THE HENRY J. KAISER FAMILY FOUNDATION

KAISER HEALTH TRACKING POLL

Public Opinion on Health Care Issues

March 2011

Little has changed on the public opinion front since President Obama signed the Patient Protection and Affordable Care Act (ACA) into law last March 23. More than half of Americans continue to report that they are confused about the law and don't understand how it will impact them personally. Meanwhile, the public remains divided in their views of the ACA, and a stark partisan opinion gap persists. In terms of next steps for health reform, a majority of Americans like the idea of allowing states to substitute their own plans for the federal one, with the caveat that the states' plans are of equal quality and cover just as many people, but most are opposed to the idea of defunding the ACA. The public is still split on repeal, with slightly more wanting to expand the law or leave it as is than wanting to repeal it entirely or replace it with a Republican alternative. A majority do want to repeal the individual mandate, but opposition falls markedly when people are told that the mandate will not change the existing health care arrangements of most Americans.

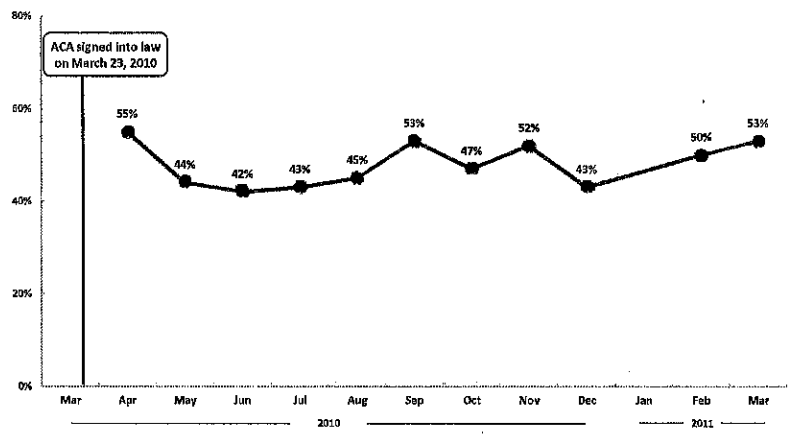
ON COMPLEX LAW, WIDESPREAD CONFUSION REMAINS

Despite ongoing education efforts by the federal government and numerous stakeholders, many Americans – legitimately distracted by the demands of everyday life, the pressures of a bad economy, and the complexity of the legislative changes – continue to report that they are confused and lacking information about how the year-old health reform law will affect them.

This month fully 52 percent of the public says they do not have enough information about the health reform law to understand how it will impact them personally, while 47 percent think they do. This is nearly identical to the proportions found immediately after passage last April, when 56 percent said they did not have adequate information.

Confusion Remains High

Percent who say that "confused" describes their feelings about the health reform law:



Q. Do you feel you have enough information about the health reform law to understand how it will impact you personally, or not?

	Yes	No
All Americans	**47%**	**52%**
Annual household income		
Less than $40,000	38%	61%
$40-90,000	52	47
$90,000 or more	55	44
Insurance status (age <65)		
Insured	51%	48%
Uninsured	40	60

Reported lack of understanding is higher among several key populations. For example, six in ten uninsured say they do not know enough about potential impacts, along with six in ten of those living in low income households.[1]

[1] Low income household defined here as household with 2010 income under $40,000.

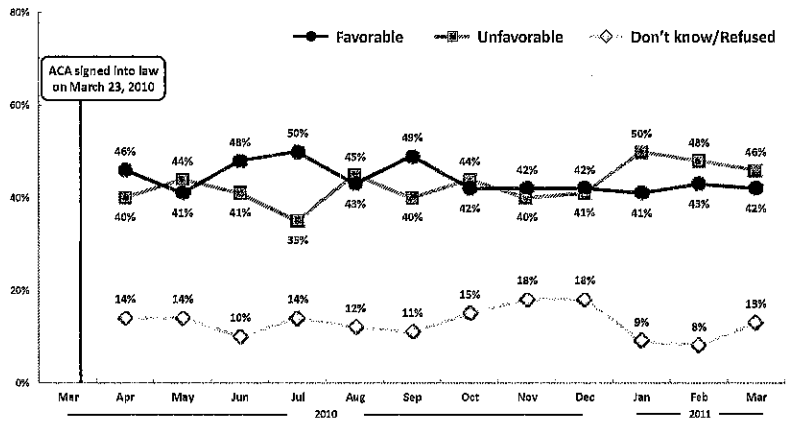
VIEWS OF LAW LITTLE CHANGED OVER COURSE OF FIRST YEAR

A year of post-passage debate on the merits of the ACA, and the beginning stages of the law's implementation, have done little to change the overall shape of Americans' opinions on the legislation. In March, one year after the law's passage, the Kaiser Health Tracking Poll found that 42 percent of Americans hold favorable views of the law while 46 percent view it unfavorably, a basic division of public opinion that has changed little during the course of the past year.

In an open-ended question, about half of those with positive views pointed to much the same things in explaining their position: expanded access to insurance and health care (mentioned by 51 percent of those who view the law favorably). Those with negative views provide a wider spectrum of reasons. At the top of the list: 20 percent are concerned about costs; 19 percent had concerns about government's role; and 18 percent mentioned opposition to the individual mandate.

At One Year Anniversary Views on Health Reform Remain Divided

As you may know, a health reform bill was signed into law early last year. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

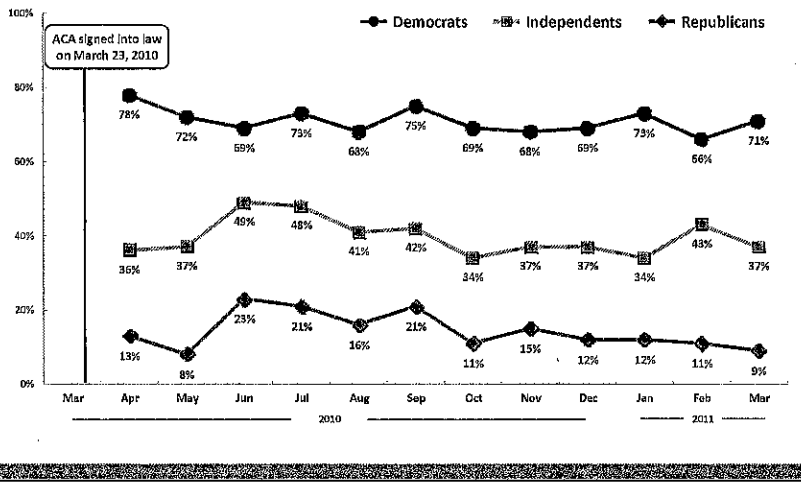


THE PARTY DIVIDE

Also stable: the partisan underpinnings of those opinions. A majority of those Americans who identify as Democrats back the law (71 percent in the current survey), and have done so throughout the year. Most Republicans, however, oppose the law (82 percent) and have done so consistently through the past 12 months. Independents are divided, currently tilting negative (37 percent hold a favorable view, 49 an unfavorable one).

Wide Partisan Divide Lasts Throughout Year

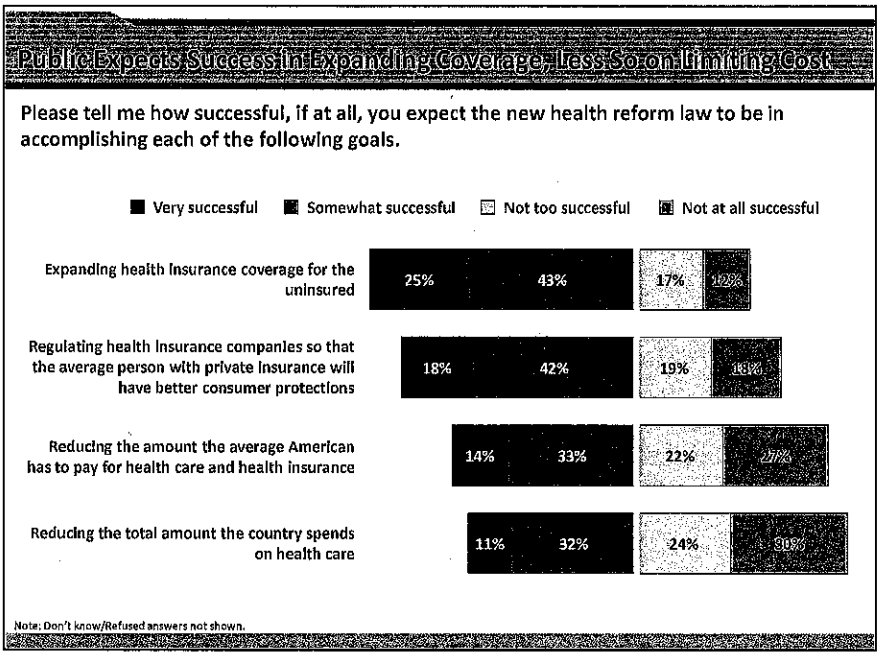
Percent who say they have a favorable opinion of the health reform law:



Another hallmark of partisan opinion on the law is Republicans' greater intensity of feeling. Shortly after passage, asked whether they felt very or somewhat unfavorably toward the law, fully six in ten Republicans chose the more extreme "very unfavorable" to describe their views, a proportion that is essentially unchanged this month (59 percent). While intensity of support among Democrats spiked around the time of passage, it settled back down last May and those with "very favorable" views of the law have hovered in the 30 to 40 percent range since then. This month 40 percent of Democrats say they have a "very favorable" view of the law.

THE EXPECTATIONS GAME: LITTLE CHANGE IN EXPECTATIONS OVER YEAR

Similarly, across the past six months neither the law's advocates nor its detractors have been able to make any progress in convincing a majority of the public the law will be a success (or a failure). According to the Kaiser Health Tracking Poll, Americans are in roughly the same place they were in August in terms of expecting the law to succeed in expanding coverage, reducing costs, and regulating insurance companies. Most Americans expect the law to be at least somewhat successful in expanding coverage for the uninsured and in enhancing consumer protections in the health insurance market, but they are divided on whether the law will bring down costs for the average American, and a narrow majority does not expect it to bring down the country's overall health spending.



Emotional reactions are also unchanged, with similar proportions now as a year ago saying they are confused (53 percent), anxious (39 percent) and angry (34 percent).

STATE SUBSTITUTION

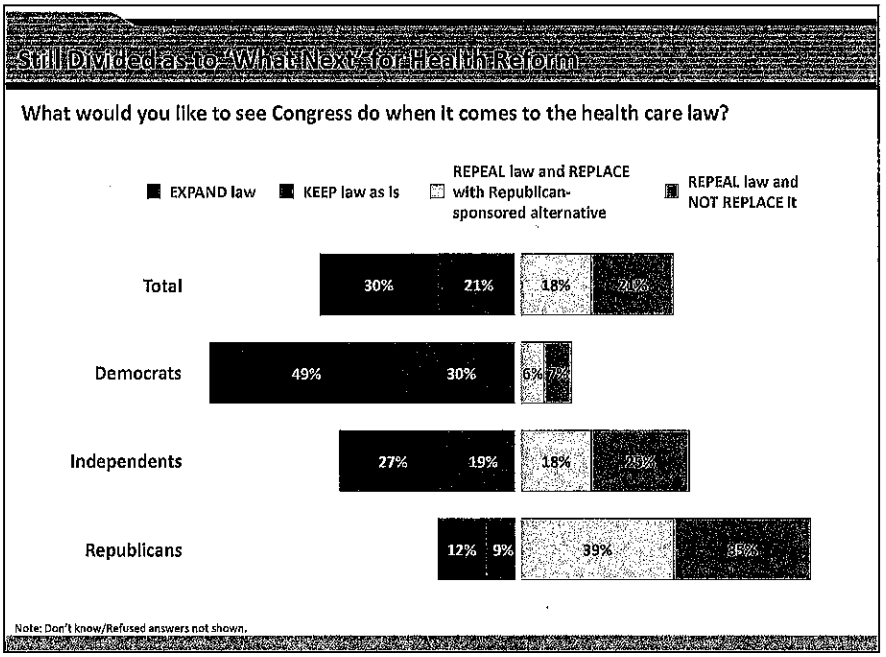
With Republicans quite critical of the law and some state officials chafing at its requirements, the issue of how much flexibility states should be granted, and with what conditions attached, has been a subject of debate in Washington. Overall, 66 percent of the public agrees that if states can provide coverage that is equally comprehensive and affordable, they should be permitted to substitute their plan for that of the ACA. Currently, states will be allowed to implement such alternatives in 2017, but several key policymakers would like to see this option made available in earlier years. This idea is popular across party groups, backed by 75 percent of Republicans and 72 percent of Independents. Democrats, who overwhelmingly favor the ACA as is, are somewhat less likely to back state substitution, but a majority still remains in favor (55 percent).

Q: If a state shows that they can create a health reform plan that covers as many people as the national health reform law, and provides them health insurance that is just as comprehensive and affordable, do you think that state should or should not be permitted to substitute their own plan for the federal one?	
Yes, states should be permitted to substitute own plan	66%
No, states should not be permitted to substitute	29
Don't know/Refused	5
Q: Would you still favor the idea of states being able to substitute their own plans if some states decided to save money by providing more limited insurance to fewer people than the national health reform law would, or would you then oppose the idea?	
Still favor states being able to substitute	26%
Oppose states being able to substitute	65
Originally	29
Once heard argument	36
Don't know/Refused	9

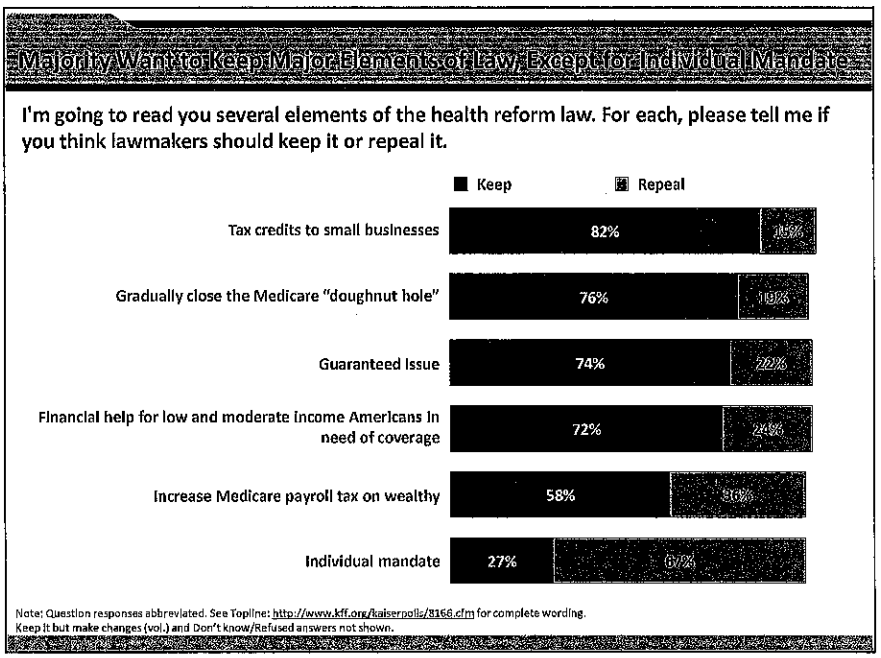
There would likely be less public support for the concept, however, if states were to attempt to save money by implementing plans that covered fewer people with more limited health insurance. The poll suggests in this scenario, roughly two in three would oppose state substitution, while 26 percent would remain in favor. Four in ten Republicans would still support state substitution under this scenario, compared to 14 percent of Democrats and 29 percent of Independents.

