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REPORT

FINAL REPORT

CHIPRA Evaluation of the Children's Health Insurance Program: Cross Cutting Report on Findings from Ten State Case Studies

May 31, 2013

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Submitted to:

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ACKNOWLEDGEMENTS

The authors would like to thank the many state officials and stakeholders across our 10 study states who gave so freely of their time and insights during our site visits; neither our case study reports, nor this cross-cutting synthesis of findings, would have been possible without their assistance and support. We would also like to sincerely thank the many parents who took the time to participate in our focus groups, tell us of their experiences, and share their honest opinions about how well the CHIP program is meeting the needs of their children. Our colleagues at Mathematica led the site visits and developed case study reports for four of the 10 study states—we draw on their findings throughout this report—and also created the tables used here. Finally, we are grateful to our federal project officer at ASPE/DHHS, Rose Chu, for her ongoing guidance, assistance, and advice.

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EXECUTIVE SUMMARY

The Children's Health Insurance Program (CHIP), a landmark initiative to broaden health insurance coverage for low-income children, was created with bipartisan support as part of the Balanced Budget Act of 1997 (BBA) and funded for a period of 10 years with an appropriation of approximately $40 billion. After two years of temporary extensions, the U.S. House of Representatives and Senate passed the CHIP Reauthorization Act (CHIPRA) [1] in January 2009. President Barack Obama signed it into law in February of that year, extending $44 billion in new funding through federal fiscal year 2013.[2] The law aims to extend and further improve a program that has already proven effective in extending coverage to millions of children and improving their access to care (Wooldridge et al. 2005). It has driven (along with Medicaid) a steady decline in the number of uninsured children in the United States, from 11.4 million (or 15.1 percent of all children) in 1997 to 7.6 million (9.7 percent of children) in 2011 (Current Population Survey, Annual Social and Economic Supplement 1998–2011).

Beyond providing significant new federal support for CHIP, CHIPRA also amended the formula for distributing federal monies to the states. State allotments are now based on actual CHIP expenditures and revised every two years based on the extent to which states spend their previous year's allotments. Other finance-related changes included in CHIPRA were the establishment of a performance bonus fund to encourage states to adopt innovative simplification policies and reward improved enrollment and retention of children in the Medicaid program, and the appropriation of $100 million to support new outreach grants to support public awareness and application assistance efforts in states, communities, and federally recognized American Indian tribes (Kaiser Commission on Medicaid and the Uninsured 2009b; PL 111-3, Section 104). Additional key CHIPRA provisions designed to spur innovations in outreach, enrollment, benefits coverage, and access to and quality of care are identified in Exhibit 1.

The CHIPRA legislation also mandated an evaluation of CHIP to help Congress understand the program's role as an insurer of children in a time of changing coverage requirements, declines in private coverage, and economic volatility in the states. In September 2010, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (DHHS) awarded Mathematica Policy Research and its partner the Urban Institute the three-year contract to conduct this evaluation, which includes both quantitative and qualitative analytical components. The CHIPRA-mandated evaluation was intentionally modeled after the previous congressionally mandated evaluation, also conducted by Mathematica and the Urban Institute, and which ASPE oversaw (Wooldridge et al. 2005).

[1] Title XXI created what was originally called the State Children's Health Insurance Program, or SCHIP; CHIPRA in 2009 simplified the program's name to CHIP.

[2] The Affordable Care Act extended funding for CHIP to 2015 and authorized the program through federal fiscal year (FFY) 2019.

Exhibit 1. Key CHIPRA Provisions by Policy Area

Eligibility
• Creates an explicit new eligibility category for pregnant women in CHIP
• Allows states to cover legally resident immigrant children and pregnant women in their first five years in the United States in Medicaid and CHIP
• Reduces barriers to creating premium assistance programs for children and families, making it easier for states to use CHIP funds to subsidize families' purchase of employer-sponsored insurance
• Prohibits states from covering parents of children enrolled in CHIP[a]
• Allows states to adopt Express Lane Eligibility (ELE)[b] for children in CHIP and Medicaid
• Requires states to verify citizenship of children applying to CHIP[c] and allows them to do so electronically through data matches with the Social Security Administration
• Requires states to provide a 30-day grace period before cancelling coverage due to nonpayment of premiums
Benefits
• Requires states to cover dental services in CHIP benefit packages[d]
• Allows states to provide dental-only supplemental coverage for children who would otherwise qualify for CHIP but have private health insurance without dental benefits
• Requires mental health parity, such that mental health benefits offered by CHIP are covered at the same amount, duration, and scope as physical health benefits
Quality Measurements
• Establishes a new initiative to improve quality of care provided to children, including the development of new child-specific quality measures and new electronic medical record systems for children, and funding of demonstration projects for child health quality improvement

[a] States previously could cover parents of children enrolled in CHIP through waiver authority; the eight States with waivers in place in 2009 were permitted to continue their programs through the end of FFY 2011 (Center for Children and Families 2009).

[b] Express Lane Eligibility allows states to use the findings of other need-based programs to establish eligibility for Medicaid or CHIP.

[c] The Deficit Reduction Act of 2005, P.L. 109-171, had previously required citizenship documentation for Medicaid applicants.

[d] Previously a state option, though nearly every state already covered dental benefits.

This report synthesizes the cross-cutting findings from in-depth case studies conducted in the evaluation's 10 study states: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. Study teams conducted four- to five-day site visits in each of the states from February to September 2012, during which the teams gathered two forms of qualitative information. First, the study teams conducted key informant interviews with approximately 40 stakeholders in each state, including state CHIP and Medicaid officials, governors' or state legislators' health policy staff, pediatric and safety-net providers, health plan administrators, child and family advocates, agencies involved with eligibility determination, and community-based organizations (CBOs) involved with outreach and application assistance. Second, the teams conducted three focus groups in each state with (primarily) parents of children

enrolled in CHIP.[3] Together, these inquiries elicited insights into how CHIP has evolved and matured since its early years; how states have grappled with implementation challenges involved with finding, enrolling, retaining, and delivering care to children; and new issues that have arisen as a result of passage of the Affordable Care Act (in March 2010) that hold implications for CHIP. Although this analysis emphasizes state actions in response to CHIPRA, the actual period examined by the case studies extends from 2005 (the end date of the previous congressionally mandated CHIP evaluation) to 2012.[4]

Key findings from the case studies are summarized in the following pages and organized to address, in turn, the policy areas of eligibility, enrollment, and retention; outreach; benefits; service delivery, access to, and quality of care; cost-sharing; crowd-out; financing; and preparation for health care reform. The findings begin with a brief overview of CHIP program characteristics in the 10 study states.

Overview of CHIP Programs in the Study States

The 10 states chosen for this study represent diverse approaches to providing CHIP coverage, are geographically diverse, and contain a significant proportion of the nation's uninsured children, among other factors (Exhibit 2). Specifically, the sample includes four states that operate separate CHIP program models (Alabama, New York, Texas, and Utah), one state that runs a Medicaid expansion CHIP program (Ohio), and five states that operate combination models that include both separate and Medicaid expansion components (California, Florida, Louisiana, Michigan, and Virginia). In addition, these 10 states, together, represent 53 percent of the nation's uninsured children and 57 percent of all children enrolled in CHIP; include the four largest programs in the nation (California, Florida, New York, and Texas); range from a state with the most liberal income eligibility limit in the nation—New York at 400 percent of the federal poverty level (FPL)—to states with some of the lowest income limits—200 percent of the FPL in Florida, Michigan, Ohio, Texas, Utah, and Virginia; represent various administrative arrangements whereby CHIP and Medicaid are managed by either the same or different agencies; and reflect a diverse range of service delivery models, including risk-based managed care, fee-for-service (FFS) models, systems in which CHIP and Medicaid provider networks are almost identical, and systems in which they are almost completely separate.

[3] For comparison purposes, a smaller number of focus groups were also held with parents of children eligible for but not enrolled in CHIP, parents of children disenrolled from CHIP, and parents of children with employer-sponsored health insurance. Several of our focus groups included parents of children with special health care needs.

[4] While reviewing these findings, readers should consider the limitations inherent in qualitative case study methods related to validity and generalizability. Quantitative findings on various impacts of CHIP from other components of the CHIPRA-mandated evaluation are forthcoming.

Exhibit 2. Key Characteristics of 10 Study States

State	Program Type	Upper Income Threshold (Percentage of FPL)	Number Ever Enrolled, 2010	Percentage of CHIP Enrollees Nationally	National Ranking, by Program Size	Percentage Uninsured
Alabama	Separate	300	137,545	1.4	19	6.8
California	Combination	250	1,731,605	22.1	1	11.2
Florida	Combination	200	403,349	5.4	4	18.3
Louisiana	Combination	250	157,012	1.9	14	11.0
Michigan	Combination	200	69,796	1.0	26	5.9
New York	Separate	400	539,614	6.9	3	8.1
Ohio	Medicaid Expansion	200	253,711	3.5	6	7.9
Texas	Separate	200	928,483	12.2	2	19.2
Utah	Separate	200	62,071	.75	30	11.0
Virginia	Combination	200	173,515	2.3	11	8.6

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Eligibility, Enrollment and Retention

Since its inception, the Children's Health Insurance Program (CHIP) has proven to be a fertile testing ground for state innovations related to eligibility policy and the simplification of enrollment and renewal procedures. With the multiple goals of expanding income eligibility, streamlining initial health program enrollment, and facilitating children's retention of coverage, these innovations have grown more numerous and diverse since the passage of CHIPRA.

More federal financial stability and administrative flexibility after CHIPRA, among other factors, led most of the study states to further expand eligibility for children. For example, 4 of 10 states raised upper income thresholds—Alabama from 200 to 300 percent of the FPL, Louisiana from 200 to 250 percent of the FPL, New York from 250 to 400 percent of the FPL, and Virginia from 134 to 200 percent of the FPL (for pregnant women). Three states added federally funded coverage of legally resident immigrant children—California, Texas, and Virginia—and three added coverage of children of state employees—Alabama, Florida, and Texas. Importantly, maintenance of effort (MOE) rules established by the American Recovery and Reinvestment Act of 2009 and extended and broadened by the Affordable Care Act protected these and other important gains by prohibiting states from cutting eligibility and enrollment policies for Medicaid and CHIP to levels more restrictive than those in place in March 2010. State officials in half the study states reported that these rules were crucial in safeguarding CHIP and Medicaid from cuts in recent years, especially as state budgets came under pressure during the Great Recession.

Enrollment simplification continued to be a major priority of CHIP programs throughout the study period. CHIPRA played a direct role in spurring this continued interest, making

performance bonuses available to states that adopted at least five of eight approved simplification strategies[5] and met Medicaid enrollment growth targets. Six of the 10 study states qualified for CHIPRA performance bonuses during one or more years of the study period—Alabama, Louisiana, Michigan, Ohio, Virginia, and Utah—totaling nearly $27 million. But all 10 states had numerous policies designed to simplify children's enrollment, as illustrated in Exhibit 3, many of which were in place before CHIPRA.

Exhibit 3. Eligibility Simplification Strategies, by State

State	12-Month Continuous Eligibility	No Asset Test	No In-Person Interview	Joint Medicaid CHIP Form	Administrative or Ex Parte Renewal	Presumptive Eligibility	Express Lane Eligibility	Premium Assistance
Alabama	X	X	X	X	X		Medicaid	
California	X	X	X	X		X		
Florida	CHIP	X	X	X	X			CHIP
Louisiana	X	X	X	X	X		Medicaid	
Michigan	X	X	X	X		X		
New York	X	X	X	X		X	X	
Ohio	X	X	X	X		X		
Texas	CHIP		X	X				
Utah	CHIP	CHIP	X	X	X	X	CHIP	CHIP
Virginia	CHIP	X	X	X	X			CHIP

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Notes: X denotes implementation in both Medicaid and CHIP.

The case studies identified numerous creative, multipronged strategies to streamline enrollment procedures and achieve high rates of participation among eligible children. For example, 9 of the 10 study states deployed online applications for their CHIP programs. To varying degrees, most of the study states had designed more integrated data systems, sometimes capable of linking across public benefits programs, and more frequently capable of linking to a range of state databases that can verify such critical information as applicants' income, employment, health insurance status, and citizenship. Eight of the 10 study states use a range of community-based application assistance models that bolster traditional outreach by enabling staff of local agencies, providers, and health plans to provide application assistance to families with uninsured children. Often reflecting the ethnicities of the communities in which they worked, key informants described these staff as "trusted," "culturally competent," and therefore particularly "successful" in helping "hard-to-reach" populations in accessing coverage. Finally, four of the states—Alabama, Louisiana, New York, and Utah—chose to add Express Lane Eligibility (ELE) to their toolbox of simplification strategies, a new option permitted by

[5] CHIPRA-approved strategies include 12-month continuous coverage; no asset test (or simplified asset test); no face-to-face interview; joint application (and same information verification processes for Medicaid and CHIP); administrative or ex parte renewals; presumptive eligibility; Express Lane Eligibility; and premium assistance.

CHIPRA that allows states to use the findings of other need-based programs (such as the Supplemental Nutrition Assistance Program [SNAP]) to establish or renew eligibility for children in Medicaid and CHIP. Families participating in the study's focus groups widely praised the ease with which they were able to apply for and obtain health coverage for their children, and particularly noted how valuable the help of application assistors was in enrolling.

States also focused considerable attention on simplifying renewal processes, understanding that achieving high retention rates is crucial to reducing churn[6] and maintaining gains in reducing the ranks of uninsured children. Generally, states apply many of the same types of strategies to renewal that they do for initial enrollment. For example, 9 of the 10 study states allow families to submit renewal applications online or by mail, thus not requiring parents to have a face-to-face interview. Six of the states allow parents to self-declare family income and then administratively verify the accuracy of parents' attestations after the fact by searching available databases, thus relieving parents of the need to submit income documentation. Six of the study states preprint renewal forms with personal and income information submitted with the child's initial application for coverage; parents are simply asked to verify that the information displayed is still accurate or submit updated information. Finally, most states that use community-based application assistance also allow assistors to help families renew their children's coverage. Once again, parents in the study's focus group described how easy most CHIP renewal processes were for them. The full range of simplification strategies employed by the study states—for both initial enrollment and renewal—are illustrated in Exhibit 4.

Exhibit 4. CHIP Enrollment and Renewal Processes

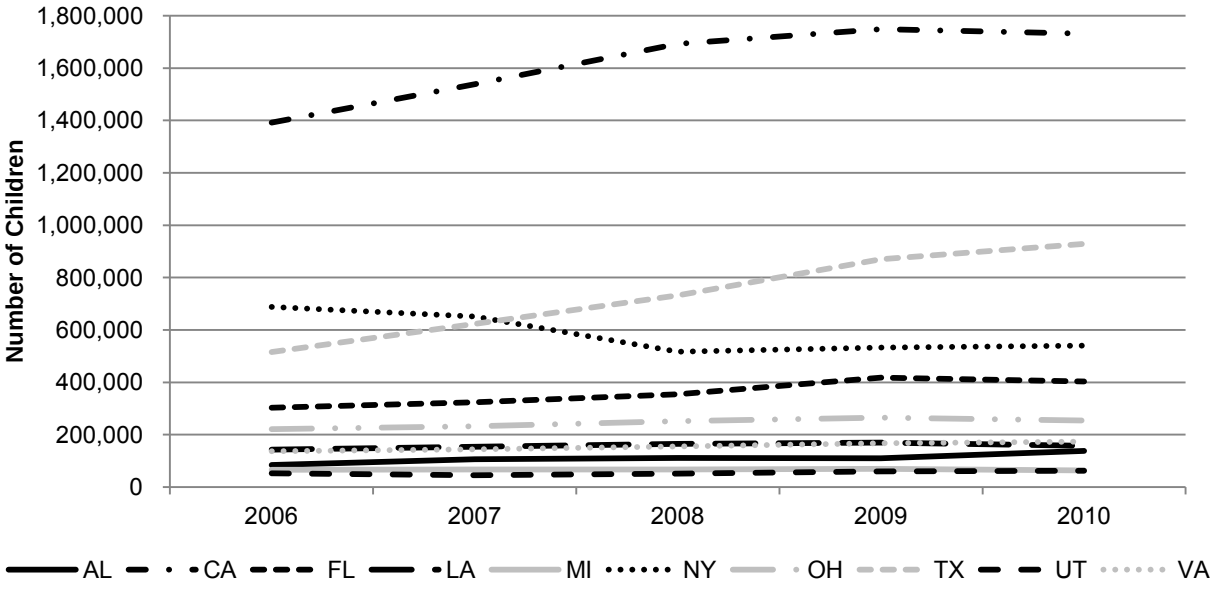
State	Mail-In Enrollment and Renewal	Online Enrollment and Renewal	Community-Based Application Assistance	Active/ Passive Renewal	Preprinted Renewal Form	Self-Declaration of Income	Ex Parte Renewal
Alabama	X	X	X	Active	X	X	
California	X	X	X	Active	X		
Florida	X	X		Active	X	X	
Louisiana	X	X	X	Passive		X	X
Michigan	X	X	X	Active		X	
New York	X		X	Active		X	
Ohio	X	X	X	Active			
Texas	X	X	X	Active	X		
Utah	X	X		Active	X		
Virginia	Enrollment Only	X	X	Active	X	X	

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

[6] Churn refers to a phenomenon whereby children lose eligibility for administrative reasons and subsequently reenroll into coverage a short time later.

During the study period, modest and steady enrollment gains were observed, perhaps facilitated by state efforts to expand and simplify enrollment and renewal (Exhibit 5).[7] Some plateaus, and even declines, were also apparent in 2007–2008; state officials attributed these to the recession, which caused many families to lose jobs and income and, thus, move from CHIP coverage into Medicaid. However, despite the steps taken to streamline the enrollment and retention processes, key informants reported that some barriers remained. These included a lack of full alignment between Medicaid and CHIP, multiple or outdated information systems that hinder efficient enrollment or transfer of children between the two programs, and ongoing disconnects between government agencies responsible for Medicaid eligibility determination and private vendors responsible for CHIP eligibility.

Exhibit 5. Number of Children Ever Enrolled in CHIP, FFYs 2006–2010



Source: Centers for Medicare & Medicaid Services (CMS) CHIP Statistical Enrollment Data System (SEDS), 2011.

Outreach

Aggressive outreach was a hallmark of CHIP programs in the late 1990s and early 2000s, as states launched strategic efforts to market the new coverage program to eligible populations. States publicized the availability of health insurance coverage through initiatives that involved both broad, statewide marketing to create a strong brand identity for their programs and more targeted, community-based efforts to attract hard-to-reach families (Hill et al. 2003; Williams and Rosenbach 2007). This evaluation's case studies found that, during the study period, CHIP outreach efforts evolved in response to state budget constraints, typically moving away from broad marketing campaigns toward a focus on community-based efforts.

[7] This trend was consistent with what occurred nationally, as found by Kenney et al. 2012.

All 10 states included in this evaluation had state-funded marketing campaigns at some point in their CHIP program's history, but only 3 states—Texas, Virginia, and Utah—continue such efforts today, and 2 of these were characterized as quite limited in scope (Virginia and Utah). Some states eliminated statewide marketing many years ago, whereas others did so more recently—typically between 2006 and 2008 when federal funding uncertainties for CHIP overall were particularly evident. This dramatic decrease in statewide marketing was, according to state officials, partially a response to state budget constraints, but also because stakeholders perceived that the CHIP brand had been well established and therefore required less ongoing marketing investment.

