dec 98 to Jun 01 |
|---|---|---|---|---|---|---|---|---|
| Alabama | 22 | 31 | 34 | 37 | 33 | 42 | 45 | 20 |
| Alaska | 0 | 4 | 7 | 9 | 10 | 11 | 11 | 11 |
| Arizona | 4 | 15 | 28 | 35 | 42 | 52 | 54 | 48 |
| California | 67 | 152 | 231 | 323 | 389 | 479 | 514 | 413 |
| Colorado | 12 | 18 | 23 | 25 | 28 | 35 | 37 | 23 |
| Connecticut | 6 | 9 | 9 | 10 | 11 | 11 | 11 | 5 |
| Delaware | 0 | 2 | 3 | 3 | 4 | 3 | 4 | 3 |
| Florida | 56 | 101 | 125 | 161 | 188 | 222 | 231 | 165 |
| Georgia | 0 | 31 | 56 | 86 | 107 | 132 | 144 | 132 |
| Hawaii | 0 | 0 | 0 | 0 | 4 | 6 | 6 | 6 |
| Idaho | 3 | 4 | 5 | 7 | 9 | 11 | 12 | 8 |
| Illinois | 25 | 35 | 47 | 53 | 61 | 62 | 69 | 38 |
| Indiana* | 25 | 29 | 35 | 40 | 46 | 48 | 48 | 23 |
| Kansas | 0 | 11 | 15 | 17 | 19 | 22 | 23 | 22 |
| Kentucky | 5 | 7 | 28 | 42 | 53 | 54 | 52 | 49 |
| Louisiana | 4 | 18 | 27 | 33 | 41 | 54 | 63 | 51 |
| Maine | 4 | 7 | 8 | 9 | 10 | 10 | 11 | 5 |
| Michigan | 16 | 28 | 32 | 35 | 42 | 50 | 53 | 34 |
| Mississippi | 8 | 8 | 11 | 21 | 31 | 43 | 47 | 35 |
| Missouri | 24 | 42 | 54 | 61 | 71 | 73 | 76 | 49 |
| Nebraska | 4 | 5 | 6 | 7 | 7 | 8 | 9 | 4 |
| Nevada | 3 | 7 | 8 | 11 | 14 | 19 | 21 | 16 |
| New Hampshire | 0 | 2 | 2 | 3 | 3 | 4 | 4 | 4 |
| New Jersey | 23 | 37 | 55 | 69 | 77 | 80 | 79 | 57 |
| New Mexico | 0 | 1 | 2 | 4 | 6 | 7 | 8 | 7 |
| New York | 271 | 352 | 426 | 522 | 529 | 486 | 480 | 215 |
| North Carolina | 18 | 44 | 56 | 65 | 72 | 60 | 51 | 42 |
| Ohio | 35 | 38 | 45 | 47 | 67 | 78 | 81 | 43 |
| Oklahoma | 16 | 25 | 33 | 35 | 37 | 38 | 39 | 22 |
| Oregon | 10 | 13 | 14 | 16 | 17 | 18 | 17 | 7 |
| Rhode Island | 3 | 5 | 7 | 9 | 11 | 11 | 12 | 8 |
| South Carolina | 38 | 46 | 44 | 48 | 44 | 47 | 47 | 9 |
| South Dakota | 1 | 2 | 3 | 4 | 6 | 7 | 7 | 5 |
| Texas | 35 | 35 | 29 | 39 | 200 | 369 | 442 | 334 |
| Utah | 4 | 10 | 14 | 17 | 20 | 24 | 25 | 19 |
| Vermont | 0 | 1 | 2 | 2 | 2 | 3 | 3 | 2 |
| Virginia | 1 | 12 | 20 | 25 | 30 | 33 | 34 | 32 |
| Wisconsin | 0 | 3 | 17 | 22 | 26 | 27 | 28 | 27 |

* Monthly enrollment reports for this state represent the average monthly enrollment for the quarter ending in the month indicat
SOURCE: KCMU analysis of data compiled by Health Management Associates from state agencies.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