REPEAL? EXPANSION?

In a more stepped back look at the ACA's future, the public again turns in a mixed verdict. Overall, 21 percent support leaving the law as is and another 30 percent even support expanding it. In contrast, 21 percent would repeal the law and not return to the subject of health reform, while 18 percent would repeal the law but then replace it with a Republican alternative. These views are predictably partisan in nature, with most Democrats supporting the law as is (30 percent) or even an expansion of the law (49 percent). Most Republicans support some version of repeal: 39 percent favor repealing the law and replacing it with a GOP-sponsored alternative and 35 percent want to repeal and *not* replace it.



Complicating this picture is the fact that even as there is no public majority in favor of the law as a whole, significant portions of the ACA are popular with the American public. As has been true in previous months, when the public is asked whether they would support repeal of *individual provisions* of the law, the only provision that a majority are ready to let go of is the individual mandate. Overall, eight in ten would like to *keep* the tax credits for small business, and upwards of seven in ten would like to keep the guaranteed issue provisions, the changes that impact the Medicare prescription drug 'doughnut hole', and the income-based health insurance subsidies. With the exception of the latter, these provisions are even supported by majorities of Republicans.



The individual mandate remains unpopular, with two thirds (67 percent) supporting its repeal. These views are, however, still somewhat malleable in the face of countervailing information. For example, told that "under the reform law, most Americans would still get coverage through their employers and so would automatically satisfy the requirement without having to buy any new insurance," support for repealing the mandate fell substantially to 35 percent. Support for repeal of this portion of the law also decreased somewhat when opponents of the mandate were told that without such a requirement, people might wait until they were quite sick to buy insurance, though this line of reasoning did not result in as dramatic a change (support for repeal fell to 48 percent).

Most Americans (60 percent) are aware of the fact that, as of now, the Republicans in Congress do not have an agreed upon alternative to the ACA, though their caucus is united in wanting it repealed. As on all matters partisan, the public is quite divided as to whether a Republican alternative would improve the current situation. For example, 25 percent say the Republicans would do a better job at lowering the amount the United States spends overall on health care, but 30 percent think they would do a worse job, and 34 percent wouldn't expect it to be any different.

DEFUNDING REMAINS UNPOPULAR

As has been true for the past two months, most Americans oppose the idea of using the legislative budgeting process to stop some or all of health reform from being put into place. Overall, 64 percent say they disapprove of this tactic, including a majority of Democrats (86 percent) and Independents (65 percent). Most Republicans (61 percent), however, would approve of cutting off funding for the law.

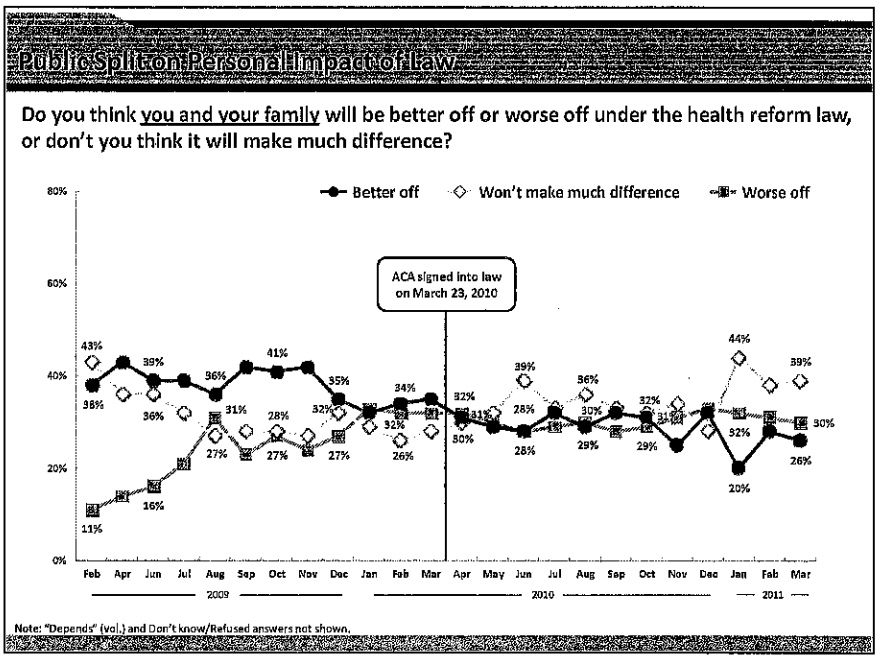
HAS HEALTH REFORM IMPACTED YOU?

At the one year anniversary, small but measurable groups of Americans say they have profited from the health reform law and, on the opposite end of the spectrum, believe they have been harmed by it. In both cases, the survey reports how the public *believes* they have been impacted, rather than how many have actually have been impacted, since it is often difficult for people to discriminate between changes wrought by new legislation and changes that would have occurred even in its absence. Overall, 13 percent say their family has benefited from health reform over the past year, while 20 percent report having suffered a negative effect.

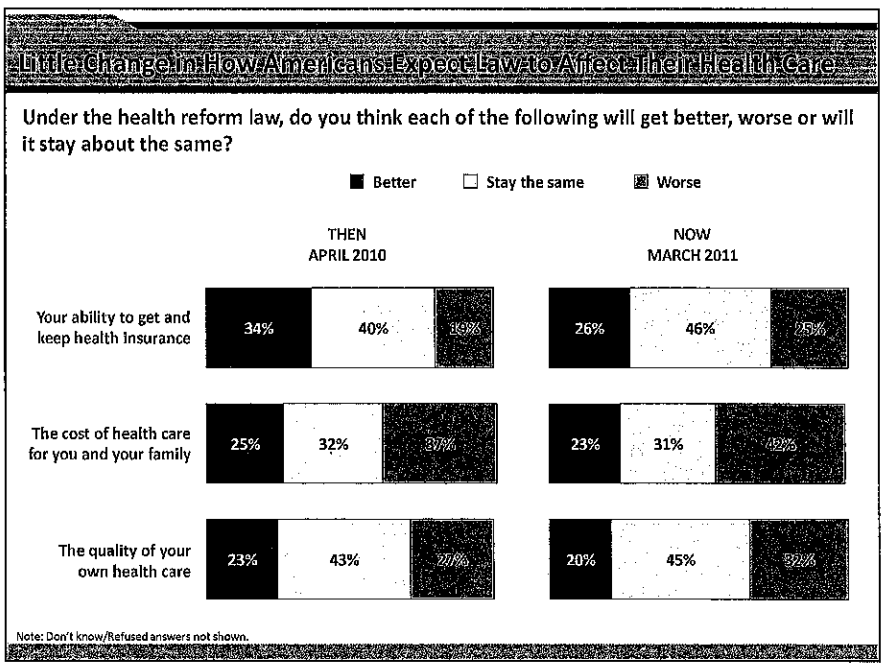
IN THEIR OWN WORDS... BENEFITS AND HARM	
Among the 13% who say they have personally benefitted from the health reform law: In what ways would you say you have benefited from the health reform law?	**Among the 20% who say they have been negatively affected by the health reform law: In what ways would you say you have been negatively affected by the health reform law?**
"I already had a free physical"	*"Costs are going up and coverage is going down"*
"I am a full time student and 25 years old so my parents were able to put me back on their plan"	*"I think because our insurance premiums have increased in anticipation of this new health reform law"*
"Our insurance premium has lowered a significant deal and we are told that it's due to the new law"	*"We will probably end up paying more taxes – we are in an upper bracket"*
"They are closing the doughnut hole for seniors and they are giving us a check for the doughnut hole"	*"We're in debt, [the] government is. The health reform [law] is going to increase our national debt. It will make our government larger. There are other ways to get people to get health care"*
"Insurance companies [won't] be able to deny [those with] pre-existing conditions"	*"In seeing the doctor they cut us back on how long we have to wait – used to see the doctor every 3 months now it's every 6 months -- that started when the law was put into place"*
"My current coverage will decrease [the] co-pay [for] doctor visits"	*"Creates angst -- it is frustrating to have government be involved in something they should not be involved in"*
"Small business deductions – those who cover employees get a tax credit"	*"We are already pay[ing] for insured people. All of us will be paying more, middle class will pay and pay, anything the federal [government] regulates is a major screw-up"*
"It would be a safety if I was to get unemployed"	*"Deeper cuts in benefits that were offered from work"*

WILL HEALTH REFORM HELP YOU?

Because most major provisions of the ACA will not be implemented until 2014, many Americans' views in year one are impacted less by tangible experience with the law's effects and more by their views of how the law *might* affect them once implemented. Since the beginning of the health care debate in earnest at the start of 2010, Americans have remained divided on the law's *potential* impact on their own family, another instance where neither the first year of implementation nor the legislative opposition to the law on Capitol Hill have managed to sway people's views of how a somewhat abstract piece of legislation will affect their own lives. Currently, three in ten say they expect to be worse off under the health reform law, a quarter (26 percent) feel they will be better off, and nearly four in ten (39 percent) believe the law will not make a difference either way.



A more fine-grained analysis of the ways Americans are anticipating the law will affect their health care situation leads to the same conclusion: no major change in opinion. Over the past year, across measures that ask Americans how they expect the quality, cost and availability of their own care and coverage to change under the ACA, there has been relatively little change. Currently, a plurality (42 percent) say they expect their own health care costs to rise under the health reform law, compared to a quarter (23 percent) who expect they will be paying less. When it comes to health care quality and access, the public is more divided. Slightly more say their health care quality will be worse than better (32 percent versus 20 percent) under the law, but a plurality doesn't expect any change. When it comes to access, the public is more evenly divided – a quarter (26 percent) believe their own access to health insurance will improve under the law, a similar share (25 percent) say that it will get worse, and the rest do not expect any change.



Q. Under the health reform law, do you think each of the following will get better, worse or will it stay about the same?

	Ages 18-29	Ages 30-49	Ages 50-64	Ages 65+
The quality of your own health care				
Better	25%	26%	13%	14%
Worse	25	28	43	32
It will stay about the same	50	42	42	50
The cost of health care for you and your family				
Better	26%	30%	15%	15%
Worse	24	39	57	46
It will stay about the same	44	28	24	35
Your ability to get and keep health insurance				
Better	29%	33%	23%	15%
Worse	16	21	35	27
It will stay about the same	53	42	40	55

One group whose views stand out as particularly negative here are those aged 50 to 64, a population beginning to grapple with increasing health problems even as they have years to wait before reaching eligibility for Medicare. Fully 57 percent in this group expect their health care costs to go up because of health reform, compared to only 24 percent among those under age 30.

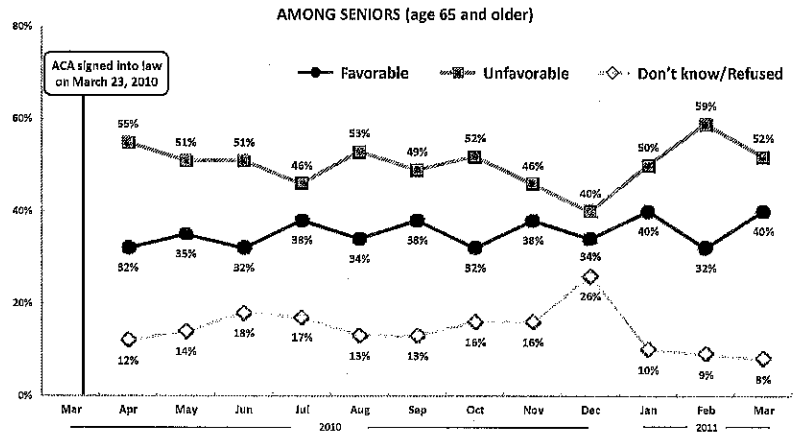
SENIORS

Throughout the past year, seniors have been more skeptical of the ACA, and they continue to be so at the one year anniversary, with just over half holding an unfavorable view of the law. March, however, saw a halt to the pattern of increasing negativity that started last December. Unfavorable views dropped among seniors by 7 percentage points over the month, while positive views increased by 8 percentage points.

In part their views may be based on the fact that by a two to one margin, they are more likely to believe Medicare will be worse off (39 percent) than better off (19 percent) because of health reform.

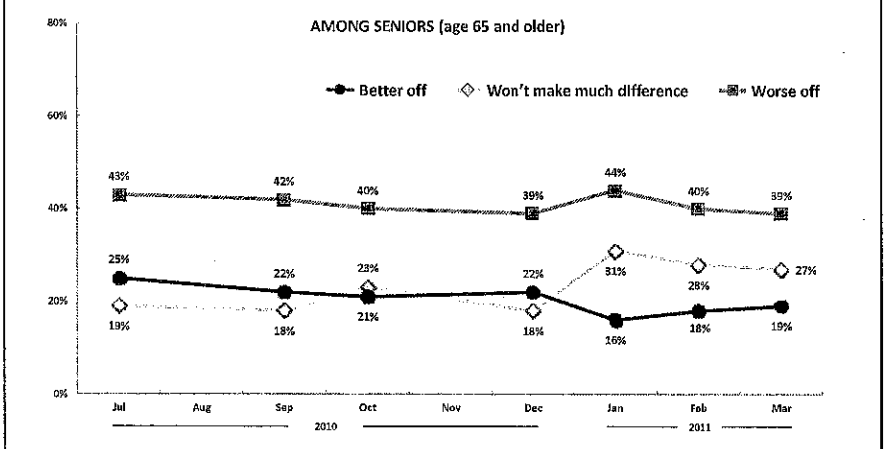
Seniors' Views Moderate Somewhat in March

As you may know, a health reform bill was signed into law early last year. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?



Plurality of Seniors Continue To See ACA as Challenge for Medicare

Do you think the Medicare program will be better off or worse off under the health reform law, or don't you think it will make much difference?

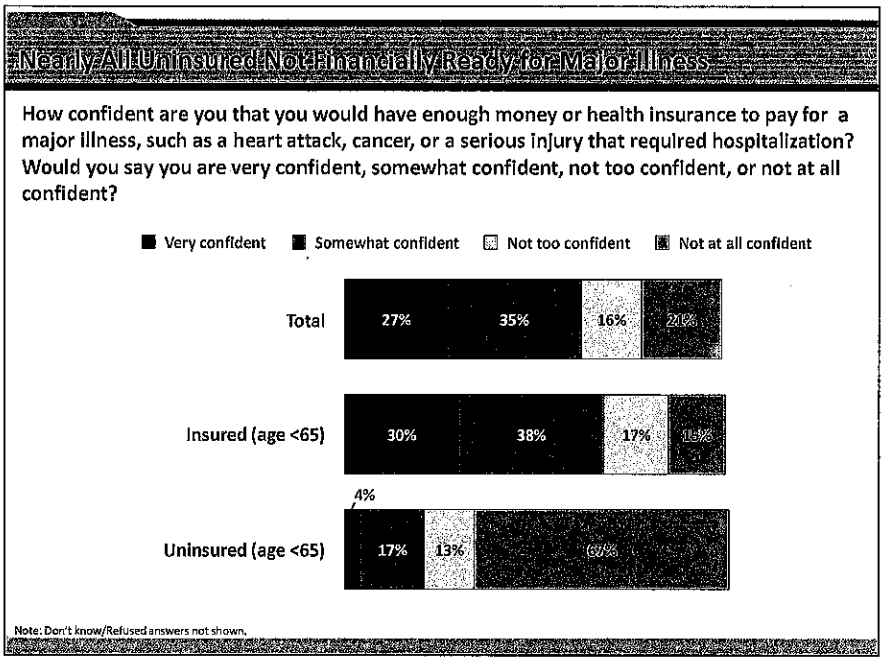


Note: Don't know/Refused answers not shown.