Although states' marketing budgets have dwindled over the years, robust community-based outreach efforts have persisted in all but two states, including California, Florida, Louisiana, Michigan, New York, Ohio, Texas, and Virginia. Strong community ties and earned trust among staff of CBOs have made this approach to outreach particularly effective, in the view of most key informants interviewed for the case studies. In states such as New York, health plans have also played a major role in CHIP outreach and marketing, filling some of the void left as states reduced and/or eliminated outreach budgets. Some states continue to directly fund community-based outreach efforts, but in others private philanthropic foundations have become a more common source of funding support.

State officials reported that CHIPRA outreach grants were very helpful in bolstering otherwise underfunded outreach efforts. The grants appear to have played a particularly significant role in supporting and sustaining community-based groups involved in outreach; each of the 10 study states received at least one CHIPRA outreach grant, and most states received multiple grants.

Benefits

Since the inception of CHIP, states with separate CHIP programs have received a degree of flexibility in designing their benefit packages, whereas states that implement Medicaid expansion CHIP programs must extend the full Medicaid benefit package to enrollees. To help ensure that separate programs offer adequate benefits, Title XXI requires that states meet certain minimum benchmark standards. Despite not being required to achieve parity with Medicaid, most states with separate programs have gone beyond benchmark minimums to add coverage of dental care and other benefits, seeking to closely align benefits between separate CHIP programs and Medicaid.

This evaluation finds that states have continued to offer generous benefit packages in CHIP despite increased budget pressures in recent years. Key informants and parents participating in the study's focus groups overwhelmingly praised the generosity of the CHIP benefit packages, though a few deficiencies were noted, including lack of coverage of EPSDT[8] and nonemergency transportation.

[8] The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a special component required of Medicaid programs that extends comprehensive preventive, diagnostic, and treatment services to child enrollees. EPSDT is not required under CHIP.

CHIPRA's impact on benefits appears to have been limited, as many states had already included comprehensive dental and mental health care in their CHIP benefits packages. In response to the law, however, some of the study states added coverage of medically necessary orthodontia. To achieve the mental health parity required by CHIPRA, states typically had to make only small adjustments to their mental health benefits and often removed annual limits to certain already-covered behavioral health benefits. Utah was the only study state that chose to reduce its medical benefits package to bring it in line with existing mental health coverage.

Service Delivery, Access, and Quality of Care

Earlier CHIP evaluations found mandatory enrollment in risk-based managed care plans to be the dominant form of service delivery for separate CHIP programs, more so than Medicaid (Hill et al. 2003). This trend continued during the current study period. Among the 10 study states, only Alabama continues to use discounted fee for service reimbursement with a single insurer—Blue Cross/Blue Shield of Alabama—for its separate CHIP program; the remainder use statewide risk-based managed care. CHIP program officials reported various reasons for choosing risk-based managed care; primarily, they view the delivery model as one that offers good access to care through provider networks that often bear a greater resemblance to commercial insurance networks than do those offered by Medicaid.

CHIPRA requires that CHIP beneficiaries be offered a choice of at least two health plans when risk-based managed care is mandatory (as Medicaid requires). This created challenges for states such as Florida and New York that previously contracted with single plans in rural areas. Both states were able to comply with the new requirement, but not without considerable effort, because it can be difficult to develop networks in sparsely populated areas.

Most CHIP (and Medicaid) managed care programs in the study states carve out behavioral health and dental care and deliver these services through other arrangements. The exceptions are New York, where health plans are responsible for all care, including behavioral health and dental services; Ohio, where plans must provide dental care but not behavioral health services; and Utah and Texas, where plans are responsible for behavioral health care but not dental. Usually, a separate plan that also bears financial risk managed the carved-out services, although this was not always the case. (For example, California's CHIP program carves out services for children with serious emotional disturbances to county mental health departments.) Key informants generally agreed that carve-outs for dental care work particularly well, because specially designed dental plans have wider networks than traditional FFS and are more experienced with managing the provision of dental services than are health plans. Key informants had more mixed opinions of behavioral health carve-outs, however; most thought that they resulted in more effective, specialized service provision for people with mental health and substance abuse needs, but others were concerned that they fragmented care across health and behavioral health systems.

Key informants and parents who participated in the focus groups in the study states expressed broad satisfaction with access to care in separate CHIP programs. Access to primary care is particularly good because of high levels of participation by pediatricians. Parents described positive experiences with primary care access and many reported ease in finding specialists. The generally positive comments about access to care in separate CHIP programs were not as evident for Medicaid expansion CHIP programs. Provider reimbursement rates are lower, on average, in Medicaid than in separate CHIP programs; key informants suggested that,

as a consequence, provider participation and access to care are generally more limited. This is particularly true for dental care.

Key informants and parents participating in the focus groups also expressed the opinion that the quality of care provided to children under CHIP is good. Still, in recent years, several provisions in CHIPRA pushed states to intensify their CHIP quality improvement initiatives. In the study states, voluntary reporting of child health quality measures had increased, grants supporting the development of CHIPRA quality demonstrations were in place in Florida and Utah, and compliance with new requirements to select an external quality review organization for their separate CHIP programs was high. Among the primary benefits of risk-based managed care, according to state officials, are the improvements in access and quality that they believe result from health plan monitoring. Most commonly, CHIP programs require plans to submit measures of access and quality from the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The case studies revealed additional experimentation and innovation, including payment incentives for providers gaining National Committee for Quality Assurance (NCQA) certification as a medical home, expanded use of electronic health records for pediatric care to support stronger quality assessment and monitoring, and performance improvement programs that reward health plans for scoring highly on standard quality measures.

Cost-Sharing

Cost-sharing has always been a prominent feature of separate CHIP programs, in part because CHIP was intended to mirror private coverage. Federal law permits states to impose various forms of cost-sharing on families enrolled in CHIP, including premiums, copayments, deductibles, and coinsurance, as long as total cost-sharing remains under 5 percent of a family's income. In contrast, cost-sharing for children with incomes below 150 percent of the FPL is strictly limited. The first CHIP evaluation found that separate CHIP programs had largely avoided controversy by establishing premiums and copayments at levels that both administrators and families viewed as fair and affordable. Many key informants believed that such cost-sharing had a beneficial effect in that it made CHIP feel more like private insurance, instilling a sense of pride and responsibility in families that contributed to the cost of their children's coverage (Hill et al. 2003). Most key informants interviewed for this evaluation continued to view cost-sharing as a positive component of CHIP, and the vast majority of parents participating in the study's focus groups viewed cost-sharing as both fair and affordable, and much less expensive than private insurance.

Cost-sharing policies vary from state to state and include annual enrollment fees (in two of the study states), monthly or quarterly premiums (in six states), copayments (in seven states), and deductibles and coinsurance (in two states) (Exhibit 6). Within each category, states use differing income guidelines to determine who is subject to cost-sharing, set premiums and enrollment fees on a per-child or per-family basis, impose copayments at differing levels for different services and income groups, and use varying administrative rules for collecting and processing payments.

Exhibit 6. Cost-Sharing Policies, by State

State	Annual Enrollment Fee	Monthly/Quarterly Premium	Copayments	Coinsurance	Deductibles
Alabama	X		X		
California		X	X		
Florida		X	X		
Louisiana		X	X	X	X
Michigan		X			
New York		X			
Ohio					
Texas	X		X		
Utah		X	X	X	X
Virginia			X		

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Six of the 10 study states increased premiums from 2006 to 2010, before the enactment of MOE rules, mostly in response to worsening state budget conditions. MOE rules in the Affordable Care Act limited the extent to which states can increase premiums, as they are considered a condition of eligibility. One state received federal approval to increase its annual enrollment fee after MOE (Alabama), because the $2-$4 per-child increase was determined to be an inflation-related adjustment. Instead, states increasingly looked to copayments as a lever to address budget pressures; most of the states imposing copayments increased them in recent years as a means of discouraging inappropriate utilization. Copayment increases have not come without some controversy. State legislators in some of the study states expressed the belief that increasing cost-sharing was the "last, best option" for preserving CHIP, whereas advocates and other policymakers were concerned that such increases could deter families from enrolling their children in CHIP, maintaining coverage in the program, or utilizing services when needed. Though no hard data were available, informants in Louisiana (for example) blamed high premiums for low enrollment in *LaCHIP Affordable Plan*, whereas advocates in Utah believed that "expensive" premiums for higher income families led to adverse selection. Similarly, some stakeholders in Texas worried that higher copayments may have prevented families from seeking timely care.

Despite these concerns, key informants characterized cost-sharing levels in CHIP as relatively modest, especially compared with commercial coverage. And state officials universally believed that very few families incurred out-of-pocket costs approaching the 5 percent of income limit. CHIPRA's requirement that states allow a 30-day grace period before disenrolling children for nonpayment of premiums was also cited as an important new protection for families.

Crowd-Out

During the initial development of CHIP, policymakers worried that the new coverage program would crowd out private insurance by encouraging families to substitute government-sponsored health insurance for existing employer-sponsored coverage for their children. Many

were also concerned that employers might stop offering dependent health coverage for their employees if their children became eligible for CHIP. In response to these concerns, the original CHIP legislation mandated that all states have "reasonable procedures" in place to protect against crowd-out despite warnings that such provisions could act as a barrier to enrollment. Most states devised a range of strategies to prevent or discourage crowd-out, but primarily relied on waiting periods during which children must be uninsured before they can enroll in CHIP.

Crowd-out was not seen as a major concern, as officials in all 10 study states expressed the belief that crowd-out prevention provisions effectively deterred families from dropping private coverage. This finding echoes that of the first CHIP evaluation (Hill et al. 2003). Currently, 9 of the 10 study states impose waiting periods (ranging from 3 to 12 months) and maintain a range of other provisions designed to discourage substitution of public for private coverage (Exhibit 7). During the study period, only Louisiana and New York imposed new waiting periods under CHIP—doing so only when they significantly expanded eligibility to higher-income families (those with incomes of at least 250 percent of the FPL in Louisiana and 400 percent of the FPL in New York). More often, states loosened their anti-crowd-out provisions by either decreasing the length of a waiting period (Florida) or adding more exceptions to the waiting period for families in need of coverage for their children.

Exhibit 7. CHIP Crowd-Out Prevention Policies, by State

State	Waiting Period	Health Insurance Status Monitored	Database Match to Private Insurance Status	Cost Sharing	Other
Alabama	X	X	X		
California	X	X	X		
Florida	X	X	X		X
Louisiana	X	X	X	X	
Michigan	X	X	X		
New York	X	X	X		
Ohio					
Texas	X	X		X	
Utah	X	X	X	X	X
Virginia	X	X			

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Financing

CHIPRA played an important role in increasing and stabilizing federal funding available to states during a period of considerable economic stress at both the federal and state levels. The onset of the Great Recession in 2007 led to a doubling of the national unemployment rate to a high of more than 12 percent in 2010 and put severe pressure on state budgets (which state constitutions generally require to be balanced). Passage of CHIPRA, however, ended a period of uncertainty concerning future federal funding for CHIP by committing $44 billion for the program through 2013. CHIPRA also amended the funding formula for states, rectifying long-standing inefficiencies by shifting to an allocation based on actual CHIP expenditures.

Although key informants in the study states described some threats of state cuts to CHIP funding, the Affordable Care Act's MOE requirement dramatically limited states' options for trimming CHIP (and Medicaid) expenditures. Previously, states experiencing budget shortfalls could cap enrollment and establish waiting lists for separate CHIP programs. (Only California did this during the study period, for two months in 2009.) As the recession deepened and pressure on state budgets intensified, key informants in several states reported that governors and legislatures had considered caps and other strategies for constraining enrollment growth, including in Alabama, New York, Virginia, and Utah. In each case, however, MOE requirements prevented the proposed changes from occurring.

States did adopt some strategies to control costs, according to state officials interviewed for this study. These included eliminating marketing budgets and limiting outreach to constrain enrollment growth, moving more enrollees into risk-based managed care, increasing copayments, and cutting benefits. MOE protections prohibited none of these actions on the part of states.

Preparation for Health Care Reform

The Affordable Care Act has far-reaching implications for CHIP and for children's coverage overall. The act extended CHIP funding through September 2015, increased federal matching rates for CHIP from FFYs 2016 to 2019, and required states to maintain CHIP and Medicaid coverage for children until October 2019. However, because federal funding after 2015 is not assured, substantial uncertainty exists about the future of CHIP in FFY 2016 and beyond. Along with these financing provisions, additional components of the Affordable Care Act have great potential to affect CHIP programs (Exhibit 8).

CHIP officials have devoted significant time preparing their programs for the changes needed to comply with the law and, to varying degrees, in assisting their states with preparing for health reform implementation. States' past and current experiences with designing and operating separate CHIP programs are directly relevant to many of the implementation-related decisions they now face, including designing benefit packages, conducting outreach, providing application assistance, and coordinating across coverage programs. As a result, CHIP officials in most states have been at the table in their states' implementation processes and were committed to ensuring that their states' CHIP program designs—which aim to provide low-income children with reliable access to high quality pediatric care—are not lost as implementation of the Affordable Care Act progresses.

Exhibit 8. Affordable Care Act Provisions Affecting CHIP

• Requires CHIP enrollees from families with incomes below 133 percent of the FPL be transitioned to Medicaid
• Allows states to cover children of public employees, if minimum agency contributions and other requirements are met
• Creates a new definition of income—modified adjusted gross income (MAGI)—that states are required to use to determine eligibility for nonelderly Medicaid and CHIP beneficiaries
• Requires states to develop automated and streamlined information systems that integrate Medicaid, CHIP, and health insurance exchange eligibility determinations

It is not yet clear how CHIP will fit into states' post-reform environment. Across the study states, two predominant and opposing sentiments emerged among key informants about whether (and how) CHIP would operate in 2014 and beyond. On one hand, some expected their state's CHIP program to continue into the foreseeable future, given CHIP's popularity and wide bipartisan support, and the fact that many CHIP enrollees might not qualify for subsidies in health insurance exchanges (Kenney et al. 2012). On the other hand, some informants reasoned that, from a consumer's perspective, it might be more advantageous for children to obtain coverage via the exchange because many of their parents are likely to be covered that way and the entire family could be enrolled in the same plan with the same provider network. Moreover, it could be administratively inefficient to continue operating separate CHIP programs, especially in light of the fact that CHIP enrollment in some states will shrink when children from families with incomes less than 133 percent of the FPL transfer to Medicaid. California is the only study state that has made a definitive decision about the future of its CHIP program. After intense debate, policymakers decided to eliminate CHIP by phasing its enrollees into Medicaid over the course of 2013, a controversial move aimed at reducing state costs that has many key informants concerned about whether children's access to care might suffer because of increased pressure on the capacity of Medicaid's delivery system.

Conclusions

Case studies in 10 states find that CHIP programs continue to innovate and adapt to changing circumstances while providing comprehensive health coverage to a growing share of the nation's children. CHIPRA provided much-needed federal financial stability to CHIP, created incentives for states to simplify and streamline enrollment and renewal, provided significant new support for outreach, broadened coverage of dental and mental health services, and promoted new child health quality improvement initiatives, among other provisions. In response, as reflected in this evaluation's sample, states expanded or maintained eligibility during the worst economic recession since the Great Depression, continued to adopt strategies that make it easier for families to apply for and maintain coverage for their children, fine-tuned benefit packages universally described as generous and comprehensive, maintained cost-sharing at levels most deemed fair and affordable, delivered services through managed care provider networks that extend good access to care, and intensified efforts to measure and report on child health quality. Meanwhile, passage of the Affordable Care Act just one year after CHIPRA meant extended authorization and funding, yet also raised fundamental questions about the future role of CHIP in a reformed health care system. Although opinions are mixed on whether CHIP will survive in its current form over the long run, CHIP officials are committed to the principle that children should continue to have easy access to comprehensive, high quality pediatric care, however health systems evolve in the years ahead.

I. BACKGROUND AND HISTORY

The Children's Health Insurance Program (CHIP), a landmark initiative to broaden health insurance coverage for low-income children, was created with bipartisan support as part of the Balanced Budget Act of 1997 (BBA) and reauthorized in February 2009 through the CHIP Reauthorization Act (CHIPRA).[9] Over its 15-year existence, the program has (along with Medicaid) driven a steady decline in the number of uninsured children in the United States, from 11.4 million (or 15.1 percent of all children) in 1997 to 8.0 million (10.0 percent of children) in 2010 (Current Population Survey, Annual Social and Economic Supplement, 1998-2011).

With initial funding of approximately $40 billion for the 10-year period ending in 2007, CHIP was structured to pick up where state Medicaid eligibility thresholds end and allow states to offer coverage to children living in families with incomes up to 200 percent of the federal poverty level (FPL) and beyond (Wooldridge et al. 2005). While Medicaid is an entitlement program with no spending cap, CHIP was designed as a block grant program that set federal allotments for each state based on the number of uninsured children residing there (as well as other factors), and is matched with federal dollars at an enhanced rate compared to Medicaid. Congress also deliberately designed CHIP to give states more control over program design compared to Medicaid. Most important, the BBA gave states three options for expanding coverage—through Medicaid, the creation of a new separate CHIP program, or through a combination of the two approaches. For states choosing to enact separate programs, additional flexibility was extended that allowed them, within certain federal parameters, to design CHIP benefit packages that were less comprehensive than Medicaid's, impose cost sharing, develop alternative service delivery systems, adopt simpler eligibility rules and processes, and set up new structures for administering the program outside of state Medicaid agencies (Hill 2000). The law also explicitly allowed states to use a portion of their administrative funds to conduct outreach for CHIP (and by extension, children eligible for Medicaid)—a new role for many states (Perry et al. 2000; Williams and Rosenbach 2007).

States quickly adopted and implemented CHIP. By the first anniversary of the BBA, 48 states had submitted plans to the federal Health Care Financing Administration[10] and 41 states had received approval (Hill 2000). As of mid-2000, every state and the District of Columbia had programs in place and were enrolling children (Hoag et al. 2011). By then, it was clear that a minority of states—18 of 51, about one-third—had elected to expand children's coverage solely by expanding Medicaid. In contrast, 36 states chose to create new separate CHIP programs, either alone or in conjunction with relatively smaller Medicaid expansions[11] (Hill 2000). The reasons given by state policymakers for this enthusiastic embrace of separate program models centered on the view that CHIP provided an opportunity to test new models of coverage patterned after private health insurance, to build new partnerships between government and the

[9] Title XXI created what was originally called the State Children's Health Insurance Program, or SCHIP; CHIPRA in 2009 simplified the program's name to CHIP.

[10] The Health Care Financing Administration was the federal agency responsible for CHIP and Medicaid administration at the time; it is now called the Centers for Medicare & Medicaid Services, or CMS.

[11] Fifteen states implemented only separate program expansions, and 18 adopted combination expansions.

private sector, and to design systems that were distinctly different from the Medicaid models of the past (Hill et al. 2003). With regard to this latter point, stakeholders often cited political resistance to expansions of Medicaid because of its entitlement nature and resulting uncontrollable budget implications, provider dislike of the program due to low payment rates, and concern in some states that consumers would be less eager to enroll their children in Medicaid due to stigma attached to the program and its onerous welfare-based eligibility systems (Hill et al. 2003).

In the first three years of the program, enrollment tripled—from about one million children ever enrolled in 1998 to 3.3 million in 2000 (Wooldridge et al. 2003). Program enrollment continued to grow over the following decade, though at a slower pace; in 2010, 7.7 million children were enrolled in CHIP at some point during the year.[12,13]

CHIP has not been a static program; over the years, Congress has legislated changes to the program, primarily related to funding. For example, early on states identified problems with the formula for determining state allotments which had resulted in some states receiving surplus CHIP funds and others experiencing shortfalls (Peterson 2006; Peterson 2009). The Balanced Budget Refinement Act of 1999 revised aspects of the state allotment formula and provided additional funding for CHIP, but disparities remained. As a result, the Deficit Reduction Act of 2005 increased funding once again to help avert state CHIP deficits (Hoag et al. 2011).

A. Passage of CHIPRA and Key Provisions

CHIP was originally legislated as a 10-year program. As the program was set to expire in 2007, Congress passed two versions of legislation with bipartisan support that would have reauthorized CHIP, but President George W. Bush vetoed both bills. A temporary reauthorization was passed at the end of the year extending CHIP through March 2009 with a $5 billion per year appropriation. In January 2009, the U.S. House of Representatives and Senate passed CHIPRA, and one of President Barack Obama's first acts as President was to sign the law on February 4, 2009. The law provided significant new financial support for the program, including $44 billion in new funding (in addition to the $25 billion already appropriated) through federal fiscal year 2013.[14]

CHIPRA also amended the CHIP funding formula: beginning in April 2009, state allotments are now based on actual CHIP expenditures, instead of the prior formula, which allocated funds to each state based on the number of low-income children, the number of low-income uninsured children, and health sector wages in each state (Czajka and Jabine 2002;

[12] CMS CHIP Statistical Enrollment Data System (SEDS) as of February 18, 2011, verified and provided by CMS

[13] Federal legislation, passed in 2000 and 2001, permitted states to utilize unspent CHIP funds to cover low-income, uninsured adults who did not qualify for Medicaid. In 2005, the Deficit Reduction Act prohibited additional states from using CHIP funds to cover adults without dependent children. By FY2007, 9 states were covering 293,983 low-income adults, including one of the study state (Michigan). CHIPRA prohibited states from providing any coverage to adults utilizing CHIP funds, but permitted existing state waivers to continue coverage through September 2011 (Parisi 2009).

[14] The Affordable Care Act extended funding for CHIP to 2015.

Sullivan 2009). In addition, during federal fiscal years (FFYs) 2009 and 2010, all states were scheduled to receive larger allotments than they had in the past, even if historically they did not spend all of their allotments (Sullivan 2009). However, beginning in FFY 2011, CHIP allotments were based on how much states spent in FFY 2010—giving states an incentive to try to enroll and retain as many uninsured children as possible, to maximize expenditures and thus maximize their allotments (Sullivan 2009). Going forward until FFY 2015, allotments will be revised every two years, based on the extent to which states spend their previous year's allotments, and a contingency fund is established for states that experience shortfalls.

Other finance-related changes included in CHIPRA were the establishment of a performance bonus fund to encourage states to adopt innovative policies and reward improved enrollment and retention of children; the appropriation of $100 million to support new outreach grants to support public awareness and application assistance efforts in states and communities (including federally-recognized American Indian tribes), and the establishment of enhanced matching rates for translation and interpretation services to support efforts to enroll harder to reach children in non-English speaking households (Kaiser Commission on Medicaid and the Uninsured 2009b; PL 111-3, Section 104).

Beyond financing changes, CHIPRA made a number of other important policy changes in CHIP. Some of the more important ones included:

Eligibility and Enrollment:

- Creating an explicit new eligibility category for pregnant women in CHIP;
- Giving states the option to cover legal immigrant children and pregnant women who were previously prohibited from obtaining CHIP or Medicaid during their first five years of residence in the U.S.;
- Reducing barriers for states creating premium assistance programs for children and families, making it easier for states to use CHIP funds to subsidize families' purchase of employer sponsored insurance;
- Prohibiting states from covering parents of children enrolled in CHIP;
- Allowing states to adopt Express Lane Eligibility[15] for children in CHIP and Medicaid; and
- Requiring states to verify citizenship of all applicant children as part of the eligibility determination process (as had been required in Medicaid by the Deficit Reduction Act of 2005, P.L. 109-171), but allowing them to do so electronically through data matches with the Social Security Administration (Kaiser Commission on Medicaid and the Uninsured 2009b).

[15] Express Lane Eligibility allows states to use the findings of other need-based programs to establish eligibility for Medicaid or CHIP.

Benefits:

- Requiring states to offer dental coverage in their CHIP benefit packages (previously a state option, though nearly every state already covered preventive dental services), and allowing states to provide dental-only supplemental coverage for children who otherwise qualify for CHIP but have private health insurance that does not include dental; and
- Requiring mental health parity, such that mental health benefits are offered at the same amount, duration, and scope as physical health benefits.

Quality Measurement and Improvement:

- Establishing a new initiative to improve the quality of care provided to children, including the development of new child-specific quality measures, creation of new electronic medical record systems for children, and funding of demonstrations projects for child health quality improvement.

B. The CHIPRA Evaluation of CHIP and its Case Studies

The CHIPRA legislation mandated that an evaluation of CHIP be conducted to help Congress understand the program's role as an insurer of children in a time of changing coverage requirements, declines in private coverage, and economic volatility in the states. In September 2010, Mathematica Policy Research, Inc. and its partner the Urban Institute were awarded the three-year contract to conduct this evaluation, which is being overseen by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (DHHS). The CHIPRA-mandated evaluation was intentionally patterned after a previous Congressionally-mandated evaluation (Wooldridge et al. 2005), also conducted by Mathematica and the Urban Institute and overseen by ASPE. Like the prior study, Urban led the case study task for this evaluation.

The current evaluation provides new insights into how the program has evolved and matured since its early years, how states have grappled with important implementation challenges related to enrolling, retaining, and delivering care to children in low-income families, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Affordable Care Act. Using a mixture of quantitative and qualitative research methods, it draws on new primary data collection efforts modeled after the previous evaluation, including surveys of enrollees and disenrollees in CHIP (10 states) and Medicaid (3 States), site visits and focus groups in the 10 study states, and a survey of program administrators in every state. The period of time examined for the case studies is from 2006 (the end-date of the previous Congressionally mandated CHIP evaluation) through 2012.

This report synthesizes the cross-cutting findings from in-depth case studies conducted in the 10 study states: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia (Table I.1). Following careful selection criteria, these 10 states were chosen for the study because they represent diverse approaches to providing CHIP coverage, are geographically diverse, and contain a significant portion of the nation's uninsured children, among other factors. Specifically, the 10 states in our sample:

- Together represent 53 percent of the nation's uninsured children, and 57 percent of all children enrolled in CHIP;
- Include the four largest CHIP programs in the nation—California, Florida, New York, and Texas;
- Include four states with separate CHIP programs (Alabama, New York, Texas, and Utah), one Medicaid expansion (Ohio), and five combination programs (California, Florida, Louisiana, Michigan, and Virginia);
- Range from a state with the most liberal income eligibility limit in the nation—New York at 400 percent of FPL—to states with some of the lowest income limits—200 percent of FPL in Florida, Michigan, Ohio, Texas, Utah, and Virginia;
- Represent various administrative arrangements whereby CHIP and Medicaid are managed by either the same or different agencies; and
- Reflect a diverse range of service delivery models, including risk-based managed care, fee for service (FFS), systems where CHIP and Medicaid provider networks are almost identical, and systems where they are almost completely separate.

Four- to five-day site visits were conducted in each of the 10 states between February and September 2012.[16] Interviews were conducted with approximately 40 key informants in each state, representing such stakeholders as state CHIP and Medicaid officials, Governors' health policy staff, state legislators involved with health issues, health plans participating in CHIP and Medicaid, pediatric and safety net providers, child and family advocates, and community-based organizations involved in outreach and enrollment. In addition, three focus groups were conducted in each state with parents of children enrolled in CHIP, exploring their experiences enrolling their children into coverage, renewing that coverage, obtaining various types of services, and paying for care, among other issues.[17] In-depth case studies of each state were developed and published separately, based on a synthesis of information gathered from the interviews and focus groups

C. Organization of Remainder of the Report

This report synthesizes findings from 10 in-depth state case studies and highlights broad themes that have emerged since the previous evaluation was conducted. Following the structure of the individual case study reports, this cross-cutting report is organized to report on state CHIP program policies and implementation experiences related to: eligibility, enrollment, and retention; outreach; benefits; service delivery, access to care, and quality; cost sharing; crowd-out; financing; and preparation for health care reform. The report concludes with a summary of cross-cutting lessons learned by the states.

[16] Detailed methods for the case studies, including key informant interviews and focus groups, are presented in Appendix A.

[17] For comparison purposes, a smaller number of focus groups were also held with parents of children disenrolled from CHIP; parents of children eligible for, but not enrolled in, CHIP; and parents of children with employer-sponsored health insurance.

Table I.1. Key Characteristics of 10 Study States

State	Program Type	Upper Income Threshold	Number Ever Enrolled, 2010	Percent CHIP Enrollees Nationally	National Ranking by Program Size	Percent Uninsured
Alabama	Separate	300%	137,545	1.4%	19	6.8%
California	Combination	250%	1,731,605	22.1%	1	11.2%
Florida	Combination	200%	403,349	5.4%	4	18.3%
Louisiana	Combination	250%	157,012	1.9%	14	11.0%
Michigan	Combination	200%	69,796	1.0%	26	5.9%
New York	Separate	400%	539,614	6.9%	3	8.1%
Ohio	Medicaid Expansion	200%	253,711	3.5%	6	7.9%
Texas	Separate	200%	928,483	12.2%	2	19.2%
Utah	Separate	200%	62,071	.75%	30	11.0%
Virginia	Combination	200%	173,515	2.3%	11	8.6%

Source: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

II. ELIGIBILITY, ENROLLMENT, AND RETENTION

Since its inception, the Children's Health Insurance Program (CHIP) has proven a fertile testing ground for state innovations related to eligibility policy and the simplification of enrollment and renewal procedures. With the multiple goals of expanding income eligibility, streamlining initial health program enrollment, and facilitating children's retention of coverage, these innovations have grown more numerous and diverse over the life of CHIP.

Reflecting the national trend in the early 2000's, the 10states included in the first congressionally-mandated evaluation's case studies rapidly adopted eligibility expansions, more than doubling their average upper income limits for children from 111 percent of the federal poverty level (FPL) to 232 percent of the FPL. That evaluation also documented widespread state efforts to implement such enrollment simplification strategies as: creating shorter joint CHIP and Medicaid application forms, eliminating requirements for face-to-face interviews with eligibility workers, permitting CHIP applications to be submitted by mail, dropping the asset test from the CHIP eligibility process, extending 12 months of continuous eligibility to children, and providing hands-on application assistance to parents interested in getting their children covered. Importantly, over time, many of the innovations that proved effective under CHIP spilled over to Medicaid, as state officials worked to align the two programs' policies. And, as CHIP programs continued to mature, state officials increasingly realized their programs were challenged in *keeping* children covered, and so began to adopt a range of simplification strategies for their eligibility renewal processes (Hill et al. 2003).

This evaluation finds that states have continued to expand coverage and simplify enrollment and renewal. Among other things, more financial stability and administrative flexibility in the aftermath of CHIPRA led the majority of this study's states to further raise upper income eligibility limits and/or add other new groups of children to coverage. Spurred by direct financial incentives in the law, states continued to adopt cutting-edge strategies to improve enrollment and retention. And with advances in technology, states have broken new ground in rolling out online applications and integrated data systems that can administratively verify applicants' income, employment, citizenship, and other information behind the scenes, generally reducing the amount of direct interaction needed between parents and programs to establish and maintain coverage. Combined, these advances provide policymakers with many lessons regarding effective, modernized eligibility systems as states prepare for health care reform implementation under the Affordable Care Act.

Challenges persist, however, especially in cases where CHIP and Medicaid policies and procedures are not fully aligned, and where administrative functions for the two programs are not co-located. Furthermore, the onset and slow recovery from the Great Recession placed new stressors not only on state budgets but also on eligibility systems, as more families lost jobs and needed public assistance. But maintenance of effort rules established by the American Recovery and Reinvestment Act (ARRA) of 2009 and extended and broadened by the Affordable Care Act proved critical in safeguarding CHIP and Medicaid programs during this difficult time and stabilized the programs' availability to needy children and families. Indeed, across the nation and despite the economic downturn, most states maintained or even improved eligibility for CHIP and Medicaid since CHIPRA and participation in the programs reached an all-time high of nearly 86 percent in 2010 (Kenney et al. 2012).

A. Eligibility Policies and Trends

As across the nation, each of the 10 states included in this evaluation either maintained or expanded eligibility during the study period of 2006 through 2012. Sometimes this was due to increases in upper income eligibility thresholds, and other times it was due to adding coverage of new groups of children or pregnant women.

1. Changes in Coverage

Table II.1 displays each study state's upper income limits as a percent of FPL, by age, for separate CHIP programs, Medicaid expansion components, and Medicaid programs. As discussed in Chapter I, study states include four with separate programs (Alabama, New York, Texas, and Utah); one Medicaid expansion (Ohio); and five combination programs (California, Florida, Louisiana, Michigan, and Virginia). Table II.2 indicates program enrollment in the states' CHIP programs in 2010, including the relative contributions that Medicaid expansion and separate program components make to total enrollment. As can be seen, in the five combination program states, the separate programs account for the majority of total enrollment, compared with relatively smaller Medicaid expansion components. The one exception to this is found in Virginia, where the separate and Medicaid expansion components are much closer to equal in size.

Four of the 10 study states expanded eligibility during the study period by raising upper income thresholds. Specifically:

- Alabama expanded the upper limit of its separate *ALL Kids* program from 200 percent to 300 percent of poverty in 2009.
- Louisiana added a new separate component to its Medicaid expansion *LaCHIP* program—called *LaCHIP Affordable*—in 2008, raising its upper limit from 200 percent to 250 percent of FPL.
- New York raised its upper limit for *Child Health Plus* to 400 percent of FPL—highest in the nation—in 2009 after President Obama rescinded the Bush Administration's directive that had limited states ability to expand children's coverage beyond 250 percent of FPL. (New York has always had a buy-in component for its CHIP program; with the 2009 expansion to 400 percent of poverty, families with incomes over that amount can buy into *Child Health Plus* for the full premium price.)
- Virginia, between 2005 and 2009, incrementally expanded its *FAMIS Moms* program for pregnant women from 134 percent to 200 percent of FPL.

The six remaining states—California, Florida, Michigan, Ohio, Texas, and Utah—maintained their upper income eligibility limits through the study period, though notable events did occur, some of which constrained enrollment and others that expanded it. Specifically:

- California, facing a severe state budget deficit in 2009, elected to freeze enrollment in its separate *Healthy Families* program for three months, representing the only state in our sample to institute such a freeze;

- Ohio received federal approval to raise income eligibility to 300 percent of poverty effective July 2009, but decided not to implement the expansion in the face of growing budget stress; and
- Utah made a significant change to its eligibility policy in 2008 when it changed from periodic to year-round open enrollment for its *CHIP* program. This brought the state's program into alignment with all others across the nation, stabilized coverage opportunities for eligible children, and contributed to steady enrollment increases, according to key informants in the state.

Several states expanded eligibility through other means during the study period. For example:

- California, Texas, and Virginia took advantage of CHIPRA authority to add coverage of legal immigrant children during their first five years of residence;[18]
- Virginia also added coverage of legal immigrant pregnant women using CHIPRA authority;
- Alabama, Florida, and Texas used authority granted by the Affordable Care Act to add CHIP coverage of income-eligible children of state employees; and
- Louisiana and Texas used the unborn child option to add coverage of otherwise-eligible uninsured pregnant women.

[18] All three of these states covered this population before CHIPRA, but did so with state-only funds.

Table II.1. CHIP Eligibility as a Percentage of the Federal Poverty Level, FFY 2012

State	Program Type	Infants			Ages 1 to 5			Ages 6 to 15			Ages 16 to 19		
		Medicaid	Medicaid Expansion	Separate Program	Medicaid	Medicaid Expansion	Separate Program	Medicaid	Medicaid Expansion	Separate Program	Medicaid	Medicaid Expansion	Separate Program
Alabama	Separate	133%	N/A	300%	133%	N/A	300%	100%	N/A	300%	100%	N/A	300%
California[a]	Combination	200%	*	300%	133%	*	250%	100%	*	250%	100%	*	250%
Florida	Combination	185%	200%	N/A	133%	N/A	200%	100%	N/A	200%	100%	N/A	200%
Louisiana	Combination	133%	200%	250%	133%	200%	250%	100%	200%	250%	100%	200%	250%
Michigan	Combination	185%	N/A	200%	150%	N/A	200%	150%	N/A	200%	100%	150%	200%
New York	Separate	200%	N/A	400%	133%	N/A	400%	133%	N/A	400%	133%	N/A	400%
Ohio	Medicaid Expansion	150%	200%	N/A	150%	200%	N/A	150%	200%	N/A	150%	200%	N/A
Texas	Separate	185%	N/A	200%	133%	N/A	200%	100%	N/A	200%	100%	N/A	200%
Utah	Separate	133%	N/A	200%	133%	N/A	200%	100%	N/A	200%	100%	N/A	200%
Virginia	Combination	133%	N/A	200%	133%	N/A	200%	100%	133%	200%	100%	133%	200%

Sources: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012. Kaiser State Health Facts.

[a] California's Medicaid Expansion CHIP program uses Title XXI dollars to effectively eliminate the assets test for children by covering those who would otherwise be Medicaid

Three of the study states maintained or expanded premium assistance programs during the study period. Florida's *CHIP In* program works with businesses and family relatives to solicit donations to help families afford CHIP premiums. The *Utah Premium Partnership*, implemented in 2006, subsidizes premiums for employer-sponsored coverage based on family income, size, and whether or not the coverage meets basic state guidelines. Virginia's *FAMIS Select* was also adopted during the study period and subsidizes dependent coverage for families with access to employer-sponsored insurance.)

Table II.2. Number of Children Ever Enrolled in CHIP, FFY 2010

State	Medicaid Expansion Programs	Separate Programs	Total
Alabama	N/A	137,545	137,545
California	388,740	1,342,865	1,731,605
Florida	1,114	402,235	403,349
Louisiana	147,532	9,480	157,012
Michigan	14,422	55,374	69,796
New York	N/A	539,614	539,614
Ohio	253,711	N/A	253,711
Texas	N/A	928,483	928,483
Utah	N/A	62,071	62,071
Virginia	81,434	92,081	173,515

Source: CMS CHIP Statistical Enrollment Data Systems (SEDS), 2011.