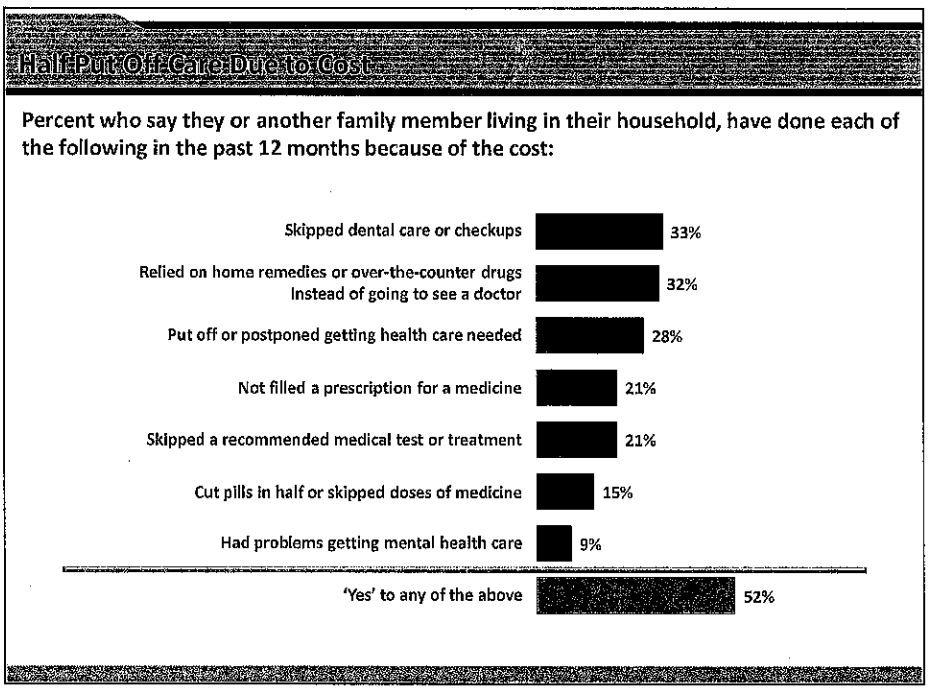
These numbers have been fairly steady since the bill was signed into law.

HEALTH CARE CONCERNS IN DAILY LIFE: MEDICAL COSTS CONTINUE TO BE MAJOR WORRY, PARTICULARLY FOR UNINSURED

The continuing debate over the ACA occasionally seems to overwhelm discussion of the problems that Americans are facing in finding and affording medical care, problems which look much the same in spring 2011 as they did in spring 2010. Overall, three in ten Americans doubt whether they have enough money or health insurance to pay their family's day to day medical costs, as was true last year at this time. Nearly four in ten (37 percent) doubt they could cover the costs in the case of a serious medical emergency, again, as was true last year (when 38 percent said so). These problems are particularly acute among those Americans who do not currently have health coverage. Fully eight in ten of the uninsured lack confidence in their ability to pay for treatment of a sudden, major illness.



These estimations are borne out in the proportion of Americans who report having had problems paying their medical bills over the past year, or skipping needed care in order to save money. Overall, nearly one in four Americans (23 percent) report that their household experienced problems paying medical bills over the past year. This is down slightly from 30 percent in March of last year. Fully half of Americans (52 percent)—and eight in ten among the uninsured—say they or a family member have put off some sort of medical care over the past year for reasons of cost.



This is not to say that there are not broad areas of satisfaction with the American health care system. The March poll found that most Americans are at least somewhat satisfied with the quality of care they receive (87 percent) and with their ability to get the latest medical treatments (79 percent). About two thirds (65 percent) say they are content with their current health care costs. And among those with health insurance coverage, 32 percent rate their plan as 'excellent' and another 58 percent as 'good'.

But worry runs high about getting and keeping health insurance. Seven in ten say they are at least somewhat worried about having to pay more for health care or health coverage, and half worry about not being able to afford needed care. Four in ten among the insured worry about losing that coverage.

In terms of concrete experiences with price increases in the insurance market, roughly half of those with health insurance say their health insurance premiums have been going up lately, and one in five say their premium increases have been a financial burden. Four in ten say their deductibles and co-pays have been going up lately.

THE UNINSURED

Asked why they don't have health coverage, uninsured respondents in the March survey were most likely to say they couldn't afford it (48 percent). Other responses include not being eligible for employer coverage (11 percent), being unemployed (8 percent), their employer not offering it (6 percent), having been turned down due to preexisting conditions (6 percent) and not needing it (5 percent).

Meanwhile, the protracted debate over the needs of the uninsured has not changed Americans' impressions of this group in at least one way: roughly half (52 percent) still believe that people without health insurance mostly live in households where no one is employed. In fact, the opposite is true, most uninsured live in households where someone is working.[2]

[2] See http://www.kff.org/uninsured/upload/7806-03.pdf

Methodology

This *Kaiser Health Tracking Poll* was designed and analyzed by public opinion researchers at the Kaiser Family Foundation led by Mollyann Brodie, Ph.D., including Claudia Deane, Sarah Cho, and Theresa Boston. The survey was conducted March 8 through March 13, 2011, among a nationally representative random sample of 1,202 adults ages 18 and older. Telephone interviews conducted by landline (801) and cell phone (401, including 171 who had no landline telephone) were carried out in English and Spanish by Princeton Survey Research Associates.

The margin of sampling error is plus or minus 3 percentage points. For results based on other subgroups, the margin of sampling error may be higher. Note that sampling error is only one of many potential sources of error in this or any other public opinion poll.

The full question wording, results, charts and a brief on the poll can be viewed online at http://www.kff.org/kaiswerpolls/8166.cfm.

Additional copies of this publication (#8166-F) are available on the Kaiser Family Foundation's website at www.kff.org.

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BadgerCare+ State Report

Line Description	Enrollment[1] Prior to BC+	JAN Enrollment	FEB Enrollment	MAR Enrollment	APR Enrollment	MAY Enrollment	JUN Enrollment	Increased[2] Enrollment
STATE TOTAL								
All Children	309790	459007	459701	460640	465045	465575	464075	154285
Adults/Caretakers	158493	253317	254567	256905	260954	259742	258889	100396
Pregnant Women	15636	18629	18586	18887	19456	19279	19097	3461
Adults-Core Plan	0	44633	42484	40137	37457	35961	34181	34181
Total	483919	775586	775338	776569	782912	780557	776242	292323
Children above 250% FPL	0	5679	5673	5515	5807	5951	6255	6255
Pregnant Women > 300% FPL	0	39	29	26	39	43	45	45
Standard Plan	483919	713807	715693	719628	727880	726775	723726	239807
Benchmark Plan	0	17146	17161	16804	17575	17821	18335	18335
Core Plan	0	44633	42484	40137	37457	35961	34181	34181

1.Enrollment Prior to BC+ counts those individuals eligible for some sort of Medicaid when the conversion to BC+ occurred in mid January 2008.
2.BC+ Increased Enrollment is the difference between the most recent Monthly column and the 'Enrollment Prior to BC+.

Which Children Are Still Uninsured and Why

John Holahan, Lisa Dubay, and Genevieve M. Kenney

SUMMARY

A strong economy and increased enrollment in employer-sponsored health insurance coverage, together with expansions in Medicaid and State Children's Health Insurance Program (SCHIP) led to reductions in uninsurance among low-income American children between 1998 and 2000 (from 15.6% to 13.3%). Nonetheless, 12% (about 9 million) of children remained uninsured. Identifying these children and understanding the factors that contribute to their continued lack of health coverage is key to providing them access to health care.

Using 1994, 1998, and 2000 census data, this article analyzes recent trends in children's health coverage, as well as the groups that make up the population of uninsured children. The picture that emerges from these analyses is one of tremendous variation in coverage for different groups of children, with some groups having a higher risk for lacking health insurance. For example, poor children, Hispanics, adolescents, and children with foreign-born parents (particularly those whose parents are not U.S. citizens) are overrepresented among the uninsured.

The authors conclude that the strong economy and concomitant increase in employer-based coverage played a bigger part in reducing uninsurance rates than did expansions in public programs. They also argue that lack of participation by eligible children rather than inadequate eligibility levels is the key policy issue, and conclude with several recommendations to increase program participation.

John Holahan, Ph.D., is the director of the Health Policy Research Center at the Urban Institute.

Lisa Dubay, Sc.M., is a senior research associate at the Health Policy Research Center at the Urban Institute.

Genevieve M. Kenney, M.A., Ph.D., is a principal research associate at the Health Policy Research Center at the Urban Institute.

CONNECTING KIDS TO COVERAGE:

Continuing the Progress

2010 CHIPRA ANNUAL REPORT

"Indeed, we have a moral obligation to move forward—to close this gap in health coverage among children."

– HHS Secretary Kathleen Sebelius, *Health Affairs*, September 3, 2010

EXECUTIVE SUMMARY

Two years ago, on February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) into law. CHIPRA offers states new financial resources and options to improve health coverage for children through Medicaid and the Children's Health Insurance Program (CHIP). The new law, combined with the financial support provided to state Medicaid programs through the American Recovery and Reinvestment Act of 2009 (ARRA), enabled states to improve their coverage rules and procedures and to insure more eligible children in Medicaid and CHIP, despite ongoing economic challenges.

CHIPRA offered a wide range of policy and programmatic "tools" to enable states to move their coverage efforts forward. In addition to providing an unprecedented amount of federal funding dedicated to outreach and enrollment efforts, the law authorized several new policy options—like Express Lane Eligibility, coverage of pregnant women in CHIP, and removing the 5 year waiting period for lawfully residing immigrant children and pregnant women to enroll in Medicaid and CHIP. All of these tools have proven significant to states' ability to find and enroll uninsured children and keep them enrolled for as long as they are eligible.

This year's enrollment growth stemmed partly from the effects of the continued economic downturn combined with the aggressive steps states and an array of stakeholders have taken to ensure eligible children get the health coverage they need. Secretary Sebelius stressed the importance of such efforts on the first anniversary of CHIPRA when she issued the *Connecting Kids to Coverage* Challenge, calling upon leaders at all levels of government and the private sector to find and enroll the nearly five million uninsured children eligible for Medicaid and CHIP and keep them covered for as long as they qualify. She emphasized that CHIPRA provides the support needed for this work to be successful, by providing the tools to modernize and build consumer-friendly, data-driven enrollment systems, and by supporting outreach and enrollment efforts at the state and community levels.

Connecting Kids to Coverage has generated a significant amount of support, with over 40 national, state and local organizations as well as two Governors officially signing on. Ohio Governor Ted Strickland was the first to accept the Challenge in March 2010 and Governor Ted Kulongoski of Oregon joined the Challenge in August 2010. Since the Secretary formally announced *Connecting Kids to Coverage* in September 2010, more than 150 organizations have registered their support on the **www.challenge.gov** website.

This report reviews the progress achieved during Federal fiscal year (FY) 2010 and highlights the steps being taken at the state, federal, and community levels to bring the nation closer to the widely shared goal of ensuring that all children in America have quality, affordable health coverage.

- **More than 2 million children gained Medicaid or CHIP coverage during federal fiscal year 2010 (October 1, 2009 – September 30, 2010). In total, Medicaid and CHIP served more than 42 million children last year.** This steady increase in enrollment is evidence of the important role that Medicaid and CHIP play for children, especially during economic downturns. The uninsurance rate for children continues to decline at a time when the rate for adults is climbing. The increase in children's enrollment demonstrates that Medicaid and CHIP are serving the purpose for which they were created—providing high quality health coverage for lower-income families.

- **13 states implemented eligibility expansions in 2010 and many others simplified their enrollment and renewal procedures.**[1] Forty-six states and the District of Columbia now cover children with incomes up to 200% of the Federal Poverty Level (FPL) in Medicaid and CHIP, with 24 of those states and the District of Columbia covering children with incomes up to 250 percent of the FPL. Twenty-two states now offer coverage to lawfully residing immigrant children and/or pregnant women, enabling states to receive federal funding for this coverage. (Fifteen states previously provided this coverage with state-only funds, so this option has resulted in new coverage for children and/or pregnant women in 7 states.)

- **CHIPRA Performance Bonuses have encouraged states to adopt and augment simplification measures in Medicaid and CHIP.** Fifteen states qualified for a total of $206 million in Performance Bonuses for FY 2010. This is a significant increase over 2009 when 10 states received bonuses totaling $75 million. The bonuses provide additional federal financial support each year to states that successfully boost enrollment above target levels among previously eligible but uninsured children in Medicaid. To qualify, a state not only has to enroll more children, but must also have implemented program features that are designed to promote enrollment of eligible children. The bonuses were designed to help offset the cost of covering the additional children that are enrolled as a result of these efforts.

- **States are increasing their use of technology to facilitate children's enrollment and retention.** Nearly two-thirds of states (32) have an on-line application that can be submitted electronically; 29 states allow electronic signatures on those applications.[2] Six states have received approval to enroll children through the "Express Lane Eligibility" (ELE) option created by CHIPRA. Thirty-three states are utilizing the CHIPRA data matching process provided by the Social Security Administration to confirm U.S. citizenship for children.

- **Outreach and enrollment grants have advanced coverage and led to public-private partnerships throughout the country to enroll more children.** Sixty-eight grantees across 41 states are working diligently to facilitate children's enrollment in health coverage (See Grantee Spotlights). A second round of $40 million in outreach and enrollment grants will be awarded in the summer of 2011.

- **Improving quality of care continues to be a priority for the federal government and the states—as well as the new Medicaid and CHIP Payment and Access Commission (MACPAC)—which began its work in 2010.** HHS awarded $100 million in quality improvement funding in the form of 10 grants that will span across 18 states to help them implement and evaluate provider performance measures and utilize health information technologies. HHS also finalized the core set of 24 child health quality measures that states may report and is preparing to provide technical assistance on implementing these measures. Finally, MACPAC was formally established and has held four public meetings with its Commissioners, with its first report scheduled for release in March 2011.

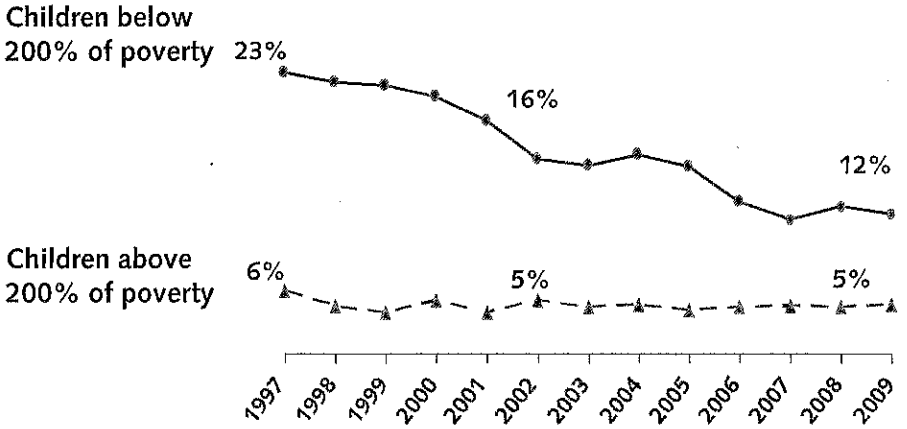
The accomplishments continue to grow, but our collective work is not complete. The U.S. Census Bureau reported that while Medicaid and CHIP are playing the critical role of providing health coverage for children, and states have continued to make steady progress, we continue to face the challenge of reaching the nearly 5 million uninsured children in the United states that are eligible for Medicaid or CHIP but are not enrolled.

INTRODUCTION

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation marked a new era in children's coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children. One of the clear goals of the legislation is to support states in developing efficient and effective strategies to identify, enroll, and retain health coverage for uninsured children who are eligible for Medicaid or CHIP but are not enrolled.

The passage of the American Recovery and Reinvestment Act (ARRA) followed soon after the signing of CHIPRA in early 2009 and has served as a stabilizing force for states by providing additional federal payments for Medicaid coverage during the economic downturn. This additional support has played a significant role in strengthening Medicaid coverage in general, and for children, in particular.

PERCENTAGE OF CHILDREN WITHOUT HEALTH INSURANCE, BY POVERTY LEVEL, 1998–2009



Source: U.S. Census Bureau September 2009.

U.S. Census Bureau data show that although more than 7 million children are uninsured, the uninsurance rate among children continued to decline from 2008 to 2009. This trend is significantly better for children than for adults, whose insurance coverage rate actually declined between 2008 and 2009.[3] On average, 82 percent of eligible children participate in Medicaid and CHIP, a further indication that these programs are fulfilling the role for which they are intended.[4]

Building on efforts that began in 2009, HHS continued to work closely with states, other federal departments and agencies, and a broad array of private and public leaders and organizations interested in children's coverage to implement CHIPRA. This report highlights federal and state activities over the course of the two years since CHIPRA was enacted and notes some of the plans for continued and enhanced activities in 2011.

CHIPRA IN 2010: CONTINUING THE PROGRESS

Eligibility and Enrollment Improvements

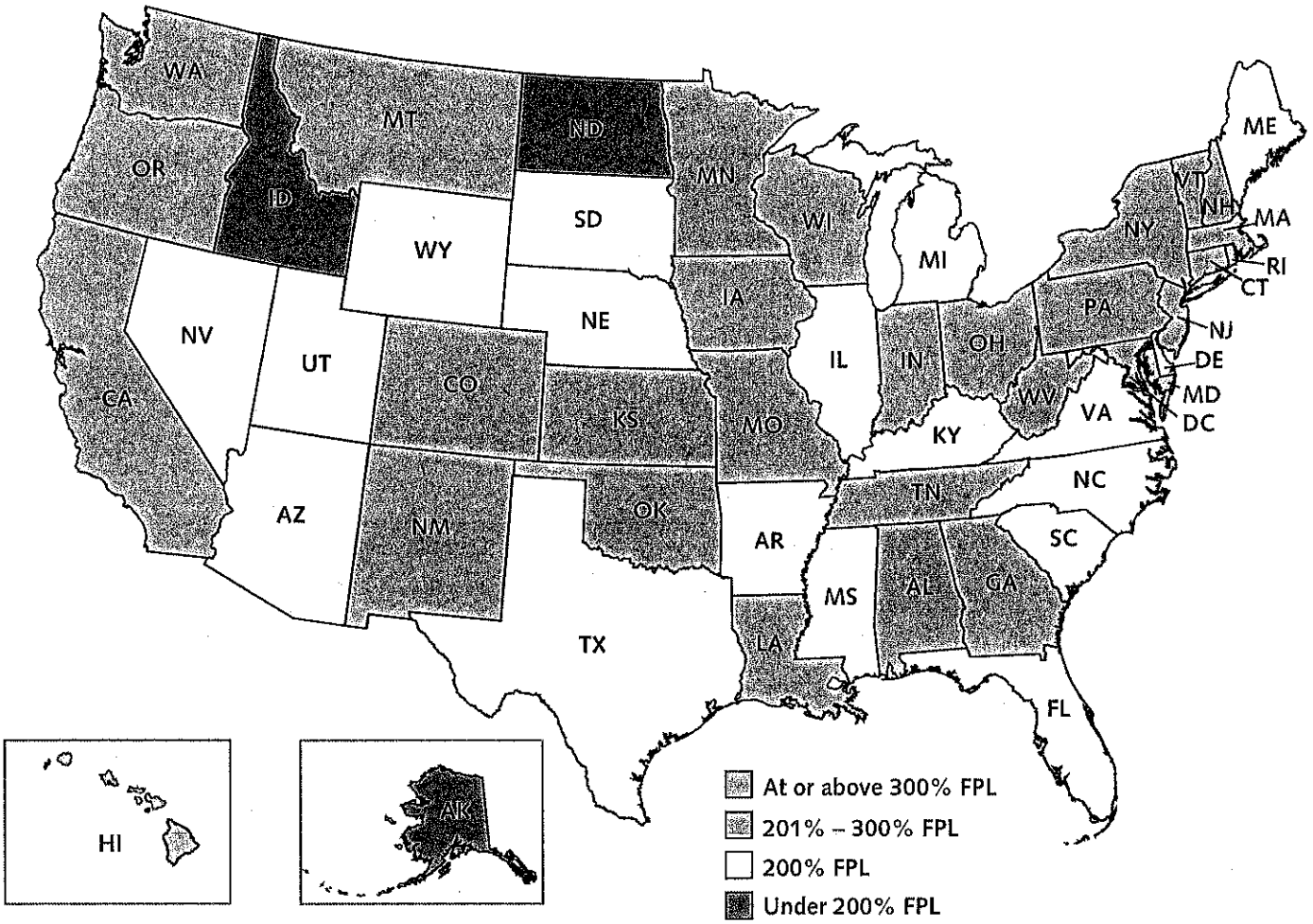
2010 was another busy year for both the federal government and states in terms of children's coverage. The Centers for Medicare & Medicaid Services (CMS) continued to provide policy guidance in the form of letters and question-and-answer documents for state health officials (state Medicaid and CHIP directors as well as public health officials) to assist states in implementing the provisions of CHIPRA. Many of the CHIPRA provisions relate to improving eligibility and enrollment practices and utilizing the new financing opportunities like the increased federal match for translation and interpretation services, among other key policy issues. CMS has released nearly two dozen policy letters and other guidance to states since CHIPRA was enacted.[5]

State progress continued at a surprising pace in 2010, particularly considering the economic downturn. According to an annual survey released in January 2011 by the Kaiser Family Foundation (prepared by the Georgetown Center for Children and Families), nearly all states maintained or made improvements to their Medicaid and CHIP eligibility and enrollment procedures. According to the study, 13 states expanded eligibility and 14 states made improvements in enrollment and renewal procedures in Medicaid and/or CHIP.[6] Arizona was the only state that restricted eligibility in 2010 by putting an enrollment cap in place in its CHIP program.

Enrollment Gains. Children's enrollment in Medicaid and CHIP increased by more than 2 million during federal Fiscal Year (FY) 2010. Together, these critical programs served more than 42 million children over the course of the year (See Appendix A). This time frame also coincided with the period during which enhanced federal Medicaid matching payments to states were made through ARRA. This enrollment increase reflects the greater need for affordable coverage options during the economic downturn. Whereas Medicaid and CHIP enrollment increases correspond with a continued decline in the uninsurance rate for children, the rate of uninsurance among adults increased between 2008 – 2009.[7] This demonstrates the value of the strong programs that states have built over the past 13 years and the new efficiencies and improvements that states have incorporated into their programs.

CHILDREN'S HEALTH INSURANCE PROGRAM

Upper Income Limits as of January 1, 2011



Raising the bar on eligibility. States have clearly committed themselves to the importance of children's coverage and the opportunities provided through the enhanced federal matching rates in CHIP. Forty-six states and the District of Columbia now cover children with incomes up to 200 percent of the Federal Poverty Level (FPL) ($44,700 for a family of four in 2011) in Medicaid and CHIP; with 24 of those states and the District of Columbia covering children with incomes up to 250 percent of the FPL ($55,875 for a family of four in 2011). Twenty-two states now offer coverage to lawfully residing immigrant children and/or pregnant women, enabling states to receive federal funding for this coverage. (15 states previously provided this coverage with state-only funds, so this option has resulted in new coverage for children and/or pregnant women in 7 states.)

Shifting the paradigm toward simplified, family-friendly enrollment and renewal processes. As states and community organizations have gained experience over the 13 years since the Children's Health Insurance Program was created and states began investing in improvements to their Medicaid programs for children, a number of program characteristics that were widely used in the pre-welfare reform era are now virtually obsolete.[8] For example:

- 48 states and the District of Columbia have eliminated the requirement for a face-to-face interview before being enrolled in coverage;
- 49 states and the District have removed the face-to-face interview requirement at renewal; and
- 47 states and the District of Columbia no longer consider a family's assets when determining eligibility for children in Medicaid and CHIP.

As strategies for streamlining enrollment and renewal processes have been proven effective and, in some cases have achieved cost-savings over the years, increasing numbers of states are learning from each other and adopting these best practices. For example:

- 48 states and the District of Columbia have a 12 month eligibility period for Medicaid and CHIP; and 23 states offer 12 months of continuous eligibility—keeping children enrolled for a full year regardless of changes in circumstances;
- 36 of 38 states that operate a separate CHIP program have a single joint application that can be used to apply for and renew both Medicaid and CHIP coverage;
- 32 states now have an on-line application and in 29 states applications can be submitted electronically; and
- 33 states and the District of Columbia are utilizing the data matching process provided by the Social Security Administration to confirm U.S. citizenship for children in Medicaid.

FY 2010 Performance Bonuses. CHIPRA established a new series of Performance Bonuses to provide additional federal funding for qualifying states that have taken specific steps to simplify Medicaid and CHIP enrollment and renewal procedures and have also increased Medicaid enrollment of children above a baseline level. The amount of the award correlates with the percentage increase in enrollment above the baseline—the more children states enroll, the higher the bonus—and states that achieve more than a 10 percent increase in enrollment receive an even larger ("Tier 2") bonus.

CMS awarded $206 million in FY 2010 CHIPRA Performance Bonuses to 15 states across the country. The number of children enrolled in Medicaid in the 15 states receiving Bonuses increased by 875,000 children above the baseline level established for FY 2010. (See Appendix) The enrollment increases in the qualifying states ranged from 6% to 36%, and 10 of the 15 states had enrollment increases of 10% or more, qualifying them for a larger, "Tier 2," award. Alabama received the largest bonus of any state for the second year in a row. This year, Alabama achieved a 36% increase in enrollment over the statutorily-set baseline and earned a $54.9 million award. All states that received a Performance Bonus in 2009 qualified again for 2010; 5 of the states receiving bonuses this year are newly qualifying states. (CMS awarded over $75 million in Performance Bonuses to 10 states in FY 2009.) The increase in Performance Bonuses for 2010 demonstrates states' ongoing commitment to covering children and improving their programs despite fiscal challenges.

FY 2010 PERFORMANCE BONUS AWARDS	
Alabama	$54,965,407
Alaska	$ 4,408,789
Colorado	$13,671,043
Illinois	$14,962,171
Iowa	$ 6,760,901
Kansas	$ 2,578,099
Louisiana	$ 3,555,853
Maryland	$10,549,086
Michigan	$ 9,268,552
New Jersey	$ 8,788,959
New Mexico	$ 8,553,431
Ohio	$12,376,346
Oregon	$15,055,255
Washington	$17,607,725
Wisconsin	$23,076,127
TOTAL:	**$206,157,744**

Performance Bonus Highlights

States received the bonuses by enrolling more currently eligible children, rather than for expanding eligibility levels. Cutting red tape and streamlining procedures enables families to more easily enroll their children in health coverage and keep them covered for as long as they are eligible. The simplification measures that help states qualify for the bonuses remain a part of the programs, and therefore have a long-term positive impact on access to coverage and continuity of care into the future. States have simplified their programs in various ways:

- **Iowa** adopted the presumptive eligibility option and, in March 2010, began implementing the program on a small scale by training 16 state-employed outreach workers to carry out eligibility determinations. In October 2010, the Department of Public Health led a joint training with the Department of Education to qualify school nurses to make determinations, as well. By the end of the year, about 300 children had been enrolled using presumptive eligibility. The state expects this number to increase substantially when it ramps up the program over the next year, in part, by allowing certified workers to use an on-line process.

- **New Mexico** Medicaid pre-populates renewal forms with the most recent income information that has been reported by the child's family. Upon receiving the renewal form in the mail, families have several options for confirming that the information is correct: they can sign the form and mail or fax it back, call a hotline, or email their confirmation. Since the inception of the simplified renewal process in October 2007, most families have used mail or telephone (including an automated voice response system), and about 20 percent have taken advantage of the fax and email options. Information from the Supplemental Nutrition Assistance Program (SNAP) or cash assistance files also can be used to renew the child's Medicaid coverage. According to state officials, prior to the use of the pre-populated renewal form, renewal rates ranged from 40% to 60%—today, about 80% of children are getting their coverage renewed.
- **Wisconsin** families have had the option to apply for children's health coverage using the state's on-line application, ACCESS, since June 2006. Currently, about 45% of applicants choose to apply online. In January 2010, the state simplified its online renewal process so that families that apply on-line can now go into their personal ACCESS account and answer a few simple questions about changes in employment or home address. If no changes have occurred, the family can sign electronically and coverage can be renewed. If changes have occurred, the family can provide the new information so that a renewal decision can be made. Wisconsin is working on additional systems enhancements that will further simplify the renewal process. For example, information from available databases will automatically update the family's case summary prior to renewal so that families will be able to review the most recent data the state has about their situation.
- Cutting red tape also reduces the administrative burden on states. Over the last decade, **Louisiana** has continuously improved its renewal processes and the state now boasts that the shift to a streamlined system is saving $19 million annually and is keeping the vast majority of eligible children from losing coverage. In August 2010, of the 45,809 children who were up for renewal, just 327—less than 1%—were not renewed for procedural reasons, such as not returning paperwork.[9]

Promising Strategies

Efforts to modernize and streamline enrollment and renewal procedures and boost children's enrollment are also actively underway in states that have not yet qualified for a performance bonus:

- Under its CHIPRA outreach grant, the **Oklahoma** Health Care Authority (OHCA) has launched "SoonerEnroll" which enlists outreach partners across the state to assist families with online enrollment. The state has noted significant increases in enrollment since the online system launched in September 2010. Oklahoma has also taken steps to improve retention. The state began making calls to families scheduled to renew their coverage and offered them the opportunity to renew by phone. The process takes five minutes and coverage is renewed immediately, meaning children needing health services experience no unnecessary gaps. In two months, more than 1,800 children and adults renewed their coverage using the telephone process.

- Despite its budget constraints, **Kentucky** has continued to train and encourage community partners to assist families in completing the state's KCHIP application. In addition to enlisting faith-based organizations and child care centers, the state has trained retired teachers and paraprofessionals making home visits to teach parenting skills. State officials also responded when it became apparent that 700 children were losing coverage each month because their premiums were not paid. Recognizing that families are experiencing difficult economic times, Kentucky suspended the $20 per month premium. The state estimates that the suspension of the premium resulted in an increase of 2,257 children in KCHIP during the two months that followed.