2. Maintenance of Effort Protections

Maintenance of effort (MOE) rules instituted by ARRA and extended and broadened by the Affordable Care Act prohibit states from cutting eligibility and enrollment policies for Medicaid and CHIP to levels that are more restrictive than those in place when the Affordable Care Act was enacted in March 2010. These requirements apply until 2014 for adults and until 2019 for children in Medicaid and CHIP, with some limited exceptions.

State officials and other key informants in four of the study states reported that MOE rules played a crucial role in protecting CHIP and Medicaid eligibility standards in recent years, as state budgets came under pressure during the recession. For example, Alabama officials, facing a $10 million shortfall in 2012, asked CMS for permission to freeze enrollment in *All Kids*, and also to raise premiums beyond specified limits. Both requests were viewed as violating MOE and were denied.[19] The New York state legislature briefly considered cutting back its CHIP expansion from 400 percent of poverty, as well as reinstating the face-to-face interview for Medicaid, but stopped when they were told the moves would violate MOE rules. The Virginia legislature moved a bill that would have reduced income eligibility for *FAMIS* from 200 percent to 175 percent of FPL but that, too, was halted by the federal safeguard.

[19] Alabama was permitted to increase copayments, however, as such a change does not affect program eligibility.

B. Enrollment Policies and Procedures

Enrollment simplification continued to be a major priority of CHIP programs in most of the study states. CHIPRA played a direct role in spurring this continued interest, making available performance bonuses for states that adopt a set of enrollment and retention simplification strategies that experience has shown to be helpful in facilitating children's access to coverage. Specifically, to be eligible for a performance bonus, states must adopt at least five of the following eight strategies:

- 12-month continuous coverage;
- No asset test (or simplified asset test);
- No face-to-face interview;
- Joint application (and same information verification processes for Medicaid and CHIP);
- Administrative or *ex parte* renewals;
- Presumptive eligibility;
- Express Lane Eligibility; and
- Offer premium Assistance.

Except for premium assistance, states must adopt these measures for *both* CHIP and Medicaid to qualify for a bonus (Kaiser Commission on Medicaid and the Uninsured, 2009). In addition to adopting these strategies, states must also meet Medicaid enrollment growth targets established by CMS that demonstrate the strategies have resulted in significant improvement in enrollment and retention.

Over the years leading up to 2009, most states across the nation had adopted some, if not all, of these strategies. In fact, the options to drop assets from eligibility determination and to eliminate face-to-face interview requirements were already in place in all but a handful of states. But other strategies—like presumptive eligibility—were much less common, and Express Lane Eligibility was a brand new option created by the law. CHIPRA therefore aimed to stimulate further and more consistent action across the states.

Parents with children enrolled in CHIP who participated in focus groups in the study states generally praised the ease with which they were able to apply for and obtain health coverage for their children (see Focus Group Box II-1).

1. CHIPRA Performance Bonuses in the Study States

Five of the 10 study states qualified for CHIPRA Performance Bonuses during one or more years of the study period—Alabama, Louisiana, Michigan, Ohio, and Virginia—but all of the states had numerous policies designed to simplify children's enrollment, and many of these were in place prior to CHIPRA (See Table II.3). The five states qualifying for bonuses had no asset test or in-person interview requirement, and all used joint CHIP/Medicaid application and renewal forms and procedures. Four had 12-month continuous eligibility in both Medicaid and CHIP. Three used administrative or ex parte renewal, while two had presumptive eligibility. Just one state—Virginia—added premium assistance so that it could qualify for bonus monies.

Focus Group Box II-1: Enrollment

Parents consistently reported being satisfied with the CHIP eligibility and enrollment process, describing it as quite easy. Some observed that the process had improved over time.

"I didn't have any problems. It was easy, really." (Louisiana)

"I didn't even know that my kids could get [CHIP] … I was pleasantly surprised and went for it." (Michigan)

"I did [the online application] three months ago. I didn't have to send anything…it was a surprise." (California)

"[This time] the application process was better…much easier than when I first applied years ago." (Florida)

"I went online…it was just a lot of questions, but it wasn't hard." (Alabama)

The primary exception was among self-employed parents who struggled to produce necessary income and other documents.

"That was a nightmare…being self-employed. I don't have the same tax papers…as a working person. I was trying to do it myself…and I would just tear my hair out every time. Until I found the [application assistor]…and it was like the sun broke through the clouds." (New York)

"The hardest part for me is just the hassle of pulling up the current bank account information…and pulling up different balances and collecting the information for the verifications that they wanted." (Utah)

Some parents described problems that arose when their circumstances changed and their children had to transfer between CHIP and Medicaid, or vice versa.

"There was a gap in coverage of maybe two months between Medicaid and [CHIP]. The agencies didn't communicate; they didn't offer to switch to [CHIP] from Medicaid." (Florida)

Several parents mentioned poor treatment by the staff or variations from county to county.

"They [county eligibility caseworkers] act like [benefits] are coming out their pocket." (Ohio)

"I've been in [three] different counties…it is a little bit different where you go and how you are treated." (Ohio)

Notably, two additional states—California and New York—also met five of the eight performance bonus criteria, but did not receive award funds. Neither state experienced sufficient Medicaid enrollment growth to earn bonuses, a sensitive and frustrating issue for officials in these states who felt they were being punished for having achieved successful enrollment in the decade leading up to CHIPRA. Utah, meanwhile, adopted its fifth strategy in FFY 2012 and will receive a bonus next year.

Table II.3. CHIPRA Performance Bonus Criteria, 2012

State	12-Month Continuous Eligibility	No Asset Test	No In-Person Interview	Joint Medicaid/ CHIP Form	Administrative or Ex Parte Renewal	Presumptive Eligibility	Express Lane Eligibility	Premium Assistance	FY 2009 Bonus Payment (in millions)	FY 2010 Bonus Payment (in millions)	FY 2011 Bonus Payment (in millions)
Alabama[a]	X	X	X	X	X				$1.47	$5.69	$19.77
California	X	X	X	X		X			N/A	N/A	N/A
Florida	X	X	X	X	X				N/A	N/A	N/A
Louisiana	X	X	X	X	X				$1.55	$3.66	$1.93
Michigan	X	X	X	X		X			$4.72	$8.44	$5.90
New York[b]	X	X	X	X		X			N/A	N/A	N/A
Ohio	X	X	X	X		X			N/A	$13.13	$21.04
Texas	X		X	X					N/A	N/A	N/A
Utah[c]		X	X	X	X	X			N/A	N/A	N/A
Virginia		X	X	X	X			X	N/A	N/A	$26.73

Sources: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012; DHHS, 2012 "CHIPRA Performance Bonuses: A History (FY2009-FY2012)."; DHHS, 2011, "FY2011 CHIPRA Performance Bonus Awards."

Notes: This table reflects the status for FFYs 2009-2011 and does not include enrollment simplifications that did not qualify a state for a performance bonus. States that met 5 out of 8 simplification strategies and did not receive a bonus (California, New York, and Utah) were not eligible due to their inability to meet enrollment growth targets in Medicaid.

[a] Alabama's FY2009 and FY2010 performance bonus amounts have been revised due to an error in the calculation of the enrollment data originally reported to CMS; these amounts are still considered preliminary while the review process continues.

[b] New York adopted and received federal approval of an Express Lane Eligibility State Plan Amendment in FFY 2012 (not shown here because this is the status for FFYs 2009-2011).

[c] Utah adopted and received federal approval of an Express Lane Eligibility State Plan Amendment in FFY 2012 (not shown here because this is the status for FFYs 2009-2011). As a result, Utah received a performance bonus in FFY 2012.

Quite significant sums of money were awarded to states through this bonus process. Alabama, for example, received bonuses in FFY 2009, 2010, and 2011, totaling nearly $27 million.[20] Louisiana and Michigan, similarly, received bonuses all three years totaling roughly $7 million and $19 million, respectively. In just two years—FFY 2010 and 2011—Ohio earned over $34 million while Virginia earned nearly $27 million in FFY 2011, alone. Officials in several states mentioned that the promise of performance bonus funds directly persuaded state legislators to support proposals to streamline enrollment and renewal. Of note, however, most state officials reported that performance bonus earnings were deposited in the states' general funds and that only a portion were directed to CHIP or Medicaid administration.

1. Innovations in Facilitating Enrollment

Having the right array of policies in place is a first step toward facilitating children's enrollment into CHIP and Medicaid. But creative and effective implementation of enrollment procedures is arguably even more important. Key informants interviewed for the case studies described the multi-pronged efforts states employed to achieve high rates of program participation among eligible children. Some of these efforts reflected new advances in technology and data systems, including increased use of online applications and the development of integrated data systems for cross-program enrollment and information verification. Others continued practices that proved effective in the early years of CHIP implementation, including community-based application assistance. Finally, Express Lane Eligibility (ELE) began to be used by two of the states—Louisiana for Medicaid (and its Medicaid expansion CHIP program), and Utah for CHIP. (Alabama also adopted ELE, but for renewal under Medicaid, which is discussed further below.[21]) Table II.4 summarizes the various enrollment processes used by the study states. Highlights of particularly innovative practices appear below.

Online Applications. Marking a significant advance since the previous evaluation, this study found that fully nine of the 10 study states had developed and deployed online applications for their CHIP programs.

- Florida, for example, offers a joint, online application for CHIP and Medicaid.[22] Fully 89 percent of families now complete their applications online, where they can either sign and submit it electronically, or print out a portable document format (PDF) version of the completed form and submit it by mail or fax.
- A majority of families in Michigan—61 percent—also apply for coverage online, using the state's joint *MIChild/Healthy Kids* application. Initial income eligibility

[20] Alabama's 2009 and 2010 bonuses are being revised due to an error in the calculation of enrollment rates in the original data submitted to CMS; these amounts are considered preliminary while the review process plays out.

[21] After our site visits, New York also adopted ELE for Medicaid, using CHIP as the partner agency for enrollment.

[22] Florida's application, unique among the study states, includes three screening questions designed to identify children with special health care needs. Answering "yes" to any of the three questions triggers a clinical screening process by nurses employed by the Title V/Children's Medical Services program and, depending on the outcome of the screening, enrollment in the special-needs CMS Network. (Such "carve out" arrangements are discussed in more detail in Chapter V.)

determination is made in real time by the online system, triggering additional follow-up questions that then determine if the child is CHIP or Medicaid eligible.

- Between 2010 and 2012, the proportion of families applying online to Virginia's *FAMIS* grew from 48 percent to 78 percent, after the state enhanced its web-based system to allow electronic signatures as well as electronic submission of verification documents.
- California rolled out a public access version of its longstanding Health-e-App in December 2010. Without the benefit of any outreach or publicity of the move, the proportion of families applying for *Healthy Families* coverage using this online form jumped to 42 percent in just one year.

Table II.4. Current CHIP Enrollment Processes, 2012

State	Mail-in Application	Telephone Application	Online Application	Community-Based Application Assistance	Integrated Data System	Express Lane Eligibility
Alabama	X		X	X		
California	X	X	X	X		
Florida[a]	X		X			
Louisiana	X		X	X	X	X[b]
Michigan	X		X	X		
New York	X			X		X
Ohio	X	X	X	X		
Texas	X	X	X	X		
Utah	X		X		X	
Virginia	X	X	X	X		

Sources: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

[a] In Florida, outstationed application assistors are present only in certain areas of the state.

[b] Louisiana uses Express Lane Eligibility to enroll children in Medicaid (including the State's small Medicaid expansion component) but not in their separate CHIP program.

Key informants praised online applications not only for their ease of use by consumers and eligibility determination staff, but also because online submissions have typically proven to be more complete and accurate than paper applications.

Integrated Data Systems. To varying degrees, most of the study states have worked to design more integrated data systems, sometimes capable of linking across public benefits programs, and more frequently capable of linking to a range of state databases that can verify such critical information as applicants' income, employment, health insurance status, and citizenship. Two notable state systems include those of Louisiana and Utah.

- Louisiana's *LaCHIP*/Medicaid program has long been a pioneer in developing advanced data systems to support its eligibility function. Since 2004, the state has used a web-based Medicaid Electronic Case Record (ECR) system to support what has become a much more efficient and largely paperless eligibility system. All documents submitted by families are scanned into the ECR. Eligibility staff across

the state can access the system via the internet and take applications in the field using laptops (a capacity that was especially critical during the aftermath of Hurricane Katrina). Louisiana's system can link to a broad range of other databases, including SNAP (Supplemental Nutritional Assistance Programs), the Social Security Administration (for Social Security income and citizenship), an integrated employer payroll database (to verify income), a private insurance/coordination of benefits database (to verify other private health coverage), the state child support enforcement system (for additional sources of income), and the federal Immigration and Naturalization system (to determine legal resident immigrant status), among others. Together, this capacity reduces administrative costs, permits faster application processing, and dramatically reduces the amount of paper verification the state needs to collect from applicants.

- Utah's *CHIP* program is noteworthy for its centralized, internet- and rules-based eligibility system called *E-Rep,* administered by the state Department of Workforce Services (DWS). Rolled out in 2009, the system employs a universal application that supports eligibility determination for CHIP, Medicaid, SNAP, TANF, and child care subsidies, allowing for a "one stop shopping" experience for consumers. In addition to accessing the application from any location with a broadband connection, consumers can visit one of Utah's 33 Employment Centers where they can apply for public benefits while searching for jobs.

State officials shared that advanced data systems like these had the benefit of not only making the application process for families easier, but also produced economic efficiencies for the states, a benefit that was especially helpful during the economic downturn when state agency staffing was often cut.

Community-based Application Assistance. A strategy that emerged in the early years of CHIP implementation, community-based application assistance revolutionized traditional outreach by allowing staff of local agencies and providers to also provide application assistance and support to families with uninsured children. Often reflecting the ethnicities of the communities in which they worked, these trusted staff are culturally competent and successful in helping hard to reach populations in accessing coverage.

Eight of the 10 study states described a range of application assistance models, including New York's Facilitated Enrollment (which relies on 41 certified agencies and 17 of 19 participating health plans), Ohio's Benefits Banks (which utilize an estimate 1,300 benefits counselors across the state's 88 counties), and

Focus Group Box II-2: Application Assistance

Parents described how helpful it was to have an application assistor available to help them through the process, make sure that information was entered correctly and that the paperwork would not get lost.

"I made an appointment with [the application assistor] who went over the whole program and what's covered. [She] was very nice…and helped me with the application and guided me, because I didn't know what to do." (California)

"My [application assistor] is on my speed-dial! Anytime I have a question, I call [her]. She even calls me and asks me how things are going!" (California)

"The [application assistor] was incredibly helpful…because I was really confused about how to do this." (New York)

"[Application assistors] were real people who could understand and answer my questions… I was much more comfortable and happy…[it was] very easy." (New York)

"You immediately get the impression [application assistors] are on your side. She made it very clear exactly what we needed…it was very streamlined." (New York)

"I always like to get help from the lady at the center [community center] so I know everything is done right." (Texas)

Virginia's SignUpNow program (which employs 16 full-time staff who train local agencies, schools nurses, and health provider in how to complete the *FAMIS* form[23]). As will be discussed in Chapter III, many of these programs have lost direct state funding support in recent years. But their proven effectiveness has convinced other funders—including local governments, philanthropic foundations, and safety-net providers—to support such operations. California, for example, funded one of the first such programs in the nation—called Certified Application Assistance—that, at its height, paid upwards of 24,000 assistors working across the state $50 per successful application. Over the years, however, state funding dwindled and was eventually eliminated. Still, a great many agencies and providers saw value in continuing the service and still provide application assistance today. Similarly, parents expressed great appreciation for the availability of application assistance (see Focus Group Box II-2).

Express Lane Eligibility. A new option created by CHIPRA, Express Lane Eligibility (ELE) permits states to use the findings of other need-based programs to establish or renew eligibility for Medicaid and CHIP. As of December 2012, a total of 13states across the country have received federal approval for ELE plan amendments in either CHIP or Medicaid, partnering with such programs as SNAP, WIC, TANF, and the National School Lunch Program to help enroll or renew coverage for children in these programs. Four of these states—Alabama, Louisiana, New York, and Utah—are in this study.

Louisiana, for example, was the first state in the nation to use ELE to automatically enroll uninsured children with SNAP into Medicaid. After a year-long process to develop links between Medicaid and SNAP data systems, over 10,500 children were enrolled into Medicaid in February 2010 based on SNAP records. Since then, data matches to identify SNAP-enrolled children who are not enrolled in Medicaid occur daily, and these children are auto-enrolled into coverage without requiring parents to do any paperwork whatsoever.

2. Challenges in Coordinating CHIP and Medicaid Operations

Despite these many noteworthy accomplishments, challenges still remain for states as they work to coordinate their CHIP and Medicaid operations. One set of challenges surrounds the extent to which CHIP and Medicaid policies are aligned. Over the years, states have mostly aligned the two programs' eligibility policies. Yet inconsistencies were identified in the case study states. Most often, these took the form of Medicaid policies that were not as generous as CHIP policies, such as Utah's maintenance of an asset test for Medicaid, but not for CHIP, or Texas' use of a six-month eligibility period for children in Medicaid, but a 12-month period for CHIP.[24] Utah grants 12-months continuous eligibility for children in CHIP, but requires children in Medicaid to re-verify eligibility each month. Such differences, while increasingly rare, still serve to impose extra restrictions on children and families that are arguably more vulnerable, and complicate the program administration and children's transitions between programs as family circumstances change.

[23] Staffing levels have vacillated considerably over the years with changes in funding levels.

[24] The 12-month eligibility period for CHIP is for those with income levels up to 185 percent of poverty. For those at higher income levels, the state conducts administrative verification of eligibility every 6 months.

Other challenges relate to how CHIP and Medicaid eligibility are administered and result when different agencies (or vendors) are unable to fully coordinate their practices. Only three of the study states—Louisiana, Ohio, and Utah—administer CHIP and Medicaid out of the same state agency. In the cases of Louisiana and Ohio, this is because the programs were launched as Medicaid expansions under Title XXI and joint program administration was always seen as one of the advantages of this approach to CHIP. In Utah, eligibility for all public benefits programs was consolidated in a single agency—DWS—in 2008. But for the remaining study states, CHIP eligibility administration occurs separate from that of Medicaid, with authority housed either in different state agencies (in Alabama, for example, where the Department of Public Health runs *ALL Kids* while the Department of Medical Services runs Medicaid), or by vendors hired by the state to act as centralized eligibility triage and determination entities. This latter arrangement is used in California and Michigan (which each contract with MAXIMUS), and Florida and Virginia (which each contract with Xerox). Texas also currently contracts with MAXIMUS for *CHIP* but will transfer *CHIP* eligibility functions to state staff (who determine eligibility for children's Medicaid) when it migrates the CHIP cases to the same system used for Medicaid in September 2013. New York, unique among the states, splits the eligibility function between local departments of social services (for Medicaid) and health plans (for CHIP). In all of these states, officials have worked very hard to improve coordination and integration between state and local government agencies doing Medicaid eligibility, and other entities and vendors doing CHIP eligibility. To a large extent, their efforts have paid off and operations were reportedly quite smooth.

Inevitably, however, problems can arise between the agencies, especially surrounding referrals and transfers of applications. For example, when a vendor reviews a joint application and determines a child is likely Medicaid eligible, they are required to transfer that application (and its supporting material) to the responsible state or county department. Applications can be delayed or even get lost during such transfers; in California, child advocates described the "black hole" that applications would sometimes fall into when they were transferred from the state's single point of entry vendor to one of 58 county departments of social services. Other problems arise because different agencies and vendors use different data systems that don't communicate with one another; Florida's four programs that make up *KidCare*, for example, employ four different information systems. Still other problems can arise when states switch vendors, and the transfer of cases between different systems results in coverage disruptions, or new vendors experience challenging learning curves and make numerous mistakes as they implement new eligibility determination operations.

Another set of challenges surround programs where local departments of social services are independent authorities, responsible for eligibility determination, as opposed to extensions of state government. This circumstance exists in three of the study states selected for this evaluation—California, New York, and Ohio—and key informants in these states described how common it was to witness inconsistent operations and cultures across counties, with some being more progressive and facilitating in their approach to eligibility determination, and others more traditional and punitive in their approaches. The latter was often described as a vestige of these agencies' roots as welfare departments, designed to avoid errors and meter out benefits only to those they were certain were eligible. County systems are often further hampered by using outdated information systems that are slow, inflexible, and hard to use. Ohio's 30-year old CRIS-E system was a prime example of such a system. Problems like these were less evident in states like Alabama and Louisiana, where county and parish (respectively) offices are arms of the

state, policies are rolled out uniformly across the state, and trainings to adjust agency culture and orient workers toward more facilitative practices can be more successfully implemented.

C. Renewal Policies and Procedures

The early years of CHIP implementation saw states struggle with retaining children in coverage. Early research found that less than half of children up for renewal were approved for continuing eligibility after redetermination (Hill and Westpfahl Lutzky, 2003). But states were quick to identify the problem and began applying many of the same simplification strategies to renewal that they had adopted for initial enrollment, including designing shorter and simpler forms, permitting renewal applications to be submitted by mail, preprinting renewal applications with information already submitted by families on their initial applications, and reducing requirements for submission of income and other documentation (Hill et al. 2003).

Findings from this evaluation indicate that most states are focusing greater attention on renewal, understanding that achieving high retention rates was crucial to maintaining progress in reducing the ranks of uninsured children. Still, some states acknowledged slower progress on this front. Following roughly parallel tracks with enrollment, simplified renewal policies and procedures have been adopted by the majority of states and technological advances are producing positive results.

1. Simplifying Renewal Procedures

The study states conducted eligibility redetermination in quite similar ways, but employed a wide range of strategies in their efforts to simplify the process (see Table II.5).

- In every state but Louisiana, CHIP programs require some level of active involvement of families in the renewal process. (Louisiana's passive renewal procedures are described further below.)
- Generally speaking, state or local agencies, vendors, or health plans send notices to families 60 or 90 days before a child's eligibility is due to expire, and then repeated reminder notices and/or phone calls to families that don't respond as the anniversary date approaches
- In six of the study states—Alabama, California, Florida, Texas, Utah, and Virginia—these notices include pre-printed renewal forms, displaying personal, demographic, and income information submitted with the child's initial application for coverage, and parents are asked to either verify that the information displayed is still accurate, or submit updated information. In the other states, blank renewal forms are included and parents are asked to re-apply for continued coverage.
- Parents can self-declare their income in six states—Alabama, Florida, Louisiana, Michigan, New York, and Virginia—and with the exception of Michigan, states administratively verify the accuracy of parents' attestations after the fact by searching available databases. In the other states, parents are asked to resubmit income documentation, but typically states also administratively verify that these documents are valid, or do so in cases where documents are missing.

Table II.5. Current CHIP Renewal Requirements and Procedures, 2012

		Renewal Requirements				Renewal Processes					
State	Program	Active Renewal	Preprinted Form	Self-Declaration of Income	State Administratively Verifies Income	Passive Renewal	Ex Parte Renewal	Rolling Renewal	Mail-in Renewal	Online Renewal	Express Lane Eligibility
Alabama	CHIP	X	X	X	X				X	X	
	Medicaid	X	X		X				X	X	X
California	CHIP	X	X						X	X	
	Medicaid/M-CHIP	X							X		
Florida	CHIP	X	X	X	X				X	X	
	Medicaid/M-CHIP	X	X[a]						X	X	
Louisiana	CHIP			X	X	X	X	X	X	X	
	Medicaid/M-CHIP			X	X	X	X	X	X	X	X
Michigan	CHIP	X		X					X	X	
	Medicaid/M-CHIP	X		X					X[b]	X[b]	
New York	CHIP	X		X	X				X		
	Medicaid	X	X		X				X		
Ohio	Medicaid/M-CHIP	X						X	X	X	
Texas	CHIP	X	X		X				X	X	
	Medicaid	X	X		X				X	X	
Utah	CHIP	X	X		X	X			X	X	X
	Medicaid	X			X				X	X	
Virginia	CHIP	X	X	X	X					X	
	Medicaid/M-CHIP				X	X	X	X	X		

Sources: Case study reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

[a] In Florida Medicaid/M-CHIP, preprinted/pre-populated forms are used unless a family's income has changed.

[b] In Michigan Medicaid/M-CHIP, beneficiaries can also renew their benefits in person at their local Department of Human Services offices.

- Every state CHIP program but New York's allows renewal applications to be resubmitted online, and every state but Virginia also allows them to be submitted by mail.
- Louisiana and Ohio allow rolling renewal of CHIP coverage; that is, if a child encounters the eligibility system before their anniversary, workers are permitted to update and renew coverage at that time and establish a new year's worth of eligibility.
- Most states that use community-based application assistance to help families enroll in CHIP also allow assistors to help families renew their children's coverage. Similarly, states that allow health plans to provide application assistance, also enlist the help of these plans in renewing children's eligibility.

Express Lane Eligibility can be used by states to facilitate children's renewal of coverage, as well as their initial enrollment. Three of the study states employ some version of ELE for renewal, as described below.

- Louisiana's and Alabama's ELE system for Medicaid extends to renewal such that, at renewal time, if the state's data match between Medicaid and SNAP shows that a child continues to be enrolled in SNAP, their Medicaid eligibility is automatically renewed.
- Utah adopted in 2012 a very different form of ELE renewal; families with children enrolled in CHIP can opt into a system whereby their adjusted gross income from the state's income tax system will be used to assess their children's ongoing eligibility status. To participate in this system, parents must grant permission to the DWS agency to access their tax records. As a safeguard for this brand new approach, Utah allows any family that does not agree with the outcome of the tax-based determination to fall back on the traditional renewal process.

Louisiana's *LaCHIP* and *LaCHIP Affordable* plans arguably employ the most sophisticated and successful renewal process in the country. State officials described four key renewal pathways that accommodate families and children in differing circumstances. For example, every child—in advance of his/her 12-month anniversary—has their case reviewed by state staff to see if it can qualify for administrative renewal. Through mining its various databases, staff can identify cases where, for example, there has been no change in eligibility status in three years and net income is less than $500 per month. In such cases, families are to report any changes to their family circumstances, and if none are reported, eligibility is automatically renewed for another 12 months. Ex parte renewal is then performed on cases that don't qualify for administrative renewal. In these cases, state staff again review existing linked databases for verifying personal, income, and employment information and extend eligibility if the client still qualifies. When neither administrative nor ex parte renewal results in a determination, cases are pushed through the Medicaid Eligibility Data System to analysts who make direct contact with the client. Notices are sent to these clients 30 days before the child's anniversary, a toll-free number is included in the notice, along with a link to an online renewal portal. Clients can renew coverage by either calling the worker on the toll-free line, or reviewing and updating the renewal form accessed online. These steps permit almost 90 percent of all renewals to be processed in a paperless fashion. In combination, these strategies have reduced the rate of case closures for procedural reasons (i.e., reasons other than a change in income) from over 22 percent in 2001 to less than one percent in 2011.

Once again, parents participating in this study's focus groups praised CHIP renewal procedures, describing them as quite easy (see Focus Group Box II-3).

Focus Group Box II-3: Renewal

Parents generally described the CHIP renewal process as uncomplicated and requiring little effort. Many attributed this to pre-populated forms, received in the mail, that they simply sent back with updated information. Some with children enrolled in the program for many years noted that the process has improved over time.

"Now [the renewal process] is good, because you don't really do anything. You do it over the phone…you don't even have to go into the office anymore. The only thing they ask is if anything changes, you notify them." (Louisiana)

"The renewal is super easy. They do make it very user friendly." (California)

"Reapplying is easier than the first time [you apply]." (Michigan)

"It's definitely…gotten easier over the years." (Utah)

"*It's pretty simple I think. They send it to you [in the mail], and they just say if anything changes, you write down what changes." (Virginia)*

"Renewal was very easy. I actually do it online and since my information is the same, there is only some information that I have to fill in and I send the check in. They actually send (the reminder) to me in email or in the mail." (Florida)

However, participants who were self-employed found the renewal process more burdensome.

"The time of the renewal is difficult. Because we are self-employed, we have to provide a lot of documentation. It would be easier to renew right after tax time when we have all the documents at hand." (Florida)

Some parents preferred to get help from their application assistors to complete the renewal process.

"I actually had all of the answers and all of the information. But it was more of a comfort going to [my application assistor] to know it is accurate, it's going to be processed, as opposed to…going into a black hole." (California)

"The [application assistor] actually called me with a reminder…saying that my renewal was coming up and that I should've gotten my packet in the mail. I hadn't, so I was grateful that they called…" (California)

Other parents in states with older, county social services-based processes found renewal to be much more cumbersome.

'I am going through [renewal] right now and it is really confusing." (Ohio)

"I hate it, I anticipate it every year because you have to redo everything. I know it is necessary. I always anticipate that they're going to deny me." (Ohio)

2. Comparisons with Medicaid

Renewal policies and procedures for Medicaid and Medicaid-expansion CHIP programs are similar to, but not as consistently simplified, as separate CHIP programs. As seen in Table II.5, fewer Medicaid and Medicaid-expansion CHIP programs allow families to self-declare their income at renewal, pre-print renewal forms, or permit online submission of renewal applications. Express Lane renewal is the exception, where two of the three examples in the study states are exclusively for children enrolled in Medicaid (because Medicaid income levels are typically more aligned with programs such as SNAP than are those of CHIP).

D. Conclusions

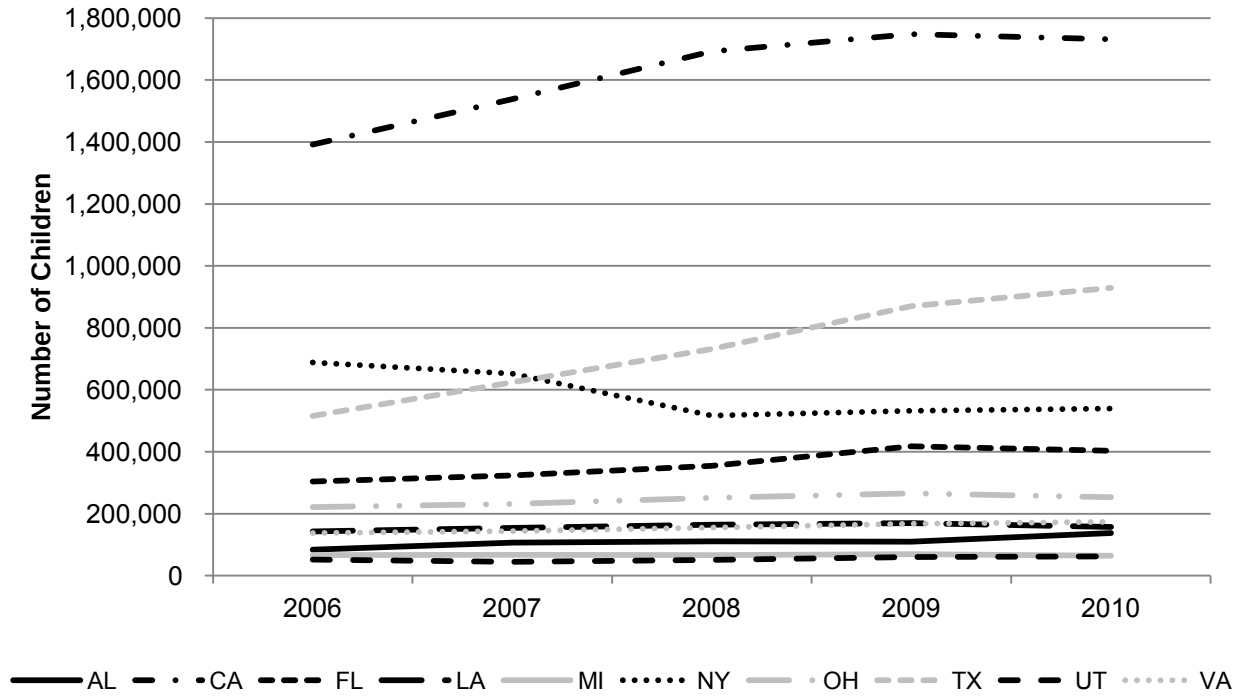
The case studies revealed an overall positive picture of eligibility, enrollment, and renewal policies and procedures in the study states. In recent years, states either expanded or maintained their income eligibility limits and some have added coverage of new groups of children and pregnant women. The availability of performance bonuses, made possible through CHIPRA, spurred many states to expand their use of enrollment and renewal simplification strategies. MOE rules established by the American Recovery and Reinvestment Act (ARRA) and extended

and broadened by the Affordable Care Act tangibly protected CHIP programs from proposed cuts to income eligibility and enrollment procedures. The results of these trends are illustrated in Figure II.1 where we generally see modest and steady enrollment gains across the states. Some plateauing or even declines in enrollment can be observed in 2007/2008; state officials explained that they believed these were due to the recession causing many families to lose jobs and income and, thus, fall from CHIP coverage into Medicaid.

Still, persistent challenges remained in several states, most notably characterized by CHIP and Medicaid policies being out of alignment, or multiple and/or outdated information systems that hindered efficient enrollment or transfers of children between the two programs, or disconnects between state or local agencies responsible for Medicaid eligibility determination, and private vendors responsible for CHIP eligibility.

Looking forward, state officials and other key informants viewed oncoming health reform under the Affordable Care Act as a way of addressing some of these system weaknesses, as the law requires modernization and better integration of eligibility data systems for Medicaid, CHIP and health insurance exchanges, changes that will certainly hold implications for CHIP systems. Furthermore, informants viewed the community-based application assistance systems developed and refined under CHIP to provide a strong foundation upon which health exchanges can build their navigator systems to help families apply for subsidized coverage. (These views are discussed in more detail in Chapter IX.)

Figure II.1. Number of Children Ever Enrolled in CHIP, FFYs 2006-2010



Sources: CMS CHIP Statistical Enrollment Data Systems (SEDS), 2011; Michigan enrollment data from the state were determined to be more accurate estimates than publicly available data. Data was provided from personal communication with B. Keisling, DCH, November 29, 2012; The CHIP numbers for Texas include their perinatal program for the year 2007 and beyond. Data was provided by Texas' Health and Human Service Commission Financial Services, November 5, 2012.

III. OUTREACH

As the first CHIP programs in the nation rolled out in the late 1990's and early 2000's, states launched strategic outreach efforts to market the new coverage program to eligible populations. States aggressively publicized the availability of health insurance coverage for children, and concluded that multi-pronged approaches involving both broad, statewide marketing to create a strong brand identity for their programs were needed, as well as more targeted, community based efforts to attract hard-to-reach families (Hill et al. 2003). Both efforts proved especially critical in firmly establishing CHIP programs (Hill et al. 2003).

Since 2005, outreach generally and statewide marketing campaigns in particular have been subject to significant cuts in the face of federal funding uncertainties (pre-CHIPRA) and severe state budget constraints during the Great Recession. In many cases, community-based outreach efforts have worked to fill voids left by state cuts to marketing and outreach, although community groups also have often had to do more with less as their funders (such as foundations) have also been hit hard in recent years. Nearly all states confirmed that community-based outreach efforts continue to be an important tool for reaching and assisting more isolated communities—including ethnic minorities, immigrant families, and families with unique language or cultural barriers. Furthermore, these community-based efforts hold great promise for transitioning or expanding to provide services in the context of the Affordable Care Act's Health Insurance Exchange Navigator Programs (discussed further in Chapter IX). We heard reports from community groups in several states about their hopes to take on those roles, as they are well-positioned to understand the issues.

CHIPRA outreach grants have played an important role funding new outreach efforts in many states since 2010. With CHIPRA, HHS authorized two rounds of grants—each lasting up to two years—which were designed to fund activities that support enrollment, renewal, and outreach. Funding amounts ranged from $200,000 to $2.5 million. In some cases, projects supported by CHIPRA outreach grants have coordinated with the states to ensure the most effective use of these additional resources—and in one case (Louisiana), the state agency was a grantee, allowing them to directly support outreach efforts.

A. Statewide Marketing and Outreach

There has been a dramatic decrease in statewide marketing efforts since the early days of CHIP, partially in response to state budget constraints, but also because state officials and other stakeholders perceive that CHIP program brands have been well-established and therefore require less mass-media investment. An exception was Florida where, despite state efforts to brand their CHIP programs under a single umbrella, consumers expressed confusion during focus group discussions, indicating that the brand was not as well known, understood, or engrained as state administrators believed. While all 10 states included in this evaluation have had state-funded marketing/outreach campaigns at some point since CHIP was first authorized, during this study's site visits only three states—Virginia, Utah, and Texas—were found to be continuing with funding of statewide marketing campaigns. Even some of these were characterized as very limited in scope (Table III.1).

Table III.1. State CHIP Outreach Strategies, FFY 2012

	Statewide Media Marketing	Community Based Efforts	Health Plan Education or Marketing
Alabama			
California		X	X
Florida		X	
Louisiana		X	
Michigan		X	X
New York		X	X
Ohio		X	X
Texas	X	X	X
Utah	X	X	X
Virginia	X	X	

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

This is a stark contrast to the early years of the program, when several states had significant advertising budgets and launched large campaigns to promote CHIP. In states with separate programs, establishing a positive brand for CHIP was a primary goal. For instance, New York's "Growing Up Healthy" campaign utilized radio and television advertisements, print media and materials, and a toll-free hotline, to promote the program as affordable healthcare with comprehensive benefits, and availability regardless of citizenship status (Hill and Hawkes 2002). But during this study's visit to New York, it was learned that the state's marketing budget was zeroed out in 2007, resulting in the elimination of the "Growing Up Healthy" campaign. Though informants universally agreed that the campaign had been instrumental in establishing New York's CHIP program early on, many also recognized that the need for a large marketing campaign had decreased over the years—as the program's reputation had been well established—and its elimination did not likely impact *Child Health Plus* enrollment.

California similarly invested significant state funds to promote its separate CHIP program, *Healthy Families*, early on (Hill and Hawkes 2002). California's marketing investments were credited with firmly establishing the program, but state marketing budgets dried up in 2005, leaving state agencies with no money to fund advertising campaigns. In California, many stakeholders acknowledged that by 2005 the program brand was very well known and, as a result, statewide marketing was no longer as critical as it had once been. On the other hand, several state administrators posited that the elimination of statewide marketing may have very well affected enrollment in recent years, particularly surrounding the 2009 *Healthy Families* enrollment freeze, which was fraught with confusion (discussed in Chapter II).