Setting the Stage for Further Coverage Improvements

HHS has initiated a multi-pronged strategy designed to ensure further improvements and to reach those children who are eligible for Medicaid or CHIP but unenrolled. In September 2010, the Secretary hosted an event that highlighted a report prepared by the Urban Institute and published in the journal *Health Affairs* that analyzed participation rates among children eligible for Medicaid and CHIP. The study found that, nationally, 82 percent of eligible children were participating in these programs. The state-specific participation rates ranged from 55 percent in Nevada to 95 percent in Massachusetts and the District of Columbia.[10] These data, combined with the Census Bureau findings that two-thirds of the 7.3 million uninsured children in the nation are currently eligible for coverage under Medicaid and CHIP program rules but are not enrolled, underscored the importance of the Secretary's *Connecting Kids to Coverage Challenge*. The Challenge is the main component of the CHIPRA-funded national outreach campaign.

GRANTEE SPOTLIGHT

Michigan Primary Care Association Uses Tech-Savvy Approach to Outreach and Enrollment

The Michigan Primary Care Association (MPCA) is using a variety of technological tools to expand the outreach and enrollment capacity of its 13 Americorp members who are working as "community navigators" throughout the state. Through its partnership with Michigan Association of United Ways, MPCA is connected to 2-1-1, the human services resource and referral system. When a 2-1-1 caller asks for health coverage, the call is transferred directly to a community navigator. Navigators, equipped with lap top computers, can use Michigan's on-line application to help families faster and more accurately, give on-the-spot feedback about eligibility, and link newly enrolled children to a medical home.

Google Maps and Voice technologies have enhanced the services MPCA offers. Google Maps is used to plot the locations of health clinics throughout the state, helping refer families to a nearby source of care. Google Voice allows MPCA to advertise one phone number that rings on both the land-line and cell phone of the navigator closest to the caller. This saves the expense of running an 800-number and ensures access to navigators when they are traveling—which is most of the time. Finally, an on-line case management system has enabled the navigators to go paperless, but maintain access to case files 24/7. A secure database with all case information allows enrollment to proceed and follow-ups to be scheduled. The system is HIPPA compliant and costs only about $100 per month per user. In its first year, MPCA's "community navigator" project has enrolled over 600 eligible children in Medicaid and CHIP. For more information, contact Phillip Bergquist, Michigan Primary Care Association, pbergquist@mpca.net

The other elements of the broader CHIPRA outreach and enrollment campaign involve use of the $100 million in federal funding provided by CHIPRA together with an additional $40 million provided by the Affordable Care Act to be dedicated to promoting outreach and enrollment strategies focused on children. CHIPRA allocated $80 million for grants to community-based organizations, states, schools, faith-based organizations and health care providers, and $10 million for grants to health care providers and Indian Tribes that serve the Native American community to find and enroll eligible children. The Affordable Care Act divided up the additional $40 million proportionately, providing an additional $4 million for the national campaign, $4 million for tribal providers, and the remaining $32 million to be devoted to grants. These funds are collectively available through FY 2015.

Outreach Grants—Closing the Gaps. As noted above, CHIPRA made a total of $80 million in outreach grant funds available between FY 2009 and FY 2013. CMS awarded the first $40 million in grant awards to 68 grantees across 42 states and the District of Columbia in September 2009. In February 2011, HHS is making available the remaining $40 million in grant funds authorized by CHIPRA. This "Cycle II" funding opportunity is directed to projects that focus on closing the gaps in coverage among some of the nation's most vulnerable populations of children. The Urban Institute study released in October 2010 found that nationally, there is an 82 percent participation rate among eligible children in Medicaid and CHIP. Another study found that, in addition to geographic disparities, certain populations of children, such as adolescents and Latinos, are more likely to be uninsured.[11] This may be due to a variety of barriers, including but not limited to language, literacy, and other cultural factors.

As such, the CHIPRA "Cycle II" grant solicitation requests that applicants select one Focus Area for the proposed grant project that will target efforts around a specific strategy or population.

- Using Technology to Facilitate Enrollment and Renewal
- Focusing on Retention: Keeping Eligible Children Covered for as Long as They Qualify
- Engaging Schools in Outreach, Enrollment and Renewal Activities
- Reaching Out to Particular Groups of Children that are More Likely to Experiences Gaps in Coverage
- Ensuring Eligible Teens Are Enrolled and Stay Covered

The grant applications are due to be submitted on April 18, 2011 and awards will be announced in late July 2011.

Tribal Outreach Grants. In April 2010, CMS awarded nearly $10 million in grant funds to 41 Tribal health providers, Indian Health Service providers, and other health providers in urban areas across 19 states. These grants are available for tribal outreach and enrollment efforts for a five year period.

CONNECTING KIDS TO COVERAGE: STEPPING UP TO THE CHALLENGE		
American Academy of Pediatrics	National Covering Kids and Families Network	United Way of Santa Cruz Co. (CA)
Center on Budget and Policy Priorities	New England Alliance for Children's Health-Community Catalyst	United Way of Silicon Valley (CA)
Children NOW (California)	Northwest Georgia Healthcare Partnership	United Way of Ventura Co. (CA)
Children's Defense Fund (and CDF affiliates in CA, LA, MN, MS, NY, OH, and TX)	PICO	United way of Connecticut
City of Tampa, Florida	Philadelphia Eagles Youth Partnership	United Way of Greater Cincinnati (OH, KY)
Families USA	The Robert wood Johnson Foundation	United Way of Greater Toledo (OH)
First Focus	SingleStop USA	United Way of Greater Williamsburg (VA)
March of Dimes	Tarrant County CHIP Coalition (Fort Worth, TX)	United Way of Kentucky
Michigan Primary Care Association	United Way Worldwide and their affiliates:	United Way of Madison County (IN)
MomsRising	Aloha United Way	United Way of the Plains
National Academy for State Health Policy	United Ways of California:	United Ways of Tennessee
National Association of Children's Hospitals and Related Institutions	United Way of Corono-Norco (CA)	Voices for America's Children
National Association of School Nurses	United Way of Kern Co. (CA)	
National Council of La Raza		

Connecting Kids to Coverage. In September 2010, the Secretary refocused attention on the *Connecting Kids to Coverage* challenge she issued on the first anniversary of CHIPRA, in which she called upon leaders in government, community and faith-based organizations, health care providers, schools, and others to identify and enroll all children who are eligible for Medicaid and CHIP within the next five years. As a result of the excitement that the Challenge has generated, more than 40 organizations have formally "stepped up" and more than 150 organizations and individuals have registered their support at **www.challenge.gov/hhs54**, a government-wide website that is tracking progress on a wide range of challenges. (See text box)

The Coaches Campaign: Get Covered, Get in the Game. During the summer of 2010, CMS launched the *Get Covered, Get in the Game* Campaign to enlist coaches of school and community youth sports teams in seven pilot states (Colorado, Florida, Maryland, New York, Ohio, Oregon, and Wisconsin) to help meet the *Connecting Kids to Coverage* Challenge. To participate in sports programs, children are usually required to have a physical exam, which can be difficult to get without health insurance. Families of uninsured children are often reluctant to let their uninsured children play, for fear they won't be able to pay the bills if the child gets hurt. *Get Covered, Get in the Game* gives schools and communities the tools they need to link youth athletes and all eligible children and teens to Medicaid and CHIP. CMS provided customized outreach materials and signage for school sports events, and helped pilot states organize events, build partnerships with youth sports organizations and generate media coverage.[12]

InsureKidsNow.gov. The *InsureKidsNow* Web site (**www.insurekidsnow.gov**) has been updated and further enhanced to include additional information for consumers interested in learning about the Medicaid and CHIP programs and providers in their states. The Web site includes direct links to individual state CHIP and/or Medicaid sites where families can access the program application or even apply on-line. It also includes links to information about how to find health care and dental providers. InsureKidsNow now serves the dual purpose of providing policy and program information for professionals and states interested in federal activities around children's coverage broadly and CHIPRA implementation specifically. This site will continue to be augmented and regularly updated and will serve as a resource for research and policy analysis conducted by government and other organizations about the effectiveness of these programs.

Thriving Public-Private Partnerships. More than a decade of successful philanthropic initiatives like the Covering Kids and Families initiative that started in the late 1990s, the Maximizing Enrollment for Kids project, the Finish Line project and the initiatives sponsored by United Way Worldwide demonstrate how much can be achieved when communities are united behind a common goal.

The Max Enroll project began in 2008 and is supported by the Robert Wood Johnson Foundation. The program provides targeted funding to eight states to help them improve their Medicaid and CHIP systems, policies, and procedures and assisting them with implementation strategies to cover more eligible children.[13] The Finish Line project is an initiative of the David and Lucile Packard Foundation that has, since 2006, worked in and across states to build efforts toward achieving the goal of providing health coverage to all children. The initiative supports policy efforts in select states to advance coverage for children; and supports the broader movement to cover all children through its support for policy advocacy organizations.[14]

A key example of the success of these efforts can be taken from the CHIPRA Performance Bonuses —11 of the 15 states that are involved in Max Enroll and/or the Finish Line project received a Performance Bonus in FY 2010.

United Way Worldwide was one of the first national organizations to step up to the *Connecting Kids to Coverage* Challenge in the fall of 2010, dovetailing its efforts to promote health and wellness among children. Several longstanding United Way initiatives present rich opportunities for finding and enrolling eligible children. For example, United Way's successful 2-1-1 human services helpline is a great way to link callers to health coverage for their children and even to help them enroll over the phone. Many United Ways sponsor Volunteer Income Tax Assistance (VITA) sites, an IRS program that provides low-income working families free help preparing their tax returns. Getting information and assistance enrolling in Medicaid and CHIP will benefit many of the families at the VITA sites who have children likely to qualify. United Way Worldwide is actively encouraging its local affiliates to step up to the Challenge in their own communities and, since September 2010, state and local United Ways in California, Kentucky, Ohio, Tennessee, Texas and Washington have committed to Connecting Kids to Coverage.

GRANTEE SPOTLIGHT

Durango Student is off and Running with Health Coverage

Whenever a family is concerned about how to pay for a child's health care, finding out if Medicaid or CHIP can help is a key first step. And thanks to a CHIPRA outreach grant awarded to the Colorado Association for School-Based Health Care (CASBHC), a Durango child got coverage and care right away.

One afternoon, 13-year-old Jackie (not her real name) showed up at her school's health center, eager to get the required sports physical so she could run track. As the nurse was going through Jackie's medical history, the first red flag went up. Jackie could not be cleared to play without further evaluation because her mother's heart problems put her at risk. The second red flag was raised when Jackie's Mom said she was uninsured. How would she get the tests, let alone specialty care if she needed it? Because Colorado has a presumptive eligibility process, the school's outreach worker was able to enroll Jackie in coverage on the spot. Just two days later, Jackie had been to a cardiologist who, after further exams, gave Jackie the green light for track. Now Jackie's off and running—with track meets ahead of her and the protection of health insurance behind her!

Jackie is just one of more than 1,000 children who were enrolled in Medicaid or CHIP, or were able to renew their coverage, in the first year of the CASBHC program. School clinics in five pilot sites participate, using data from the National School Lunch Program and school-level data on insurance status to identify children who might qualify for coverage. For more information about Colorado's efforts, contact Stacey Moody, Colorado Association for School-Based Health Care, moody@casbhc.org.

Assuring Access to Quality Care for Children

Core Quality Measures. Relying on a collaboration between the Agency for Health Care Research and Quality (AHRQ), CMS, and a National Advisory Committee made up of experts in quality and performance measurement, HHS developed a proposed core set of 24 child health quality measures that states, health insurance issuers, and managed care entities may adopt to monitor and assess access to care and health outcomes among children served by Medicaid and CHIP. As a follow-up to identifying the initial core set of children's health care quality measures, CHIPRA required the establishment of a Pediatric Quality Measures Program (PQMP) of grants and contracts. Results of the PQMP are to be used to develop future enhanced and improved core sets of measures and provide for development of new measures as needed. To meet these requirements, AHRQ has issued a funding announcement for a Coordinating and Technical Assistance Center and also for a CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence funding opportunity. The proposed priorities for the PQMP have been made available for public comment in the Federal Register.[15]

Quality Demonstrations. CHIPRA provided $100 million in federal funding for a series of demonstration projects designed to establish and evaluate a national quality system for children's health care. In February 2010, the Secretary awarded 10 grants to improve health care quality and delivery systems for children enrolled in Medicaid and CHIP. The awardees represent both single-state projects and multi-state collaborations. Grantees working in multi-state partnerships will share award funds with those partners—to be distributed among 18 states in total.[16] The grants, which are available over a five year period, will help states implement and evaluate provider performance measures and utilize health information technologies such as pediatric electronic health records and other quality improvement initiatives.

While this first year is largely the planning phase of the grants, states are undertaking promising interventions related to behavioral health, care coordination, and oral health services for children. Maryland (with Georgia and Wyoming), North Carolina, and Pennsylvania plan to enhance children's access to behavioral health services by testing different approaches to paying for and coordinating physical and behavioral health services. Maine (with Vermont), Illinois (Florida's partner), and Massachusetts have created opportunities to improve care coordination for children by using electronic health records and offering incentives to ensure referral information is shared among providers. Other grantees including Florida and Oregon are building better connections between their medical homes and dental care services provided to their pediatric patients. This coming year holds even more promise as grantees begin moving from planning into implementation of clinical interventions, collecting the CHIPRA initial core measures, and testing pediatric health record format.

Improving Access to Dental Care. Improving access to dental care for children is a high priority for HHS, for the Medicaid and CHIP programs and an area of emphasis in CHIPRA. The legislation made dental services a mandatory benefit for separate CHIP programs and required states to provide a listing of all participating Medicaid and CHIP dental providers through the *InsureKidsNow* website. The purpose of this requirement was to give families the opportunity to more easily identify participating dental providers in their community. In addition, the Center for Medicaid, CHIP and Survey & Certification within CMS has begun a major initiative to work with states to improve access to preventive dental care. In April 2010, CMS announced two specific goals for improvement in this area:

- To increase the rate of children ages 1–20 enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over a five-year period; and
- To increase the rate of children ages 6–9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period.

CMS held national stakeholders meetings with states in October and November 2010 and with provider, policy and advocacy organizations in January 2011 and has shared a draft Dental Strategy with a wide range of stakeholders for informal comment before finalizing the plan which will be posted on the *InsureKidsNow* website as well as the CMS website.

GRANTEE SPOTLIGHT

Massachusetts: Enrollment Help "On Call" for a Day

In September 2010, Health Care for All, a Massachusetts health care advocacy organization and CHIPRA grantee conducted its first one-day Phone-A-Thon, part of the group's campaign, "Got Coverage? Health Coverage for Children and Teens." From 9 am to 9 pm, 15 staff and volunteers responded to calls requesting health coverage information and helped to enroll children over the phone. In one day over 400 calls were answered and 300 children were enrolled in health coverage. (The HelpLine typically enrolls 150 to 200 children in the course of **three months**.)