Some states eliminated statewide marketing efforts early on in their program's history (Michigan, for instance, halted funding for statewide outreach in 2002), while others did so more recently—typically between 2005 and 2008 when funding uncertainties for CHIP overall were particularly evident. An anomaly to the overall trend, Texas initially scaled back on statewide outreach in 2003, but reinvested in statewide efforts in 2006, with annual funding of $2 million. Informants in Texas noted that the state chose to reinvest in statewide outreach as a result of concerns about large drops in enrollment. In turn, they implemented a two-pronged approach

which entails a) statewide back-to-school and end-of-school media campaign, and b) providing grants to community-based outreach programs. Alabama also made a significant investment in statewide marketing as recently as 2010 to promote its eligibility expansion to children with family incomes up to 300 percent of FPL. At that time, the state launched a new advertising campaign—leveraging athletic events to get the word out about the recent *ALL Kids* expansion. As part of this campaign, regional outreach coordinators attended University of Alabama football games, and *ALL Kids* would sponsor other prominent athletic events. All outreach in Alabama, however, was halted in late 2011 in an attempt to curtail enrollment as the program faced severe budget constraints.

Back-to-school campaigns have been maintained in states that otherwise significantly scaled back their state outreach budgets in recent years. For instance, Virginia, which has retained a limited state outreach budget, continues to fund a back-to-school campaign annually and also provide grants to the Virginia Health Care Foundation (VHCF). VHCF uses these funds to support community-based outreach programs (discussed further in the next section). Utah, having also cut its state outreach budget significantly in 2009, has retained a small back-to-school campaign, which has essentially involved including brochures for the *CHIP* program in back to school packets.

As illustrated in Focus Group Box III-1, parents reported hearing about CHIP in a variety of ways, including statewide marketing campaigns.

B. Community-Based and Health Plan Outreach Strategies

While states' marketing budgets have dwindled over the years, robust community-based outreach efforts have persisted in most states including California, Florida, Louisiana, Michigan, New York, Ohio, Texas, and Virginia. Strong community ties and earned trust among staff of community-based organizations (CBOs) have made this approach to outreach particularly effective, with a lifespan that has extended beyond the large, expensive branding campaigns launched early on. In some states, health plans have also contributed to outreach and marketing to fill some of the voids left as state outreach budgets are eliminated. Moreover, as CHIP programs have become better known, CBOs and health plans have been critical in working with and enrolling harder to reach populations, and keeping people from churning on and off programs.

In some cases, such as Virginia, Texas, and Louisiana, we learned that community-based efforts have received funding from the state, but private foundations—and more recently CHIPRA outreach grants—are more common sources of support.

As described in Chapter II, CBO outreach efforts often involve culturally competent application assistance, which many state informants pointed to as a critical component of their state's success in enrolling children in CHIP and Medicaid. For instance, New York's Facilitated Enrollment (FE) program provides application assistance and health plan selection guidance. Both key informants and consumers cited the FE program as critical to navigating what can be a complicated application process—particularly for self-employed parents. In California, the state initially dedicated several million dollars to funding community-based application assistance—granting a finder's fee to application assistors through their Certified Application Assistance (CAA) program upon establishing its *Healthy Families* program. California's CAA's continue to play a significant role assisting families with CHIP and Medicaid enrollment today, despite the elimination of state funding. In recent years, CAA efforts have instead been funded by a variety of grants, or by health plans and local government (i.e., counties) themselves. In Texas, the state funded a pilot program in which interested organizations and volunteers are trained to become navigators, with the ability to assist families with filling out CHIP and Medicaid applications online. The state is moving ahead with statewide implementation in 2013. Texas has found this direct assistance program to be helpful in reaching uninsured children in the state.

Focus Group Box III-1: Outreach

Families in focus groups reported hearing about CHIP through both formal and informal channels.

"My mom worked at a doctor's office, so she told me about it." (Michigan)

"I heard about it from school…they gave something out." (California)

"My husband lost the work…that's when my friend told me about it." (California)

"I got it online…the information is there…" (New York)

"I was originally on Medicaid, and then I made too much money, so they referred me to CHIP." (Utah)

A few parents reported hearing about CHIP through broad marketing strategies; some parents recalled them from a long time ago.

"On the television you hear a lot about the CHIP program so people know that there is insurance for children who don't qualify for Medicaid." (Texas)

"My neighbor called me to say that she saw a commercial online that your child could get insurance.… I'm always trying to get insurance." (Ohio)

"We were driving…and saw a big billboard." (Alabama)

"I saw lots of commercials about it. My children were on Medicaid, but when my Social Security disability came through, we were kicked off Medicaid. They needed constant medical attention. It wasn't a very long wait. I saw a commercial and tried again to sign up." (Florida)

"They did have some ads on the TV, which is how I initially learned about it…I think when the program was first starting up." (Utah)

One parent expressed disappointment with outreach in their state.

"I don't see much in terms of exposure… Different communities [and] ethnicities don't know that something like this is available…so I think they should have [more] community outreach." (New York)

Florida, Louisiana, Michigan, Ohio, and Virginia also provide application assistance through CBO outreach models. Importantly, we found that the community-based organizations involved with this level of outreach typically wear multiple hats, and will also regularly participate in health fairs, and distribute promotional materials (such as brochures and program applications) to educate the public on available programs.

In three of the states visited, health plans are also integrally involved in outreach and application assistance. New York, for instance, has fully embraced the role that health plans can play in marketing CHIP and Medicaid and enrolling potential members, as well as retaining them—relying on the plans' self-interest to be a significant motivator. For example, as mentioned above, the state's Facilitated Enrollment program empowers not only CBOs, but health plans as well, to provide application assistance to families with uninsured children. To offset concerns that health plans will take advantage of this role by attempting to steer applicants to their plans, New York has also put in place several checks designed to detect abuse, including secret shoppers who monitor health plan activity, careful review of health plan enrollment patterns, and oversight of health plan marketing materials. Utah, which also involves health plans in CHIP outreach, has been more cautious. Though state officials are appreciative of the role that health plans can play in promoting CHIP, they are also wary of the potential for inappropriate marketing and have thus carefully overseen the development of materials to ensure that CHIP, and not the plans, is being marketed.

In Michigan, where state outreach funds for *MIChild* and *Healthy Kids* were eliminated in 2002, MAXIMUS—the state's third party administrator—and health plans participating in the two programs have been primarily responsible for outreach. This has involved participation in health fairs, exhibits, and school/community activities, as well as sponsoring occasional radio and television campaigns. In light of the recent recession, health plans in Michigan have also reported making presentations to large businesses planning layoffs in order to introduce Medicaid and CHIP to the newly uninsured.

Louisiana expects to see growing health plan involvement in outreach in the coming years. The state has been directly funding the Covering Kids and Families outreach program since support from the Robert Wood Johnson Foundation ended in 2004, but has decided it will no longer do so in 2013, with the expectation that *Bayou Health*, the state's new managed care program for CHIP, will pick up responsibility for outreach and marketing.

C. CHIPRA Outreach Grants

With CHIPRA outreach grants, federal funding for outreach was provided as state funds were evaporating. These grants, targeted primarily at community based organizations, have played a significant role in supporting and sustaining outreach efforts, enabling such groups to maintain a high level of involvement. Groups in each of the 10 states we visited have received at least one CHIPRA outreach grant, though multiple grants were awarded in most of these states (see Table III.2 for a list of CHIPRA outreach grantees by state). These grants have played varying roles in each of the states, and appear to have worked particularly well when building on existing efforts. Across the board, however, key informants argued that CHIPRA outreach grants have been a very important provision of the legislation, allowing outreach to continue in the midst of drastic state funding cuts.

In Virginia, for instance, CHIPRA outreach grant funds were used to support the state's "Sign Up Now" and "Project Connect" programs, which have been successfully operated by the Virginia Health Care Foundation for many years. An advantage to this approach is that VHCF was able to deploy staff immediately, avoid start-up costs, and simply expand an already successful outreach model by hiring and training additional staff. In Utah, CHIPRA outreach grant funding was used by the Urban Indian Center of Salt Lake City to fill an important role reaching eligible but not enrolled American Indians along the Wasatch Front and other areas of

the state. The state's second grantee—the Association for Utah Community Health (AUCH)—used funds from its CHIPRA outreach grant to hire application assistors and place them in four different federally qualified health centers (FQHCs)—two large urban centers, one small rural center, and one Healthcare for the Homeless clinic—which together assisted 10,000 families over the two year grant period. Ohio, a state with no state-funded outreach since 2005, received four CHIPRA outreach grants, which have played a very important role in sustaining outreach and application assistance in the state, with a focus on improving awareness of *Healthy Start* among school based staff to increase referrals to community-based organizations that assist families with enrollment.

The degree of coordination between CHIPRA outreach grantees and state agencies has varied. For instance in New York, where the CHIP brand has been well-established and there exists a robust network of application assistors, the state agency felt that CHIPRA outreach grantees—who were not CHIP program facilitated enrollers—had not optimally coordinated with existing state efforts. In Alabama, on the other hand, the Alabama Primary Care Association (APCA) worked closely with the state on a grant to design to place kiosks in health centers and other enrollment sites where families could apply for coverage using a web-based tool. The kiosks also double as account management portals and can be set up to communicate with electronic health records at a given health clinic. While the kiosks remain somewhat underutilized according to key informants in the state, they are still seen as a useful tool, and one that may become even more important in years to come if Alabama expands Medicaid coverage of adults under the Affordable Care Act. The Michigan Primary Care Association (MPCA) received two CHIPRA outreach grants and is deploying community navigators to assist families with initial applications and implementing innovative methods for retaining families. The MPCA received an award from HHS for its efforts.

D. Conclusions

States' early investments in broad-based marketing and outreach paid off, establishing well known and well regarded brands for state CHIP programs. But over the years, CHIP outreach has evolved—responding to both specific state needs and ongoing budget constraints—shifting away from broad-based marketing campaigns to community-based efforts. With shrinking state support, funding from foundations, CHIPRA outreach grants, and other sources has been critical in continuing the challenging work of reaching families that are most isolated and most in need of public health insurance coverage.

While most child advocates and state administrators interviewed for this study expressed continued commitment to reaching eligible but unenrolled children, some states struggling with particularly challenging budget circumstances have scaled back outreach efforts specifically to limit the growth of the program. The impact of these changes, however, has been mitigated by the fact that states invested heavily early on in establishing brand recognition for their CHIP programs. In addition, CBOs continue to work to enroll harder to reach populations, while health plans (in certain states) have continued broad-based marketing efforts. Moreover, CHIPRA outreach grants have played an important role in recent years—stabilizing funding for CBOs that have been awarded grants, and sometimes generating new efforts that have been tailored to meet the specific needs of a state, community, or healthcare setting.

Table III.2. CHIPRA Outreach Grants, 2012

State	Year	Grantee	Amount	Purpose of Grant
Alabama	FY 2010	Alabama Primary Care Association	$987,732	Establish computer-equipped kiosks for applications and renewals at FQHCs, hospitals, and other locations.
	FY 2010	Tombigbee Healthcare Authority (THA)	$141,167	Hire outreach coordinators for rural clinic
California	FY 2010	Providence Little Company of Mary Foundation	$317, 144	Implement community-based enrollment and retention strategies in six Los Angeles neighborhoods
	FY 2010	Yolo County Children's Alliance (YCCA)	$399,900	Assist with outreach, enrollment, and retention efforts through a partnership with the Medi-Cal administration
	FY 2011	Alameda Health Consortium	$850,000	Improve retention at eight FQHCs using multilingual materials
	FY 2011	Los Angeles Unified School District	$982,170	Target outreach and enrollment in 13 wellness center school complexes
	FY 2011	Mendocino County Office of Education	$769,313	Improve retention when children move from primary school to middle school and middle school to high school
	FY 2011	California Primary Care Association	$1,000,000	Increase the number of application assistors and implement a media campaign
	FY 2011	Fresno Healthy Communities Access Partners	$1,259,565	Facilitate enrollment using multilingual assistors and a web-based application
Florida	FY 2010	Fanm Ayisyen Nan Miyami, Inc. (FANM)	$69,102	Conduct targeted outreach to Haitian community in Miami-Dade County
	FY 2010	University of South Florida	$988,177	Increase application and renewal assistance capacity through Florida Covering Kids and Families and county-based local project partnerships
	FY2011	Sacred Heart Health Systems Inc.	$754,200	Promote program awareness, enrollment, and retention through an internet, social media, and mobile technology campaign
Louisiana	FY 2010	Louisiana State Department of Health and Hospitals	$955,681	Recruit 10 non-traditional community partners to focus on engaging rural settings, Hispanic families, and families impacted by recent hurricanes
	FY 2010	TECHE Action Board	$234,808	Develop local, community-based outreach infrastructure in faith-based community
Michigan	FY 2010	Michigan Primary Care Association	$915,079	Increase the number of enrollment centers and place outreach specialists throughout the state
	FY 2010	YMCA of Greater Grand Rapids	$293,040	Develop a marketing, education, and enrollment assistance program
	FY 2011	Michigan Primary Care Association	$814,801	Deliver renewal assistance through technology-driven model

Table III.2 *(Continued)*

State	Year	Grantee	Amount	Purpose of Grant
New York	FY 2010	The Mary Imogene Bassett Hospital	$498,718	Operate a network of community-based outreach workers focused on rural families
	FY 2010	Structured Employment Economic Development Corporation	$988,177	Target outreach to African-American, Hispanic, legal immigrant children as well as children living in mixed immigration status households
	FY 2011	Hudson River Healthcare Inc.	$2,476,500	Expand and improve the use of online applications in 17 counties
	FY 2011	Mothers & Babies Prenatal Network of South Central New York	$505,370	Conduct school-based outreach in eight New York counties
	FY 2011	Community Service Society of New York	$1,000,000	Hire enrollment and retention specialists focused on African American and Hispanic families
Ohio	FY 2010	Dayton Public Schools	$327,900	Provide enrollment assistance and follow-up using Community Health Advocates' coalition approach
	FY 2010	Legal Aid Society of Greater Cincinnati	$316,418	Partner with school health centers and community partners to provide one-on-one application assistance
	FY 2011	Legal Aid Society of Greater Cincinnati	$360,000	Collaborate with two school districts and county Medicaid offices to engage families
	FY 2011	Economic and Community Development Institute	$200,000	Target outreach and enrollment to children of low-income micro-entrepreneurs and their employees
Texas	FY 2010	Texas Leadership Center	$988,177	Identify and enroll children in 7 school districts with a high Latino population using school-based outreach
	FY 2010	YMCA of Lubbock, TX, Inc.	$384,680	Overcome language barriers for Hispanic enrollments through community-based outreach coalition
	FY 2011	Texas Association of Community Health Centers, Inc.	$978,714	Target outreach and enrollment efforts to Hispanic children, including children of migrant and seasonal farm-workers
	FY 2011	Community Council of Greater Dallas	$898,954	Partner with WIC to provide application assistance in WIC offices
	FY 2011	Texas Leadership Center	$1,000,000	Target outreach to adolescents and their families in 17 high schools
Utah	FY 2010	Association for Utah Community Health (AUCH)	$762,580	Implement clinic-based outreach and one-to enrollment assistance
Virginia	FY 2010	Catholic Charities USA (CCUSA)	$957,617	Lead a consortium of 11 local affiliates targeting linguistic minorities and immigrants
	FY 2010	Virginia Health Care Foundation	$988,154	Contact businesses that do not offer health insurance to recommend and promote FAMIS

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012; DHHS, InsureKidsNov.Gov, “CHIPRA Performance Bonuses.”

IV. BENEFITS

Since the inception of CHIP, states with separate CHIP programs have been afforded a degree of flexibility in designing their benefit package, while states that implement Medicaid expansion CHIP programs are required to extend the full Medicaid package to enrollees. But in an effort to ensure that adequate benefits are offered in separate programs, Title XXI requires that certain minimum benefit standards are met. Specifically, states are required to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. For benchmark coverage, three options are specified in the legislation:

1. Benefits offered in the standard Blue Cross/Blue Shield Preferred Provider option offered under the Federal Employees Health Benefits Program (FEHBP);
2. A health benefits plan that is offered and is generally available to State employees; or
3. Benefits offered by the HMO with the largest non-Medicaid commercial enrollment in the state.

Alternatively, states can design a benefit that is actuarially equivalent to one of these plans, or seek approval from the Secretary of DHHS for another benefit package. Three states—New York, Pennsylvania, and Florida—were allowed to grandfather coverage that existed prior to CHIP authorization.

Separate CHIP programs have no mandate to offer the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit—an entitlement in Medicaid designed to ensure that low-income children with actual or potential health problems are screened and diagnosed early to facilitate treatment before they become permanent, lifelong disabilities. Many child health advocates believe this is a weakness of separate CHIP programs, especially since EPSDT requires states to cover any service a child needs that is identified during an EPSDT screen. But despite not being required to achieve parity with Medicaid, most states with separate programs have gone beyond benchmark minimums to add coverage of dental and other benefits, and worked hard to align benefits between separate CHIP programs and Medicaid to ease transitions between the two programs, such that just a few notable differences remain (e.g. EPSDT and medically necessary transportation).

CHIPRA reinforced alignment of the two programs by requiring coverage of preventive dental services and medically necessary orthodontia (which were already required in Medicaid by virtue of EPSDT protections), as well as mental health parity. CHIPRA reinforced alignment of the two programs by requiring coverage of preventive dental services and medically necessary orthodontia (which were already required in Medicaid by virtue of EPSDT protections), as well as mental health parity. During site visits to the 10 study states, however, interviews with state officials consistently revealed that these CHIPRA provisions did not often require significant adjustments to state benefit packages; most had already adopted comprehensive dental benefits, and several had also enriched their mental health benefits by offering specialized wrap-around benefits for children with special healthcare needs. Once again, this is illustrative of the approach that states have generally taken with respect to separate CHIP programs—going further than required by statute and covering benefits that often surpass those of private insurance policies, according to key informants and consumers alike (see Focus Group Box IV-1).

A. Program and Policy Characteristics

Of the 10 states included in this evaluation, all but one (Ohio) has implemented a separate CHIP program, either alone or in combination with (typically smaller) Medicaid components. These states vary in the benchmarks they have chosen for their benefits. California, Louisiana, Michigan, and Virginia, for instance have utilized state employee health plans as their benchmarks, while Alabama, Texas, and Utah selected commercial, non-Medicaid HMO plans. As noted earlier, Florida and New York have grandfathered plans for their separate CHIP programs (*Child Health Plus* and *Healthy Kids*, respectively).