In preparation for the Phone-A-Thon, Health Care for All conducted intensive, targeted outreach for three weeks before the event. Postcards and posters were distributed to nearly 400 organizations, with a focus on Spanish- and Portuguese-speaking communities, which are most likely to include higher numbers of eligible, uninsured children. The group made presentations at individual churches and with faith-based networks and appeared on more than 30 Spanish, and Portuguese, language radio shows. A commercial featuring the Phone-A-Thon was developed and aired on two Brazilian TV channels, as well as on Univision and Channel 7, which covered the Phone-A-Thon on the news. Massachusetts now boasts a 1% uninsured rate for children, the lowest in the country. Yet groups like Health Care for All continue to execute innovative new strategies to find and enroll children who still may be missing out on health coverage. For more information, contact Dayanne Leal, Health Care for All, leal@hcfama.org.

CONCLUSION: FORGING AHEAD, BUILDING ON SUCCESS

During the two years since CHIPRA was enacted, millions of uninsured children have gained coverage in Medicaid and CHIP and, as a direct result, the portion of children in America are going without health insurance continues to decline despite job losses and the difficult economic circumstances facing families. While participation rates in Medicaid and CHIP—averaging 82% nationally[17]—are higher than the levels achieved in most other means-tested programs, boosting participation remains the key step in closing the coverage gap for children.

Further improvements in outreach, enrollment, and retention are needed if states and communities are to be successful in ultimately covering the nearly 5 million uninsured children who are already eligible for Medicaid or CHIP coverage. State efforts to improve these programs and corresponding data shows that it is possible to ensure that eligible children are enrolled, but these efforts will not be sustainable unless all stakeholders continue to come together, pool resources, and share best practices over the next three years as we make the transition to 2014 and the seamless system of health coverage that lies ahead. These partnerships will be the key to our success in creating a culture of coverage where all Americans, adults and children alike, are enrolled and receive the health care they need.

APPENDICES

1. FY 2010 Children's Enrollment in Medicaid and CHIP by State
2. Children's Health Coverage: 2011 Upper Income Limits
3. FY 2010 CHIPRA Performance Bonus Awards Chart

REFERENCES:

[1] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[2] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[3] Urban Institute analysis of 2008 and 2009 American Community Survey data. Between 2008 and 2009, uninsured rates improved for children relative to adults 12 of the 16 states that were sampled—Alabama, California, Colorado, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, and Virginia.

[4] J Genevieve M. Kenney, Victoria Lynch, Allison Cook and Samantha Phong. Who And Where Are The Children Yet To Enroll in Medicaid And The Children's Health insurance Program? Health Affairs, 29, no. 10 (2010): 1920-1929. Available at http://www.urban.org/health_policy/url.cfm?ID=1001449). For state-specific participation rates for 2008 see http://insurekidsnow.gov/facts/index.html

[5] For a complete listing of CMS policy guidance on CHIPRA see http://www.insurekidsnow.gov/professionals/federal/index.html

[6] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[7] Urban Institute analysis of 2008 and 2009 American Community Survey data. Between 2008 and 2009, uninsured rates improved for children relative to adults 12 of the 16 states that were sampled—Alabama, California, Colorado, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, and Virginia.

[8] The following examples are based on the Kaiser Family Foundation's annual survey for 2010. M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, available at http://www.kff.org/medicaid/8130.cfm

[9] Ruth Kennedy, Deputy Medicaid Director, Louisiana Department of Health and Hospitals, presentation to CMS during a visit to the Louisiana Medicaid office, New Orleans, LA, October 2010.

[10] J Genevieve M. Kenney, Victoria Lynch, Allison Cook and Samantha Phong. Who And Where Are The Children Yet To Enroll in Medicaid And The Children's Health insurance Program? Health Affairs, 29, no. 10 (2010): 1920-1929. Available at http://www.urban.org/health_policy/url.cfm?ID=1001449). For state-specific participation rates for 2008 see http://insurekidsnow.gov/facts/index.html

[11] Kaiser Commission on the Uninsured and the Urban Institute in December 2009, available at http://www.urban.org/uploadedpdf/411981_Progress_Enrolling_Children_11_10.pdf

[12] Get Covered, Get in the Game outreach materials can be found at http://www.insurekidsnow.gov/professionals/campaigns/getcovered/index.html

[13] The National Academy for State Health Policy directs the Max Enroll project. The eight Max Enroll states are Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. For more information about Max Enroll see http://www.maxenroll.org/

[14] The Georgetown University Center for Children and Families (CCF) provides technical assistance and guidance to the Finish Line project. The organizations receiving Finish Line funding are: Arkansas Advocates for Children and Families, California 100% Campaign (Children Now, Children's Defense Fund-CA and The Children's Partnership), Colorado Children's Campaign, the Iowa Child and Family Policy Center, Voices for Ohio's Children, Rhode Island KIDS COUNT, Children's Defense Fund of Texas, Washington Children's Alliance. For more information see http://ccf.georgetown.edu/index/finish-line

[15] A *Federal Register* notice seeking public input on priorities for the PQMP has been posted at http://edocket.access.gpo.gov/2010/2010-30262.htm

[16] The complete list of states receiving grant funds is available at http://www.hhs.gov/news/press/2010pres/02/20100222a.html. A summary of the grants can be accessed at http://www.insurekidsnow.gov/professionals/CHIPRA/grants_summary.html.

[17] Genevieve M. Kenney, Victoria Lynch, Allison Cook and Samantha Phong, "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" Health Affairs, October 2010, available at http://content.healthaffairs.org/content/29/10/1920.abstract. See http://www.insurekidsnow.gov/facts/index.html for state-by-state information.

APPENDIX 1:
FY 2010 Number of Children Ever Enrolled in Medicaid and CHIP

STATE AND PROGRAM TYPE	NUMBER OF CHILDREN EVER ENROLLED BY PROGRAM TYPE						PERCENT GROWTH OVER 2009
	CHIP		Medicaid		CHIP and Medicaid		
	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	
Alabama (S)	110,158	137,545	519,672	846,766	629,830	984,311	56.3
Alaska (M)	11,655	12,473	75,040	78,034	86,695	90,507	4.4
Arizona (S)	66,275	39,589	888,175	951,092	954,450	990,681	3.8
Arkansas (C)	101,312	100,770	408,574	404,307	509,886	505,077	-0.9
California (C)	1,748,135	1,731,605	4,333,458	4,457,183	6,081,593	6,188,788	1.8
Colorado (S)	102,395	106,643	418,966	452,636	521,361	559,279	7.3
Connecticut (S)	21,874	21,033	264,551	282,100	286,425	303,133	5.8
Delaware (C)	12,599	12,852	83,521	83,857	96,120	96,709	0.6
District of Columbia (M)	9,260	8,100	81,576	89,402	90,836	97,502	7.3
Florida (C)	417,414	403,349	1,751,232	1,915,980	2,168,646	2,319,329	6.9
Georgia (S)	254,365	248,268	1,047,790	1,098,937	1,302,155	1,347,205	3.5
Hawaii (M)	24,691	27,256	99,235	114,736	123,926	141,992	14.6
Idaho (C)	44,319	42,208	149,682	169,216	194,001	211,424	9.0
Illinois (C)	376,618	329,104	1,951,325	2,080,461	2,327,943	2,409,565	3.5
Indiana (C)	142,665	141,497	660,617	670,047	803,282	811,544	1.0
Iowa (C)	52,608	63,985	273,031	293,103	325,639	357,088	9.7
Kansas (S)	48,090	56,384	204,258	201,038	252,348	257,422	2.0
Kentucky (C)	73,143	79,380	455,384	490,486	528,527	569,866	7.8
Louisiana (C)	170,082	157,012	636,440	662,861	806,522	819,873	1.7
Maine (C)	31,349	32,994	139,380	142,931	170,729	175,925	3.0
Maryland (M)	124,622	118,944	401,412	437,840	526,034	556,784	5.8
Massachusetts (C)	143,044	142,279	483,167	488,191	626,211	630,470	0.7
Michigan (C)	72,035	69,796	1,158,502	1,188,936	1,230,537	1,258,732	2.3
Minnesota (C)	5,470	5,164	482,792	482,352	488,262	487,516	-0.2
Mississippi (S)	86,839	95,556	589,784	618,332	676,623	713,888	5.5
Missouri (C)	103,709	86,261	568,309	548,085	672,018	634,346	-5.6
Montana+ (C)	25,749	25,231	56,612	70,175	82,361	95,406	15.8
Nebraska (M)	48,139	47,922	162,738	164,435	210,877	212,357	0.7
Nevada (S)	33,981	31,554	176,845	212,426	210,826	243,980	15.7
New Hampshire (C)	13,197	10,630	89,019	94,531	102,216	105,161	2.9
New Jersey (C)	167,009	187,211	577,553	617,895	744,562	805,106	8.1
New Mexico (M)	11,169	9,654	356,332	372,989	367,501	382,643	4.1
New York (S)	532,635	539,614	2,001,995	2,080,412	2,534,630	2,620,026	3.4
North Carolina (C)	259,652	253,892	1,035,284	1,243,785	1,294,936	1,497,677	15.7
North Dakota (C)	6,983	7,192	39,256	43,568	46,239	50,760	9.8
Ohio (M)	265,680	253,711	1,100,316	1,150,356	1,365,996	1,404,067	2.8
Oklahoma (C)	123,681	122,874	415,414	477,181	539,095	600,055	11.3
Oregon (S)	51,835	64,727	253,823	289,123	305,658	353,850	15.8
Pennsylvania (S)	264,847	273,221	1,196,395	1,228,017	1,461,242	1,501,238	2.7
Rhode Island (C)	19,596	23,253	106,906	108,321	126,502	131,574	4.0
South Carolina (C)	85,046	73,438	508,374	485,322	593,420	558,760	-5.8
South Dakota (C)	15,249	15,872	45,296	46,994	60,545	62,866	3.8
Tennessee (C)	83,333	81,341	759,080	781,567	842,413	862,908	2.4
Texas (S)	869,867	928,483	2,916,283	3,279,846	3,786,150	4,208,329	11.2
Utah (S)	59,806	62,071	219,464	237,125	279,270	299,196	7.1
Vermont (S)	7,092	7,026	72,180	72,891	79,272	79,917	0.8
Virginia (C)	167,589	173,515	562,093	603,166	729,682	776,681	6.4
Washington (S)	27,415	35,894	730,194	705,950	757,609	741,844	-2.1
West Virginia (S)	38,200	37,539	240,813	247,953	279,013	285,492	2.3
Wisconsin (C)	153,917	161,469	489,706	520,003	643,623	681,472	5.9
Wyoming (S)	8,871	8,342	54,409	58,277	63,280	66,619	5.3
TOTALS:	**7,695,264**	**7,705,723**	**32,292,253**	**34,441,217**	**39,987,517**	**42,146,940**	**5.4**

(S) – Separate child health programs (M) – Medicaid expansion programs (C) – Combination programs (NR) – Not Reported

Data Source: SCHIP Statistical Enrollment Data System (SEDS) forms CMS-21E, CMS-64.21E, and CMS-21waiver (1/10/11)
Montana changed to (C) 10/1/09

APPENDIX 2: Children's Health Coverage: 2011 Upper Income Limits

STATE	% FPL	ANNUAL INCOME LIMITS
Alabama	300%	$67,050
Alaska	175%	$48,897
Arizona	200%	$44,700
Arkansas	200%	$44,700
California	300%	$67,050
Colorado	250%	$55,875
Connecticut	300%	$67,050
Delaware	200%	$44,700
District of Columbia	300%	$67,050
Florida	200%	$44,700
Georgia	235%	$52,523
Hawaii*	300%	$77,130
Idaho	185%	$41,347
Illinois	200%	$44,700
Indiana	300%	$67,050
Iowa	300%	$67,050
Kansas	241%	$53,864
Kentucky	200%	$44,700
Louisiana	250%	$55,875
Maine	200%	$44,700
Maryland	300%	$67,050
Massachusetts	300%	$67,050
Michigan	200%	$44,700
Minnesota	275%	$61,462
Mississippi	200%	$44,700
Missouri	300%	$67,050
Montana	250%	$55,875
Nebraska	200%	$44,700
Nevada	200%	$44,700
New Hampshire	300%	$67,050
New Jersey	350%	$78,225
New Mexico	235%	$52,523
North Dakota	160%	$35,760
Ohio	300%	$67,050
Oklahoma	300%	$67,050
Oregon	300%	$67,050
Pennsylvania	300%	$67,050
Rhode Island	250%	$55,875
South Carolina	200%	$44,700
South Dakota	200%	$44,700
Tennessee	250%	$55,875
Texas	200%	$44,700
Utah	200%	$44,700
Vermont	300%	$67,050
Virginia	200%	$44,700
Washington	300%	$67,050
West Virginia	250%	$55,875
Wisconsin	300%	$67,050
Wyoming	200%	$44,700

All figures based on the 2011 Federal Poverty Level (FPL) for a family of four ($22,350).

Note: Alaska's FPL for a family of 4 is $27,940 and Hawaii's FPL for a family of 4 is $25,710.

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APPENDIX 3: FY 2010 CHIPRA Performance Bonus Awards Chart

State	Program Features								Enrollment Target*			FY 2009 Bonus Payment Amount (if applicable)	FY 2010 Bonus Payment Amount
	Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-Person Interview	Same App and Renewal Form	Auto/ Admin. Renewal	PE	Express Lane	Premium Assistance Subsidies	Additional enrollment above 2010 baseline (#)	% increase in enrollment over 2010 baseline	Tier 2 enrollment reached?		
AL	X	X	X	X	X				132,999	36%	Yes	$39,752,546	$54,965,407
AK	X	X	X	X	X				7,553	12%	Yes	$707,253	$4,408,789
CO		X	X	X		X		X	37,359	14%	Yes	n/a	$13,671,043
IL	X	X	X	X	X	X			106,047	8%	No	$9,460,312	$14,962,171
IA	X	X	X	X		X			27,729	14%	Yes	n/a	$6,760,901
KS	X	X	X	X		X			14,809	9%	No	$1,220,479	$2,578,099
LA	X	X	X	X	X				36,857	6%	No	$1,548,387	$3,555,853
MD		X	X	X	X		X		43,152	10%	Yes	n/a	$10,549,086
MI	X	X	X	X		X			93,113	10%	Yes	$4,721,855	$9,268,552
NJ		X	X	X	X	X	X		44,387	9%	No	$3,131,195	$8,788,959
NM	X	X	X	X	X	X			37,094	13%	Yes	$5,365,601	$8,533,431
OH	X	X	X	X		X			92,503	9%	No	n/a	$12,376,346
OR	X	X	X	X	X				40,373	20%	Yes	$1,603,336	$15,055,255
WA	X	X	X	X				X	74,815	14%	Yes	$7,861,411	$17,607,725
WI		X	X	X	X			X	85,557	23%	Yes	n/a	$23,076,127
												Total Bonus Payments for FY 2010	**$206,157,744**

States shaded blue had at least 5 of 8 program features in place for FY 2009.

****The enrollment target is a baseline level of Medicaid child enrollment that is calculated based on a formula that accounts for population growth and for increases in enrollment during an economic recession. States that exceed their enrollment target have increased enrollment above what would have been expected without expanded outreach efforts.***

States that exceed their enrollment target by more than 10% qualify for a "Tier 2" performance bonus payment, in which additional enrollment is rewarded at a higher rate.

InsureKidsNow.gov

For more information about connecting eligible children to health coverage, visit **www.insurekidsnow.gov**

Wisconsin: Single Year Uninsured Estimates (ACS)

Compare Wisconsin to: United States

Single Year Uninsured Estimates (ACS)

Uninsured Estimates of the Total Population, American Community Survey (ACS), 2009 Compare

	WI #	WI %	US #	US %
Insured	5,045,182	90.6%	255,807,333	84.9%
Uninsured	520,873	9.4%	45,664,741	15.1%
Total	5,566,055	100.0%	301,472,074	100.0%

(show/hide notes)

Uninsured Estimates of Children 0-17, American Community Survey (ACS), 2009 Compare

	WI #	WI %	US #	US %
Insured	1,237,430	95.0%	67,989,330	91.4%
Uninsured	65,407	5.0%	6,369,023	8.6%
Total	1,302,837	100.0%	74,358,353	100.0%

(show/hide notes)

Uninsured Estimates of Adults 18-64, American Community Survey (ACS), 2009 Compare

	WI #	WI %	US #	US %
Insured	3,084,582	87.2%	150,243,840	79.4%
Uninsured	452,815	12.8%	38,937,384	20.6%
Total	3,537,397	100.0%	189,181,224	100.0%

(show/hide notes)

Uninsured Estimates of Women, American Community Survey (ACS), 2009 Compare

	WI #	WI %	US #	US %
Insured	2,600,612	92.5%	133,227,790	86.6%
Uninsured	211,746	7.5%	20,699,006	13.4%
Total	2,812,358	100.0%	153,926,796	100.0%

(show/hide notes)

Uninsured Estimates of Men, American Community Survey (ACS), 2009 Compare

	WI #	WI %	US #	US %
Insured	2,444,570	88.8%	122,579,543	83.1%
Uninsured	309,127	11.2%	24,965,735	16.9%
Total	2,753,697	100.0%	147,545,278	100.0%

(show/hide notes)

New Federalism
National Survey of America's Families
An Urban Institute Program to Assess Changing Social Policies
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SCHIP
State Children's Health Insurance Program Evaluation

How Familiar Are Low-Income Parents with Medicaid and SCHIP?

Genevieve Kenney, Jennifer Haley, and Lisa Dubay

Almost all low-income parents are aware of at least one publicly subsidized insurance program for children.

A greater number of low-income children are now eligible for public health insurance coverage than at any time in the past. With expansions in Medicaid eligibility for children that began in the late 1980s and the more recent expansions in coverage under the new State Children's Health Insurance Program (SCHIP), more than 80 percent of all uninsured children are now eligible for publicly subsidized coverage (Dubay and Haley forthcoming). A major challenge facing Medicaid and SCHIP programs today is how to reach and enroll the millions of children who are eligible but who remain uninsured (Mills 2000). Relatively little is known about why these uninsured children are not covered. Knowledge gaps, confusion about program rules, and problems associated with the enrollment process appear to be contributing factors (Kaiser Commission 2000, Stuber et al. 2000).

Enacted in 1997, SCHIP gave states the opportunity to expand coverage to children with incomes up to 200 percent of the federal poverty level (FPL) or higher, using Medicaid programs or state-specific programs that are separate from Medicaid. By 2000, all states and the District of Columbia had approval for expansions under SCHIP, with 18 states expanding coverage by relying exclusively on Medicaid and 33 states implementing separate programs as part or all of their SCHIP expansion (Health Care Financing Administration 2000, Hill 2000).

For this brief, new questions on the 1999 National Survey of America's Families (NSAF) were used to assess the familiarity of low-income families (defined as below 200 percent of the FPL) with Medicaid and SCHIP programs.[1] This analysis showed that although the vast majority (88 percent) of low-income uninsured children have parents who have heard of either the Medicaid or SCHIP program in their state, only 38 percent have parents who have heard of at least one of the programs and also know that children can participate even if the family is not receiving welfare. Moreover, while 86 percent of low-income uninsured children in states with separate SCHIP programs had parents who had heard of the Medicaid program, by 1999, just 47 percent had parents who had heard of the separate SCHIP program in their state. The 1999 NSAF data also indicate substantial variation across states in awareness of these programs and confusion about eligibility.

The NSAF: Data and Methods

The NSAF is a household survey that provides nationally representative estimates and has large samples in 13 states. In the 1999 NSAF, we asked parents[2] whether they had heard of the separate SCHIP program in their state;[3] whether they had heard of the Medicaid program in their state;[4,5] and, for those who had heard of

either Medicaid or SCHIP, whether they knew if their state's programs covered children in families that do not receive welfare. If parents responded either that families had to be on welfare or that they did not know whether families had to be on welfare for their children to participate in these programs, we characterized them as not understanding the basic rules. To some extent, responses to this question reflect perceptions about eligibility requirements for both Medicaid and SCHIP; however, most responses reflect how well the parents understand the eligibility rules for Medicaid.[6]

For this analysis, we focused on low-income children.[7] Insurance status at the time of the survey was categorized using a hierarchy that gives first priority to Medicaid/SCHIP/State coverage and second priority to private coverage. We analyzed the following three insurance categories: (1) Medicaid/SCHIP/State,[8] (2) private,[9] and (3) uninsured.

More than half (53 percent) of all low-income parents either are not aware of any child health insurance program in their state or do not know that enrollment in welfare is not a precondition for participation.

Findings

Only 9 percent of all low-income children have parents who have not heard of either the Medicaid or SCHIP program in their state, indicating that almost all low-income parents are aware of at least one publicly subsidized insurance program for children (table 1). However, 44 percent have parents who have heard of at least one of the programs but do not understand that their families do not need to participate in welfare for their children to be eligible for coverage. Thus, altogether, more than half (53 percent) of all low-income parents either are not aware of any child health insurance program in their state or do not know that enrollment in welfare is not a precondition for participation. In states with separate SCHIP programs, parents who have heard of the separate SCHIP program are less likely to be confused than parents who have heard only of the Medicaid program in their state, which indicates that there is greater confusion about Medicaid (data not shown).

Not surprisingly, low-income children enrolled in either Medicaid or SCHIP are more likely than other low-income children to have parents who have heard of the programs and who understand the basic eligibility rules (65 percent for Medicaid/SCHIP-covered children, compared with 38 percent for uninsured children and 34 percent for children with private coverage). But even so, 30 percent of the low-income children enrolled in Medicaid or SCHIP have parents who are confused about the basic eligibility requirements.

Only 38 percent of low-income uninsured children have parents who have heard of Medicaid or SCHIP programs and who also understand the basic eligibility rules. In particular, although fully 88 per-

TABLE 1. *Familiarity with Medicaid/SCHIP Programs among Parents in Low-Income Families, Nationally, by Child's Insurance Status, 1999*

	All Low-Income Children	Insurance Status		
		Private	Medicaid/SCHIP	Uninsured
Have not heard of program(s) or do not understand basic rules	53	66*	35	62*
Have not heard of Medicaid/SCHIP	*9*	*11**	*5*	*12**
Heard of program(s) but do not understand basic rules	*44*	*55**	*30*	*49**
Heard of program(s) and understand basic rules	47	34*	65	38*

Source: 1999 National Survey of America's Families (NSAF).
Note: An asterisk indicates group is significantly different from the reference category, which is Medicaid/SCHIP/State, at the 0.01 level.

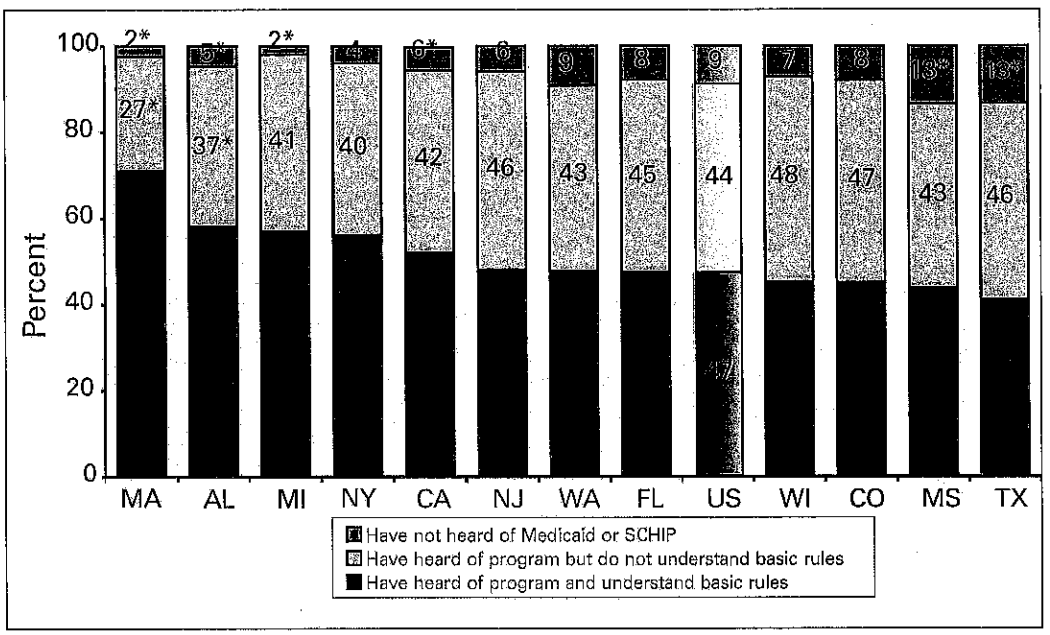
cent of all low-income uninsured children have parents who are aware of either Medicaid or SCHIP, 50 percent have parents who have heard of the programs but do not understand the basic eligibility rules. Familiarity with Medicaid and SCHIP is similar between low-income parents with uninsured children and those with privately insured children.

Familiarity with public health insurance programs does not appear to be uniform among low-income families in different states (figure 1)—more than 70 percent of all low-income children in Massachusetts have parents who have heard of the Medicaid/SCHIP program in their state and who understand that families do not need to be on welfare to participate, compared with just 41 percent in Texas. It is not clear why such differentials exist, although they appear to be correlated with underlying factors in these states. For example, public coverage reached very different shares of the low-income populations of Massachusetts and Texas, the two states at opposite ends of the spectrum: In 1999, 60 percent of all low-income uninsured children in Massachusetts were enrolled in the state's Medicaid/SCHIP program compared with just 26 percent in Texas (Kenney, Dubay, and Haley 2000). In addition, Massachusetts and Alabama, the two states with the highest levels of basic awareness and understanding, were also among the earliest to implement their SCHIP expansions and major outreach initiatives, while Texas and Mississippi, the two states with the lowest levels of basic understanding, rolled out the major portion of their SCHIP expansions after 1999 (Ullman, Hill, and Almeida 1999, Hill and Westpfahl Lutzky 2000).

Not surprisingly, given the relative "newness" of SCHIP, low-income families are more aware of Medicaid than of separate SCHIP programs; 90 percent of all low-income children have parents who have heard of Medicaid, while only 49 percent have parents who have heard of the separate SCHIP program in their state (figure 2). For each insurance group, only a small proportion of low-income children—less than 5 percent—had parents who had heard of the separate SCHIP pro-

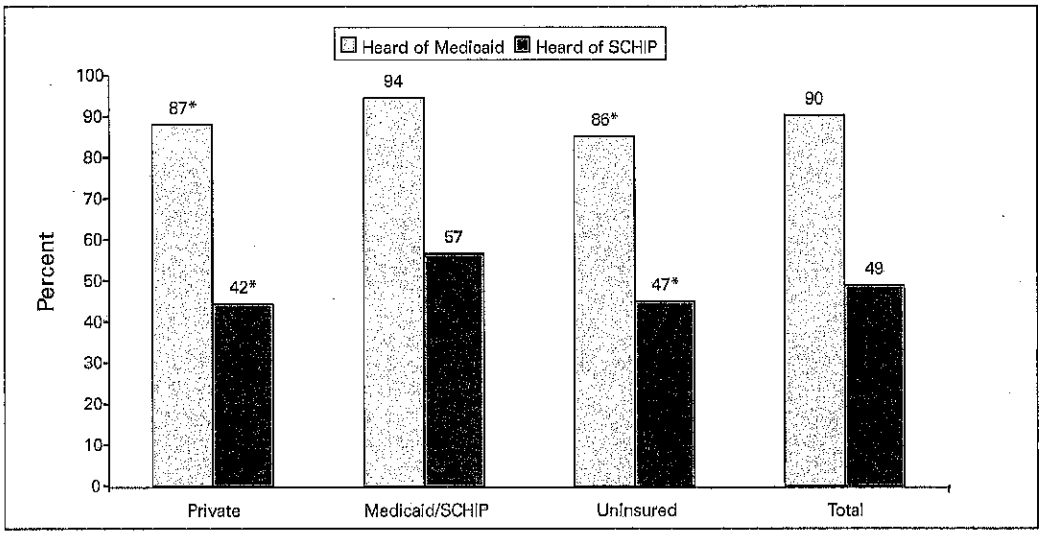
More than 70 percent of all low-income children in Massachusetts have parents who have heard of the Medicaid/SCHIP program in their state and who understand that families do not need to be on welfare to participate, compared with just 41 percent in Texas.

FIGURE 1. Familiarity with Medicaid/SCHIP Programs among Low-Income Families, by State, 1999



Source: 1999 National Survey of America's Families (NSAF).
Note: An asterisk indicates state is significantly different from the national average at the 0.05 level or lower.

FIGURE 2. Awareness of Medicaid and Separate SCHIP Programs among Low-Income Families, Nationally, by Insurance Status, 1999



Source: 1999 National Survey of America's Families (NSAF).
Note: An asterisk indicates group is significantly different from the reference category, which is Medicaid/SCHIP, at the 0.01 level. Measured in 25 states with separate SCHIP programs in 1999.

Ninety percent of all low-income children have parents who have heard of Medicaid, while only 49 percent have parents who have heard of the separate SCHIP program in their state.

gram but not the Medicaid program, whereas between 40 percent and 49 percent had parents who had heard of Medicaid but not the separate SCHIP program (data not shown). Consistent with the data presented above, children enrolled in Medicaid or SCHIP were more likely than other children to have parents who were aware of the separate SCHIP program in their state. But even so, more than 40 percent of all low-income children with Medicaid/SCHIP coverage had parents who had *not* heard of the separate SCHIP program.[10]

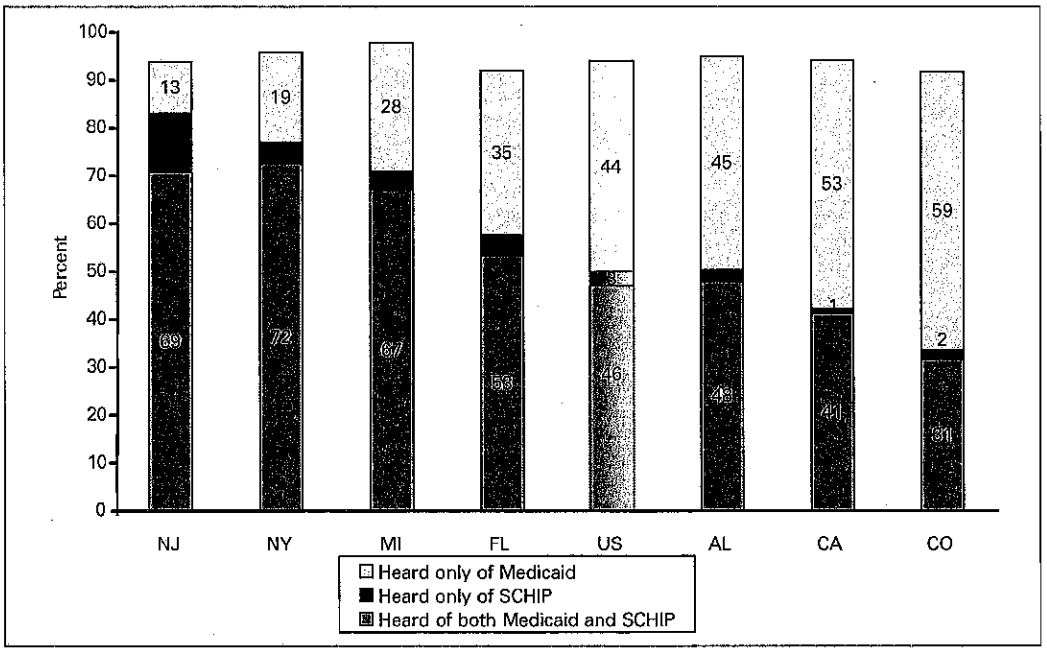
Awareness of Medicaid and separate SCHIP programs was 86 percent and 47 percent, respectively, among the parents of low-income uninsured children. Thus, fewer than half of all low-income uninsured children had parents who had heard of the separate SCHIP program in their state. The comparable figures for children with private coverage were 87 percent and 42 percent, respectively.