Focus Group Box IV-1: Benefits

Focus group participants spoke highly of the benefits covered under CHIP

"I think [the benefits are] excellent – I don't know what I would do without it, I'm just really grateful for it." (Michigan)

"I had to use it to take her to a sexual abuse expert and I was really grateful because they are expensive. I didn't think that [specialists] were covered … I was grateful that they took it." (Michigan)

"I didn't see a difference [between private insurance benefits and CHIP benefits]." (California)

"We haven't had anything yet that's not been covered." (New York)

"There are some things that aren't covered, and I can understand that. My daughter was told she needed braces…but that was something I would have had to pay for out of pocket." (New York)

"My son is autistic, but he's healthy so he doesn't need a lot. I was nervous about it, but I have to say … I've had such good care for my kids when they needed it.. I've been happy with the care." (Ohio)

"We couldn't do without it." (Ohio)

"They get a physical every year that's paid for. Whereas, private insurance you get a physical every other year typically, or some private insurance companies don't cover well-child checkups after the age of six." (Alabama)

Only one state changed its benchmark during the study period. Utah changed its original benefit package from a benchmark-equivalent package that was actuarially equivalent to the plan provided to state employees, to a commercial health plan benchmark. In 2007, the state passed a law requiring *CHIP* to adopt the largest HMO plan sold in the commercial market as the program's new benchmark, and also required that the *CHIP* package be updated annually to maintain its actuarial equivalence with the HMO benchmark. A legislator and CHIP Advisory Council member with experience as a health insurance broker in the private market championed the benchmark change; he and other supporters reasoned that *CHIP* benefits should be as comprehensive—no more and no less—as coverage available to children in the commercial market.

B. CHIPRA Impact on Benefits

Each of the 10 study states included in this evaluation had a dental benefits package that preceded the 2009 CHIPRA mandate requiring coverage of preventive dental services. Several states—including Alabama, California, Florida, Michigan, New York, and Texas—were required to make some small changes (such as eliminating limits or expanding services covered) to come into compliance with the law. In addition, New York and Michigan were required to add medically necessary orthodontia to their suite of benefits to become compliant with the CHIPRA provisions.

The mental health parity provisions of CHIPRA required somewhat more adjustment to state benefit packages to gain compliance. Michigan and Ohio (which is a Medicaid expansion program) were the only study states that already met the mental health parity requirements. California, Texas and New York were required to eliminate limits on the number of covered

inpatient days and outpatient visits, and Louisiana eliminated the need for prior authorization for behavioral health services in its new separate program. In Utah, uniquely, state officials chose to cut some of the physical health services they offered to meet the lower bar established for mental health, rather than increase mental health services to achieve parity.

C. Implementation Experiences

While CHIP benefits are typically lauded as very comprehensive, there were some shortcomings noted by key informants in the study states, as well as parents participating in the study's focus groups (see Focus Group Box VI-2). As noted above, an ongoing concern of child advocates has been that separate programs don't extend EPSDT protections to children, as in Medicaid. While this was cited as a weakness by some advocates, several state administrators—including those in Virginia and California—asserted that the benefits offered by their separate CHIP programs closely approximated the EPSDT entitlement. Another shortcoming we heard about from some key informants (but not parents) included a lack of coverage of non-emergency transportation, a benefit which is available through Medicaid.

Focus Group Box VI-2: Benefits

While parents were generally satisfied with the CHIP benefit coverage for their children, some expressed frustration with prescription drug, vision, dental, and behavior health coverage limits.

"I had to get him put on [a private prescription-drug only] insurance to get the ADD medicine covered. That's an out of pocket expense at $196 a month, and he only gets 30 pills." (Louisiana)

"At one time [my daughter] had low iron and they wanted her to take iron supplements and they gave me a prescription for it and it wasn't covered. I had to pay $30 for it … But mostly they covered everything." (Michigan)

"Eyeglasses…are [covered] but they only cover like the cheapest frames." (Utah)

"My kid was sick when he was six months old with eczema… …[so I went to] this dermatologist…I had to pay for the cream $150 myself. (Virginia)

"My son needs speech therapy and…it's not covered unless he's had a traumatic brain injury." (Utah)

"There's some medications that don't have a generic…we've had to pay full price." (Alabama)

"Substance abuse treatment [is] not the best because they don't cover but so many visits, so many stays at this residential, so many evaluations a year…" (Alabama)

This was a particular concern in rural areas where getting to a provider can be challenging. In addition, some pointed to the lack of coverage of certain dental procedures (including white instead of silver fillings and non-medically necessary orthodontia), as gaps in coverage. Despite these gaps, CHIP benefits were consistently described as adequate at least, and approximating private coverage in most cases.

D. Conclusions

CHIP benefit packages remained strong throughout the study period, despite states universally experiencing severe economic stress during the Great Recession. While options for reducing spending were limited by MOE requirements, only one state visited—Utah—looked to benefit cuts to achieve savings by substantially reducing its medical benefits during the study period. In response to new CHIPRA requirements, benefits for dental and mental health services were expanded in a few states, but most already had generous benefit packages and only had to make slight adjustments to meet the new standards. In all, CHIP benefits have passed or exceeded the test of adequacy, undoubtedly contributing to the popularity of CHIP programs.

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V. SERVICE DELIVERY, ACCESS TO, AND QUALITY OF CARE

The CHIPRA legislation contained several provisions aimed at ensuring that children gain access to high quality care once enrolled in CHIP and Medicaid. This section examines state changes in service delivery organization during the study period as well as changes made in response to CHIPRA related to access and quality monitoring and reporting.

A. Service Delivery

States can use fee-for-service (FFS) reimbursement, primary care case management (PCCM), risk-based managed care, or some combination of these arrangements as a way to finance and deliver services to CHIP enrollees. Since the initiation of CHIP, the dominant form of service delivery for separate CHIP programs has been mandatory enrollment in risk-based managed care plans (Hill, et al. 2003). CHIP evolved at a time when risk-based managed care was becoming more prevalent for commercial and public health insurance programs alike, and CHIP contributed to the acceleration of this pattern.

CHIP program officials reported various reasons for choosing risk-based managed care. Specifically, they view this type of delivery model as a way to offer good access to care through provider networks that often bear a greater resemblance to commercial insurance networks than to those offered by Medicaid. Risk-based managed care also allows CHIP programs to transfer many administrative functions—e.g., contracting with providers, paying claims—to health plans.

The trend towards greater reliance on risk-based managed care has continued into the current evaluation period for the 10 study states. One state that originally had risk-based managed care in only certain regions for its separate CHIP program (Virginia) has continued to expand that delivery model, and as of 2012 it was virtually statewide.[25] In addition, while Louisiana previously relied on a PCCM model, it recently implemented statewide risk-based managed care for both Medicaid and CHIP.[26] Alabama is the notable exception among the study states, as it continues to use discounted FFS reimbursement with a single insurer—Blue Cross/Blue Shield of Alabama—for its separate CHIP program.

Table V.1 shows enrollment for children in risk-based managed care for Medicaid and separate CHIP programs in the study states. (Data are not separately available for Medicaid expansion CHIP programs.) Mandatory statewide enrollment in Medicaid managed care was the policy in only one of the 10 study states—Ohio. In contrast, in 2010, seven of the 10 study states used mandatory statewide risk-based managed care for separate CHIP programs—all but Alabama, Louisiana, and Virginia. The proportion of children in risk-based managed care plans is substantial (approaching 90 percent or more for separate programs) in these states.

[25] Tangier Island—an isolated fishing community—is the only part of Virginia that does not have risk-based managed care for CHIP enrollees.

[26] In the new program, initiated in 2012, the state contracts with 5 plans statewide (3 on a full-risk basis and 2 on a partial-risk basis).

Table V.1. CHIP Enrollment in Comprehensive Risk-Based Managed Care Programs, 2010

State	Medicaid Children (all populations, %)[c,]	Separate CHIP Program (%)	Mandatory Enrollment (Statewide or Regional)	
			M-CHIP	S-CHIP
Alabama[a]	0.0	NA	NA	NA
California	63.0	88.4	Regional	Statewide
Florida	90.0	95.9	Regional	Statewide
Louisiana[a]	0.0	NA	NA	NA
Michigan	83.7	89.9	Regional	Statewide
New York	78.5	99.8	Regional	Statewide
Ohio[b]	92.6	NA	Statewide	NA
Texas	60.0	100.0	Regional	Statewide
Utah	0.1	100.0	Regional	Statewide
Virginia	77.9	82.6	Regional	Regional

Sources: MACPAC, March, 2012 and June (2012); MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2012.

[a] Alabama and Louisiana did not have comprehensive risk-based managed care in 2010.

[b] Ohio does not have a separate CHIP program.

[c] Enrollment rates in risk-based managed care are not available for M-CHIP separately. Medicaid populations in risk-based managed care data are from FY 2009.

Most Medicaid mandatory risk-based managed care programs in the study states were still operating only in selected regions in 2010, although with a pattern of gradual expansion into new regions. Consequently, enrollment in risk-based managed care for Medicaid expansion CHIP programs (which use the same service delivery networks as Medicaid) is somewhat lower than in separate CHIP programs. In the case of Utah, the Medicaid program was not using risk-based managed care during the time period of the data available (FY 2009). However, following in CHIP's footsteps, the state will move to statewide mandatory risk-based managed care for Medicaid beneficiaries in 2013.

CHIPRA requires that CHIP beneficiaries be offered a choice of at least two health plans when risk-based managed care is mandatory (plan choice is also required for Medicaid).[27] This has created challenges for states that previously had contracts with single plans in rural areas, such as Florida and New York. Both states have since been able to attract at least two plans, but with some difficulty, since it can be a struggle for plans to establish networks and meet access requirements in rural areas. For example, Florida worked hard to come into compliance and did so in June 2011.

[27] Specifically, CHIPRA requires that states operating a CHIP managed care delivery system have at least two managed care plans or a managed care plan and an alternate delivery system (e.g., FFS, PCCM) to provide CHIP benefits. States that currently offer only one delivery system may contract with a second managed care plan, create a FFS option, or contract with the existing Medicaid provider network.

1. Carve Outs

CHIP risk-based managed care programs in the study states have various structures. Comprehensive risk-based managed care plans are responsible for providing all basic services such as hospital care and physician services, and often a wider array of services such as behavioral health, dental services, and pharmacy. However, some states choose to carve out one or more populations or services from comprehensive risk-based managed care plans to either to FFS or to a special type of managed care plan.

Population carve-outs exempt certain children from enrollment in the plans used by most of the CHIP population. For example, as shown in Table V.2, the CHIP program in Florida carves out Children with Special Health Care Needs (CSHCN) to a special managed care program run by the state Title V/CSHCN agency—Children's Medical Services (CMS). Once children are identified as eligible for the program—i.e., because they meet Title V CSHCN criteria—they receive all services (primary care, specialty medical care, behavioral health and dental) from a specially designed network of private providers and local public health agencies that coordinate the full array of care needed by these vulnerable children and their families. Services provided through the CMS network are reimbursed on a FFS basis.

More common are arrangements that carve out specific services from the responsibility of managed care plans (see Table V.2). For example, the majority of Medicaid and CHIP risk-based managed care programs in the study states carve out behavioral health and dental care, and deliver these services through other arrangements. The exceptions are New York (where health plans are responsible for all care, including behavioral health and dental services), Utah (where plans are responsible for behavioral health care), and Ohio (where plans must provide dental care). Usually the carved-out services are managed by a separate plan that also bears financial risk, although this is not always the case. For example, in Florida not all parts of the state are served by dental plans, so the state pays for dental services in those counties on a FFS basis.

Table V.2. Populations and Services Carved Out from CHIP Risk-Based Managed Care Plans, 2010

State	Program	Children with Special Health Care Needs	Behavioral Health	Dental	Prescription Drugs
California	Medicaid	X	X	X	X
	Separate CHIP	X	X	X	
Florida	Medicaid	X	X	X[a]	
	Separate CHIP	X	X	X	
Michigan	Medicaid		X	X	
	Separate CHIP		X	X	
New York	Separate CHIP				
Ohio	Medicaid		X		
Texas	Separate CHIP			X	X[c]
Utah	Separate CHIP			X	
Virginia	Medicaid		X[b]	X	
	Separate CHIP		X[b]	X	

Source: Gifford, 2011.
Notes: Alabama and Louisiana did not have risk-based managed care in 2010.

[a] FFS or managed dental care depending on county.
[b] Children with Serious Emotional Disturbance (SED)
[c] This pharmacy carve out subsequently was dropped in 2012.

In the case of behavioral health, contracted comprehensive health plans are typically responsible for covering a certain number of mental health visits for all enrollees, before care for those with more intensive needs is carved out to a behavioral health plan or county-based mental health system. In Michigan, for example, comprehensive health plans cover 20 outpatient visits and behavioral health plans cover visits beyond that threshold. A CHIP enrollee's diagnosis might also trigger a service carve out. For example, in Virginia mental health services for children with Serious Emotional Disturbance (SED) are carved out, while mental health services for children with mild or moderate behavioral health needs remain the responsibility of the comprehensive health plan. Key informants in Virginia explained that most view the integration of medical and behavioral health services as a preferred way to deliver services, especially for mild and moderate conditions that might be treated in primary care settings.

CHIP officials in the study states suggested that there are distinct trade-offs when carving out behavioral health services. On one hand, behavioral health plans or mental health agencies have more specialized experience delivering services to children with such needs. On the other hand, carving these services out gives health plans a built-in incentive to refer children with behavioral health needs to the separate systems as soon as possible, so that they can relinquish responsibility for coverage. Key informants in California, for instance, noted that the state's behavioral health carve-out often leads to fragmentation between medical care and behavioral health care service delivery.

Dental care was previously an optional CHIP benefit, but was offered to some extent by all states. CHIPRA, however, included new protections to expand coverage of dental services to prevent disease, promote oral health, restore health and function, and treat emergency conditions. There was general agreement among informants in the study states that carve-outs for dental services work well, because specially designed dental plans have wider networks and are more experienced with managing the provision of dental services than medical plans. Even in New York, where dental services are the responsibility of comprehensive plans, nearly all of those plans subcontract with specialized dental plans.

Two other less-common carve-outs are for pharmacy and vision care. In 2010, a pharmacy carve-out was used in California's Medicaid program and for the separate CHIP program in Texas. While Texas has subsequently dropped the arrangement, Louisiana's recently established risk-based managed care program includes a pharmacy carve-out. As with mental health services, including pharmacy services within health plans' responsibilities was viewed by key informants as a way to achieve more integrated and coordinated care, but carving it out has some administrative advantages, such as providing a single formulary to physicians. Vision care is typically provided by comprehensive managed care plans, but sometimes it is carved out; for example, California's separate CHIP program contracts with three special vision plans.

2. Contracting with Health Plans and Rate-Setting

Most of the states in our study use competitive bidding to select plans initially, and then contracts are awarded for a relatively long period (e.g., in Michigan contracts are for three years with three one-year extensions allowed). Medicaid expansion CHIP programs use the same plans as those for Medicaid children, which assures continuity of care if changes in an enrollee's financial circumstances or family size spurs a shift from Medicaid to CHIP eligibility (or vice versa). This type of complete plan overlap does not always happen for separate CHIP programs, since the process of selecting and contracting with plans can be entirely separate between

Medicaid and CHIP. As shown in Table V.3, in 2010 there was very substantial overlap between Medicaid and separate CHIP plans except in Florida and Michigan. Of 97 Medicaid plans and 80 separate CHIP plans in the study states, 69 participate in both programs.

The process for becoming a Medicaid or CHIP risk-based managed care plan is complex. For example, in Michigan plans must be licensed as a risk-based managed care organization, become accredited by the NCQA (which is not required in all states), and meet solvency and capital requirements. In some of the study states with separate CHIP programs (e.g., California, Florida, and New York) plans are required to negotiate contracts and rates for Medicaid and CHIP with different agencies in the state. For example, in New York health plans participating in CHIP negotiate with the Department of Insurance, while those participating in Medicaid negotiate with the Department of Health. This can lead to inconsistencies in contracts and capitation rate structures, and complexities for plans.

Table V.3. Number of Comprehensive Risk-Based Managed Care Plans, 2010

State	Contract with Medicaid	Contract with Separate CHIP Program	Contract with Both
Alabama[a]	N/A	N/A	N/A
California	19	21	18
Florida	18	9	7
Louisiana[a]	N/A	N/A	N/A
Michigan	9	9	5
New York	21	19	18
Ohio[b]	7	N/A	N/A
Texas	14	15	14
Virginia	5	5	5
Utah	4	2	2
Total	**97**	**80**	**69**

Sources: Howell et al., 2012. Utah Department of Health "Children's Health Insurance Program"; Utah Department of Health, "Medicaid Member Guide, 2012."

[a] Alabama and Louisiana did not have risk-based Medicaid managed care in 2010.

[b] Ohio does not have a separate CHIP program.

The number of plans participating in Medicaid (ranging from 4 in Utah to 21 in New York) and CHIP (ranging from 2 in Utah to 21 in California) largely reflects the size of the respective populations in the states. Often plans participate only in certain counties or regions and not statewide, so in larger states the number of plans available to an individual enrollee is usually far fewer than the total number of participating plans. For example, in Florida only one plan participates statewide.

The number of plans participating in CHIP and Medicaid has declined at least in some states. For example, in 2001 there were 26 CHIP plans in California and 30 in New York, compared to 19 and 21—respectively—a decade later. Key informants explained that the decline was primarily due to mergers rather than plans exiting the programs, although there has been some turnover. This trend towards fewer plans could reverse, particularly for Medicaid, as states expand their programs in anticipation of the Affordable Care Act's Medicaid expansions in 2014.

Capitation rates for CHIP can be set either administratively by the state, through a competitive bidding process, or through negotiation between plans and the state; generally, the study states reported that they update rates annually. There are no federal requirements that separate CHIP program capitation rates be actuarially sound, as there are for Medicaid capitation rates,[28] although some separate programs (e.g., Virginia and Utah) reported adopting a similar approach to rate setting for CHIP as Medicaid. In spite of the lack of actuarial soundness requirements, most informants in the study states—including both state officials and health plan representatives—felt that separate CHIP program rates were fair and sufficient. In addition, the fact that programs are able to achieve adequate plan participation suggests that rates are likely reasonable to cover plans' costs including administrative fees and profit. An important reason for this, according to informants, is that separate CHIP programs tend to have fewer high-cost outlier children than Medicaid, making rate setting more straightforward.

Though the evaluation was not able to obtain CHIP capitation rates in most of the study states, the rates that were obtained from a handful of states indicate considerable variation, which is unsurprising given differences in how CHIP managed care programs are structured (i.e., differences in benefit packages and carve-out arrangements, or in populations included/excluded from managed care) and in health care costs across states more generally. For example, rates in separate state programs for 2012 range from a low of $79 per member per month (PMPM) in Michigan (which, notably, performs a retrospective cost adjustment for Blue Cross which has the bulk of managed care enrollees) to a high of $144 PMPM in Utah.

3. Enrollee Plan Selection and Auto-Assignment

CHIP enrollees learn about managed care plans choices and enrollment options in a variety of ways (see Focus Group Box V-1). Usually plans advertise themselves through brochures and other informational materials that are provided to new enrollees shortly after eligibility is established, and through limited marketing campaigns. The CHIP programs in the study states generally offer a single benefit package, so health plans cannot compete for enrollees on the basis of generosity of benefits. Rather they compete through, for example, community outreach programs and targeted incentives, such as reduced monthly premiums. They also compete based on the extent of their provider network and their member satisfaction scores, among other factors.

CHIP beneficiaries enroll in managed care plans in one of two ways. First, parents may proactively select a plan for their child, often at the same time they complete program applications. Key informants reported that the leading reason parents select a particular plan is its provider network. This was confirmed by parents participating in the evaluation's focus groups (see Focus Group Box V-1). However, at the same time, other parents expressed that they did not have a specific purpose in selecting a plan, and just chose one randomly.