Figure 3 demonstrates that states had achieved very different levels of name recognition with their separate SCHIP programs and that some states had been able to achieve high levels of awareness with their programs by 1999. In New Jersey and New York, more than 75 percent of all low-income children had parents who had heard of the separate SCHIP programs in those states. At the other end of the spectrum, only 34 percent in Colorado and 42 percent in California had heard of the separate SCHIP programs. The New York program dates back to the early 1990s, before the federal legislation that created SCHIP, which could partially explain the high levels of awareness. In contrast, the New Jersey program was created in 1998, just one year before the survey, but it did receive high-profile support from the governor's office (Hill and Westpfahl Lutzky forthcoming), which could have been key to raising its profile in the state. Like New York's, the Colorado program predates the enactment of SCHIP, so the low levels of awareness of the Colorado program cannot be attributed simply to the program being new. However, the pre-SCHIP program in Colorado was small in scale and scope, and public coverage for low-income children in Colorado was far below the national average in 1999 (Kenney, Dubay, and Haley 2000).

Policy Implications

It is encouraging that the vast majority of low-income parents have heard of at least one public health insurance program in their state. Although one might expect

FIGURE 3. Awareness of Medicaid and Separate SCHIP Programs among Low-Income Families, by State, 1999



Source: 1999 National Survey of America's Families (NSAF).
Note: Awareness of separate SCHIP programs is significantly higher than the average of the states with separate SCHIP programs in New Jersey, New York, Michigan, and Florida, and significantly lower in California and Colorado, at the 0.01 level.

most parents to have heard of the long-established Medicaid program, the fact that half of all low-income children had parents who had also heard of these newer separate SCHIP programs by 1999 is perhaps surprising. This is promising evidence that, only two years after the SCHIP legislation was passed, these new programs were already becoming an established part of the landscape.

However, many low-income parents were not aware of the existence of the non-Medicaid SCHIP programs in their state in 1999 or were confused about whether participation in welfare programs was a prerequisite for enrolling in Medicaid or SCHIP. Confusion was not limited just to families whose children do not participate in Medicaid or SCHIP; almost a third of all children enrolled in Medicaid or SCHIP had parents who were unsure whether receipt of welfare was necessary for participation. Moreover, there may be greater confusion about whether welfare participation is necessary for participation in Medicaid than for separate SCHIP programs. Reducing barriers to Medicaid participation is critical to increasing coverage, given that 60 percent of all uninsured children are eligible for Medicaid under Title XIX (Dubay and Haley forthcoming). To remove the obstacles posed by these knowledge gaps, states likely will need to continue to invest in outreach—more so in states where awareness and understanding of Medicaid and SCHIP programs are low.

Another challenge facing states is to make more low-income families aware of Medicaid and SCHIP programs. For SCHIP expansions to reduce uninsurance among children, it is critical that families know about the coverage available through separate non-Medicaid SCHIP programs, as an estimated four of five children eligible for coverage under Title XXI are eligible for these separate programs (Dubay and Haley forthcoming). In addition, while early enthusiasm for the new SCHIP program translated into large amounts of creative energy and funds going to outreach and awareness, the prospects of an economic downturn and growing pressures on state budgets could lead to decreased investment in outreach, leaving new gener-

States likely will need to continue to invest in outreach—more so in states where awareness and understanding of Medicaid and SCHIP programs are low.

ations of eligible families lacking information about these programs.

Although states are somewhat limited in the extent to which they can draw on federal funds to publicize their separate SCHIP programs, it is not clear how much of a constraint states actually face with regard to the federal funds on which they can draw to finance outreach. Several states have indicated that the cap on administrative expenses constrained their investments in outreach (Rosenbach et al. 2001). However, states can also use Medicaid Title XIX funds to finance general purpose outreach efforts, which could be aimed at publicizing both Medicaid and separate programs and reducing confusion about eligibility. In addition, states are not constrained by federal law in the amount of state dollars they use for outreach.

Finally, nearly 40 percent of low-income uninsured children have parents who have heard of Medicaid or SCHIP and understand that nonwelfare families are eligible but still did not enroll their children. Awareness of the availability of publicly subsidized coverage does not automatically lead to participation; while hearing of the program and understanding the basic rules are important first steps, parents also must value the public health insurance coverage that is available and understand how to apply. Thus, enrolling more uninsured children may require improvements in Medicaid and SCHIP enrollment, redetermination, and service-delivery systems in addition to expanded outreach efforts.

Endnotes

1. Additional information on Medicaid/SCHIP enrollment barriers that was collected in the 1999 NSAF is analyzed in another brief (Kenney and Haley 2001).

2. Detailed information was collected from the adult who knew the most about the education and health care of the child; we refer to this adult as the parent because 95 percent of all these respondents were the child's parent.

3. Responses to this question were analyzed for children who lived in 25 states that had separate SCHIP programs in 1999 with names that were different from the Medicaid program in their state. An estimated 60 percent of all children live in these 25 states. The weights used to analyze this question reflect a reallocation of a small fraction of the sample in the balance of the nation to permit state-specific estimates for all states. As a result, 31 cases were excluded from figures 2 and 3 because they were not asked about separate SCHIP programs and thus could not be classified by whether they had heard of the program.

4. There is a possibility that some respondents may report having heard of Medicaid because of reasons endogenous to the survey itself: A small proportion of respondents in the 1999 NSAF had been interviewed in the 1997 round of the survey and may have heard of the program only because of the earlier interview. Although the re-interviewed group did report higher levels of awareness of Medicaid than did the newly contacted group, the difference was small (less than 3 percentage points) and might be explained by demographic differences between the groups of the sample. Furthermore, the overlap group is less than a quarter of the total NSAF sample (Wang, Cantor, and Safir forthcoming).

5. We recoded answers given to these questions in 13 states resulting from possible ambiguities introduced because SCHIP programs were Medicaid expansions or because the separate SCHIP programs had the same program name as Medicaid. Minnesota was excluded from the state-specific analyses because we did not refer to the Medicaid program directly as MinnesotaCare at this point in the interview, which is likely to have led to lower name recognition.

6. Sixty-seven percent of the sample were reporting whether they understood the eligibility rules for the Medicaid program in their state, 31 percent were reporting whether they understood the eligibility rules for Medicaid in the separate SCHIP program, and 2 percent were reporting whether they understood the eligibility rules for the separate SCHIP program.

7. This analysis excludes 33 ot the 13,497 total low-income children who were either emancipated minors (who were not asked about their Medicaid/SCHIP knowledge) or whose parents did not indicate whether they had heard of Medicaid or SCHIP. An additional 17 low-income children were excluded from analyses presented in table 1 and figure 1 because their parents refused to answer the question regarding whether children have to participate in welfare to be eligible for Medicaid or SCHIP.

8. Includes coverage through Medicaid, separate SCHIP programs, or other state-financed health insurance programs and is called Medicaid/SCHIP in the remainder of the brief.

9. Includes coverage from a current or former employer or union, coverage under the CHAMPUS or other military programs, and privately purchased coverage.

10. Awareness of separate SCHIP programs was almost universal among parents whose children were reported to be enrolled in the separate programs in 1999, whereas 47 percent of low-income children reported to be enrolled in Medicaid programs had parents who had not heard of the separate SCHIP program (data not shown).

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This series presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at **http://newfederalism.urban.org**.

The NSAF is part of ***Assessing the New Federalism,*** a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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Children's Health and System Performance Measures for Wisconsin

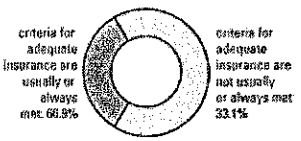
Measure	Nationwide Overall Results	Statewide Overall Results	Statewide BY Special Health Care Needs		Statewide BY Health Insurance Type	
	% Pop. Est. Nationwide	% Pop. Est. Statewide	% Pop. Est. CSHCN	% Pop. Est. Non-CSHCN	% Pop. Est. Public	% Pop. Est. Private
CSHCN: Child has one or more ongoing health condition requiring above-routine amount or complexity of health services (children age 0 to 17 years)	**19.2** 14,136,454	**20.3** 266,540	--	--	**27.7** 76,816	**18.3** 173,887
Chronic Conditions: Child currently has one or more of 21 chronic health conditions specified (children age 0 to 17 years)	**43.0** 31,728,058	**41.5** 545,745	**89.9** 239,523	**29.2** 306,222	**57.2** 158,573	**36.8** 349,996
Weight Status: Height-to-weight ratio (BMI) at or above 85th percentile for child's age and sex (children age 10 to 17 years)	**31.6** 10,001,679	**27.9** 162,772	**34.8** 51,270	**25.6** 111,502	**35.5** 35,588	**25.8** 113,739
Developmental Risk: Parent concerns indicate moderate or high risk for developmental or behavioral problems (children age 4 months to 5 years)	**26.4** 6,135,063	**22.8** 89,258	**43.4** 23,289	**19.5** 65,969	**35.3** 35,310	**18.2** 49,980
Uninsured: Child does not currently have health insurance coverage (children age 0 to 17 years)	**9.1** 6,697,766	**5.7** 75,332	**5.1** 13,476	**5.9** 61,857	--	--
Insurance Gaps: Child is currently uninsured or was uninsured for one or more periods of time during past 12 months (children age 0 to 17 years)	**15.1** 11,098,007	**10.4** 135,752	**8.9** 23,528	**10.7** 112,224	**14.2** 39,207	**2.2** 21,213
Insurance Adequacy: Coverage does not meet child's health needs, does not allow child to see health care providers they need, and/or family's out-of-pocket medical expenses are unreasonable (currently insured children, age 0 to 17 years)	**23.5** 15,744,885	**27.4** 338,931	**31.3** 78,903	**26.4** 260,028	**23.9** 66,273	**28.4** 270,473
Well Visits: Child had one or more preventive medical care visits during past 12 months (children age 0 to 17 years)	**88.5** 64,575,112	**84.2** 1,098,682	**92.8** 245,637	**82.0** 853,045	**88.2** 243,616	**84.7** 801,027
Dental Visits: Child had one or more preventive dental care visits during past 12 months (children age 1 to 17 years)	**78.4** 54,293,506	**80.2** 1,002,195	**84.7** 220,402	**79.1** 781,793	**71.4** 188,417	**83.4** 752,859

HRSA U.S. Department of Health and Human Services
Health Resources and Services Administration

The National Survey of
Children with Special Health Care Needs
Chartbook 2005–2006

Adequacy of Current Insurance Coverage

Percent of Insured CSHCN with Inadequate Insurance



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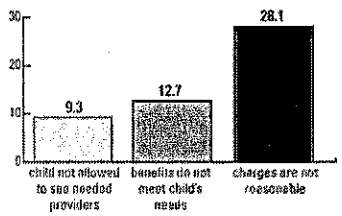
Percent of CSHCN Whose Insurance Does Not Meet Each Criterion for Adequacy*



*The criterion is not usually or always met.

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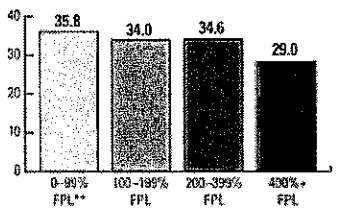
Percent of Insured CSHCN with Inadequate Insurance:* Family Income



*One or more criteria are not always or usually met: adequate benefits, access to needed providers, and reasonable charges. **Federal Poverty Level. In 2005, the DHHS poverty guidelines defined 100 percent of poverty as $19,350 for a family of four.

[D]

The parents of CSHCN with health insurance were asked three questions about their children's coverage:

- Does the plan allow the child to see the health care providers that he/she needs?
- Does the plan offer benefits and cover services that meet their needs?
- Are the costs not covered by the plan reasonable?

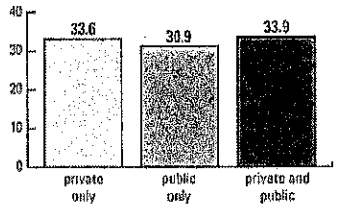
If parents answered "usually" or "always" for all three of these questions, then the child's coverage is considered to be adequate. All others are considered to have inadequate insurance coverage.

Overall, one-third of CSHCN were reported by their parents to have inadequate insurance coverage. Nine percent of CSHCN were reported to have coverage where the child was not allowed to see needed providers, almost 13 percent were reported to have a plan where the benefits do not meet the child's needs, and 28 percent were reported to have a plan with charges that are unreasonable. These figures are not mutually exclusive and the parents of some CSHCN may have reported more than one of these problems with their child's coverage.

Adequacy of insurance coverage among CSHCN varies by family income. CSHCN with family incomes below 100 percent of the poverty level are most likely to be reported to have inadequate insurance coverage (36 percent), while the parents of CSHCN with family incomes of 400 percent of poverty or more are least likely to report that their children have inadequate insurance (29 percent). The perceived adequacy of insurance coverage also varies by type of insurance. Children with public insurance alone are less likely to be reported to have inadequate coverage (31 percent) than children with private insurance alone or in combination with public coverage (34 percent).

Perceived adequacy of insurance coverage among CSHCN also varies noticeably by the impact of the child's condition. Children who are reported by parents to have a condition that never affects their abilities are the least likely to have inadequate insurance (26 percent), followed by children who are sometimes affected by their condition (36 percent). Children who are affected usually, always, or a great deal by their condition are the most likely to have inadequate insurance; 41 percent of these children are reported to have a plan that does not usually or always meet all of their needs.

Percent of Insured CSHCN with Inadequate Insurance:* Insurance Type



*One or more criteria are not always or usually met: adequate benefits, access to needed providers, and reasonable charges.

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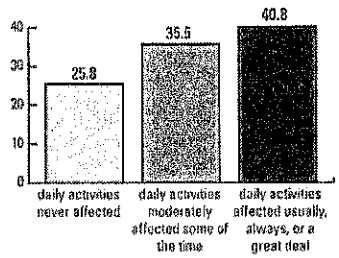
Percent of Insured CSHCN with Inadequate Insurance:* Impact of Child's Condition on Functional Ability



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