[28] Per the 1997 Balanced Budget Act (and subsequent regulations made effective in 2002) Medicaid managed care programs must ensure that capitation rates are "actuarially sound," or developed in accordance with actuarial principles that are appropriate for the populations and services covered, and which have been certified by an actuary.

Focus Group Box V-1: Service Delivery

While some parents proactively selected their children's health plan based off of provider coverage, others reported just choosing a plan randomly.

"I switched my son [from one plan to another] because there's certain providers that are covered." (Utah)

"I got a paper in the mail saying to [pick a plan]. The first thing I did was to call the kids' doctor and ask, 'Which one do you take?' They told me and I called the 800-number and [said what I wanted]" (Ohio)

"After my kids were on it, I did find out about some differences [between health plans]. I made a good choice, but I didn't know I was making a good choice at the time. I just kind of got lucky." (Utah)

Although the majority of parents had no problems in plan selection, a few reported problems when their children moved back and forth between Medicaid and CHIP.

"They were never in [the CHIP program] more than three or four months [and they would] automatically jump to… Medicaid without me being informed. When I would go to the doctor's they would tell me, 'Oh, you have Medicaid and they assigned you [to a different health plan].' Or half my kids would have one health plan and half would have a different plan … I'm like, 'Oh my God, what's going on.'" (Michigan)

The second way children end up in health plans is through auto-assignment, whereby the state assigns children to a plan based on an algorithm. Usually states give parents some period of time to choose a plan for their children, but if they do not do so the state auto-assigns the child to a plan. An exception is Florida's separate CHIP program, which auto-assigns initially and then gives parents 90 days to switch plans. Depending on the state, auto-assignment algorithms may: rotate assignment among plans in a given region to assure adequate enrollment across plans; weight assignment towards plans with high scores for administrative efficiency or health care quality; or match beneficiaries with plans based on geographic proximity to plans' primary care providers. A state's process for plan selection usually applies both to the comprehensive plans and to carve-out (e.g., dental) plans.

In some states, parents of CHIP enrollees are asked to choose both a primary care provider and a dentist for their child at the time of plan selection. This can add to the complexity of the choice process for parents. While after plan selection enrollees are generally locked in to a selected plan for a year, they are usually allowed to switch primary care providers at any time.

In addition, as indicated above, some plans do not participate in both Medicaid and CHIP. This can create problems in plan selection for children who move from Medicaid to CHIP (and vice versa) because of changes in family circumstances, and for families that have children in different programs (a situation that occurs when states' eligibility levels for Medicaid and CHIP vary by children's age). This is exemplified in one of the focus group quotes (see Focus Group Box V-1) in which a parent describes her frustration when her child bounced from CHIP to Medicaid and then back, each time prompting a change in health plan options for her child.

B. Access to Care

According to key informants and parents in the study states, there is broad satisfaction with access to care under CHIP. Access to primary care is particularly good because of high levels of participation by pediatricians. Parents who participated in focus groups described positive experiences with primary care access, but many also reported ease in finding specialists (see Focus Group box V-2).

Focus group participants with children in CHIP plans had particularly positive things to say about commercial separate CHIP plans, such as Blue Cross/ Blue Shield and Kaiser Permanente (plans that do not usually participate in Medicaid), because broad provider participation in these plans translates to very strong access to care for enrollees, in networks that are identical (or very similar) to those offered to privately insured individuals. In Alabama the CHIP program has contracted on a FFS basis with Blue Cross/Blue Shield, and key informants there reported that access to care for CHIP enrollees is excellent.

Focus Group Box V-2: Access to Care

In general, parents had positive experiences with primary care and specialty access.

"My daughter goes to [the same place] since she's been born and they've been wonderful." (Ohio)

"We've had wonderful doctors…and an abundance of choices…all just 20 minutes away." (New York)

"We love our pediatrician…you wait maybe two minutes before you're in…I can't say enough good things about it." (New York)

"There were a lot of [choices]" (Virginia)

"I called and…all [the specialists] accepted MIChild-I got in within a day or two" (Michigan)

"I don't know of anybody who doesn't take [CHIP] because it's got that Blue Cross Blue Shield umbrella." (Alabama)

However, some parents reported provider shortages in their area that led to long waiting times.

"If I do get an appointment in the morning, I'll be in there until two or three. They take too long." (California)

"I've waited 3-4 hours in the waiting room, with an appointment. I had to tell them, I have a job and I have to get back to work!" (Texas)

At the same time, some parents described difficulties in accessing dentists and particular types of specialty care.

"When [care is needed that is] rare or outside the ordinary, that's when your options get…very limited. Or you have to wait for a really long that before you can see the one specialist that's available and still taking patients." (Louisiana)

"A lot of specialty providers around here don't accept [CHIP]" (Florida)

"I experienced more limited choices when I applied for dental care for my child" (California)

"There wasn't a choice. It was dentist or no dentist." (Utah)

At the same time, these generally positive comments were not uniformly confirmed by key informants in the study states. Some spoke of problems with access to specialty, dental, and behavioral health care. For example, in California and Florida, informants reported serious concerns with access to specialists for children with chronic illnesses and disabilities. Similar access issues were reported for dental and behavioral health services in Texas. Even in the states where access was generally reported as very good, informants noted that there were pockets (especially rural areas) with access problems because of shortages of specialists, dentists or mental health providers.

Case study informants reported that dental access is improved when states contract with special dental care plans, and that this is a major reason that states choose to use such plans. Ohio's Medicaid expansion CHIP program does not have such an arrangement and dental provider participation and dental access for children are reportedly very problematic there. On a related note, states such as New York and Virginia have increased dental provider reimbursement to address access issues, and informants in these states suggested that access had improved as a result.

The generally positive comments about access to care for enrollees in separate CHIP programs were not as evident for Medicaid expansion CHIP programs. Provider reimbursement rates are lower, on average, in Medicaid than in separate CHIP programs; key informants

suggested that as a consequence, provider participation and access to care are generally more limited. This is particularly true for dental care. Notably, key informants and focus group participants reported more access problems in Louisiana and Ohio—where most or all CHIP enrollees are in Medicaid expansion CHIP programs—than in the other states.

As indicated above, CHIPRA enacted certain provisions targeted at improving dental and behavioral health benefits, such as requiring that these be included in the benefit package and meet the standards of a benchmark plan. As discussed in Chapter IV, separate CHIP programs are now subject to the Mental Health Parity and Addiction Equity Act of 2008, resulting in fewer benefit limits. However, at the time of the site visit a number of parents still struggled to access specialty, dental and behavioral health care, primarily due to shortages of providers rather than coverage provisions. Some key informants expressed concern that such provider shortages would be exacerbated when the Affordable Care Act coverage expansions are implemented in 2014.

Focus Group Box V-3: Quality of Care

While many parents were satisfied with the quality of care their children received, others felt that it could be better, particularly for specialty and dental care.

"[The specialists] have been amazing; I think they're the top of their line in their field." (Utah)

"I think I have the best dentist…all the kids love to go there." (Virginia)

"That's why I don't mind waiting. They check her from head to toe, and that's good." (California)

"We pay out of pocket for a dermatologist because the dermatologist we could get through [the separate CHIP program] was not good." (Florida)

"I didn't like that [dentist] because I felt like they were taking advantage of Medicaid, and they wanted to put crowns on baby teeth." (Louisiana)

"I'm thinking of switching dentists. They're not that good…they're not that friendly, and they seem like they're in a rush" (Virginia)

C. Quality of Care

Quality of care under CHIP also is generally considered to be good, as reported by key informants and focus group participants in the study states. As was the case with access, however, concerns about quality of care were occasionally voiced with regard to specialty and dental care (see Focus Group Box V-3).

Over the past five years CHIP quality improvement initiatives have intensified, stimulated by several provisions of CHIPRA aimed at strengthening quality monitoring, including:

- Voluntary reporting to CMS of up to 24 measures of quality (Sebelius 2010; Mann 2011);
- Grants for developing CHIP quality demonstration programs (10 grants, covering 18 states, were awarded in February 2010, including to 2 study states, Florida and Utah); and,
- A requirement that states select an External Quality Review Organization (EQRO) for their separate CHIP programs (as has been required of Medicaid programs for many years).

Among the primary benefits of risk-based managed care, as perceived by many key informants, are the improvements in access and quality that result from health plan monitoring. Most commonly, CHIP programs require health plans to submit data measuring access and quality from the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Health plans are typically required by states to submit these data regularly; submission is also required for certification by the

NCQA. Louisiana officials indicated that a major motivation for its recent shift to risk-based managed care was to improve access to and quality of health care.

While most CHIP programs have always had a focus on quality improvement, the CHIPRA requirements make these efforts more standardized. At the same time, experimentation and innovation are continuing. Some examples of the changes that study states reported making to their quality monitoring processes in recent years include the following:

- California now requires the submission of claims/encounter data for quality monitoring in its separate CHIP program, an effort that was previously resisted by plans.
- California, among other states, recently contracted with an EQRO to assist with quality monitoring.
- Louisiana pays primary care providers a monthly bonus for becoming certified as a medical home by NCQA.
- Louisiana used federal Health IT funds to implement electronic health records for pediatric care, which will support stronger quality assessment and improvement.
- Michigan and Ohio have implemented performance improvement programs whereby plans are rewarded for scoring highly on quality measures, and such scores may be considered when renewing contracts with plans.
- Florida publishes quality monitoring scores on the state's website.
- Ohio uses quality scores in its auto-assignment algorithm.

As noted above, two study states received five-year CHIPRA demonstration grants to test a variety of approaches to improving health quality under Medicaid and CHIP.[29] Florida, in partnership with Illinois, is testing collection and reporting of quality measures, developing new approaches to using electronic health records, working with pediatric providers to develop primary care medical homes, and focusing on neonatal quality improvement. Utah, in partnership with Idaho, is undertaking similar initiatives, and will also focus on coordination of care and support for children with chronic and complex conditions and their families. Both demonstrations are using learning collaboratives to achieve quality objectives. The information technology and medical home initiatives fostered by the CHIPRA quality grants are closely allied with similar privately- and publicly-supported initiatives in those states, and are also tied to national initiatives funded by the HITECH Act and other federal initiatives to foster integrated care models.

There are few findings, so far, from either quality monitoring or from the quality demonstration grants to document variations in access and quality under CHIP. However, voluntary reporting of selected access/quality measures from separate CHIP programs to CMS has been underway for some time as part of the CHIP Annual Report Template System

[29] The CHIPRA quality demonstration programs are being evaluated under a separate contract from the Agency for Healthcare Quality and Research to Mathematica Policy Research and the Urban Institute.

(CARTS).[30] CARTS is currently the vehicle for reporting CMS' initial core set of 24 health care quality measures for children in both Medicaid and CHIP.[31]

Table V.4 shows the number of measures that were voluntarily reported through CARTS by study states in FFY 2010 and 2011. As shown, while reporting was limited in 2010 it expanded substantially in 2011. For example, in FFY 2010 only three study states (Alabama, Florida, and Michigan) reported at least 10 measures. By FFY 2011, eight study states reported on over 10 measures. States and health plans are continuing to upgrade their information systems over time, which will facilitate access to the data needed to create more of the measures.

To date, the most frequently reported measures are child and adolescent well-child visits. The higher rate of reporting for these measures reflects that these measures are easier to calculate from claims/encounter data than many of the other initial core set measures. (For example, immunization status—a very basic measure of pediatric quality—is difficult to calculate accurately from claims data.) All study states except Texas have reported the percentage of young children receiving at least one well child visit in the previous year to CARTS since 2006. Five states (Alabama, Louisiana, Ohio, Utah, and Virginia) have reported the percentage of infants under 15 months having at least six visits to CARTS since 2006.

Table V.4. Voluntary Reporting of Initial Core Set of Children's Health Care Quality Measures by Study States, FY 2010 and 2011

State	Number of Measures Reported by State	
	FFY 2010	FFY 2011
Alabama	13	17
California	9	11
Florida	12	20
Louisiana	5	6
Michigan	12	16
New York	9	12
Ohio	3	11
Texas[a]	0	12
Utah	3	8
Virginia	3	11

Source: CARTS FFY 2010 reports; Sebelius, 2011; Sebelius, 2012.

[a] Texas submitted a CARTS report for FFY 2010, but did not submit data on any of the performance measures.

The limited data from 2006 to 2010 for these measures are shown in Appendix B and suggest that access to preventive care may be improving over time for CHIP enrollees. These two quality indicators improved in all study states that provided data to CARTS. While about half the study states are above the median and about half are below the norm, generally the rate of improvement is greater for study states than nationally.

[30] See an earlier report from this evaluation for more information from the CARTS data system (Hoag, et al. 2011).

[31] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf

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VI. COST SHARING

Cost sharing has always been a prominent feature of separate CHIP programs. Federal law permits states to impose various forms of cost sharing on families enrolled in CHIP, including premiums, copayments, deductibles, and coinsurance, as long as total cost sharing remains under five percent of a family's income. In contrast, cost sharing for children below 150 percent of FPL is strictly limited. The first CHIP evaluation found that separate CHIP programs had largely avoided significant controversy by establishing premiums and copayments at levels that were viewed as fair and affordable by both administrators and families. In fact, such cost sharing had a beneficial effect in the opinion of most in that it made CHIP feel more like private insurance, instilling a sense of pride and responsibility in families who were contributing to the cost of their children's coverage (Hill et al. 2003).

Most informants interviewed for this evaluation similarly regarded cost sharing as a positive component of the program. Likewise, parents who participated in focus groups generally viewed cost sharing positively and felt it was both fair and affordable. Nevertheless, officials in some states noted concerns about a perceived heavy cost sharing burden on some families enrolled in CHIP due to cost sharing increases that were enacted during the study period.

Although several states looked to address budget challenges by increasing cost sharing, maintenance of effort (MOE) rules in the Affordable Care Act limited the extent to which states could increase cost sharing burdens. Specifically, MOE provisions limited states' ability to increase premiums, as they are considered conditions of eligibility.[32] States are, however, permitted to modify copayments and other forms of cost sharing not imposed at enrollment, such as coinsurance and deductibles, which several study states chose to do. Although CHIPRA did not have a large impact on cost sharing, it did offer families an additional protection regarding cost sharing by requiring that states implement a 30-day grace period for non-payment of premiums.

A. State Cost Sharing Policies

Nine of the 10 study states impose various forms of cost sharing on families; Ohio is the only one without cost sharing (see Table VI.1). Within each category, states use differing program structures and income guidelines to determine who is subject to cost sharing and at what levels. Notably, states that only have Medicaid expansion programs (Ohio) are required to follow Medicaid cost sharing rules, while those with combination programs are permitted to have cost sharing in their separate CHIP components only.

[32] Under maintenance of effort, states are permitted to increase premiums based on language state plans or demonstration waivers approved before the passage of maintenance of effort. In addition, states can enact inflation-related adjustments to premiums and impose premiums for new coverage groups (http://www.kff.org/medicaid/upload/8204-02.pdf).

Table VI.1. Cost Sharing Provisions in Separate CHIP Programs, FFY 2012

State	Name	Annual Enrollment Fees?	Premiums?	Copayments?	Deductibles?	Coinsurance?
Alabama	ALL Kids	X		X		
California	Healthy Families		X	X		
Florida	Healthy Kids		X	X		
	MediKids		X			
Louisiana	LaCHIP Affordable Plan		X	X	X	X
Michigan	MIChild		X			
New York	CHPlus		X			
Texas	CHIP	X		X		
Utah	CHIP (Plans A-C)		X	X	X	X
Virginia	FAMIS			X		

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012.

Only one state (Virginia) does not impose premiums or enrollment fees, while the remaining eight states with cost sharing use one or the other. Specifically, Alabama and Texas impose annual enrollment fees on families with children in CHIP, while California, Florida, Louisiana, Michigan, New York and Utah impose either monthly or quarterly premiums. As summarized in Table VI.2, all of these states vary enrollment fees and premiums by income level; however the level where these begin or increase differs greatly across the states. For instance, though both California and New York charge premiums, families in California between 101 and 150 percent of FPL pay $4 to $7 per child, while families in New York under 160 percent of FPL pay no premiums at all. Similarly, premiums for families at 200 percent of FPL range from $0 in Louisiana (where premiums begin at 201 percent of FPL), to $25 per month in Utah.

A majority of the study states also charge copayments at the point of service; of the nine states with cost sharing, seven require copayments. As illustrated in Table VI.3, the range of copayments between these seven states is significant, as copayments are tied to income level and also vary depending on the type of service. For example, copayments for medical office visits range from $2 in Virginia for families between 101 and 150 percent of FPL, to $25 in Utah and Texas for families with higher incomes. Prescription drug copays also vary greatly, as states charge different amounts for generic and brand name medications. In Texas, for instance, families with incomes up to 150 percent of FPL receive free generic prescriptions, while families in California in the same income bracket pay $10 per generic prescription. Emergency room visit copayments were generally the most expensive across the seven states, particularly for non-emergency use. Specifically, families between 151 and 200 percent of FPL pay between $25 in Virginia to $300 in Utah for a visit to the emergency room.

In addition to premiums and copayments, both Utah and Louisiana also impose deductibles and coinsurance on families in the upper income ranges of their CHIP programs, and are the only two states in the nation to do so. Officials in both states noted that this makes the program feel more like private insurance and approximates the level of cost sharing they might encounter in the private market.

Table VI.2. Cost Sharing Provisions, Enrollment Fees and Premiums, 2012

State	Program	% FPL	Annual Enrollment Fee Amount	Premium Amount	Grace Period
Alabama	ALL Kids	101-150%	$52/child; $156/year family max	NA	Families are given until the end of the year to pay their annual enrollment fees
		151-300%	$104/child; $312/year family max	NA	
California	Healthy Families	101-150%	NA	$4-7/child/month; $14/month family max	60 days
		151-200%	NA	$13-16/child/month; $48/month family max	
		201-300%	NA	$21-24/child/month; $72/month family max	
Florida	Healthy Kids	101-150%	NA	$15/family/month	30 days
		151-200%	NA	$20/family/month	
	Healthy Kids Full Buy-In	>200%	NA	$133/child/month	
	MediKids	133-150%: ages 1-5	NA	$15/family/month	
		151-200%: ages 1-5	NA	$20/family/month	
	MediKids Full Buy-In	>200%: ages 1-5	NA	$196/child/month	
Louisiana	LaCHIP Affordable Plan	201-250%	NA	$50/family/month	When a premium is not paid, the family is advised in writing that the case will be closed. If the premium is not paid within 10 days of the notice, coverage will end.
Michigan	MIChild	186-200%: ages 0-1	NA	$10/family/month	30 days
		151-200%: ages 1-19			

Table VI.2 (*Continued*)

State	Program	% FPL	Annual Enrollment Fee Amount	Premium Amount	Grace Period
New York	CHPlus	160-222%	NA	$9/child/month; $27/month family max	30 days
		223-250%	NA	$15/child/month; $45/month family max	
		251-300%	NA	$30/child/month; $90/month family max	
		301-350%	NA	$45/child/month; $135/month family max	
		351-400%	NA	$60/child/month; $180/month family max	
	CHPlus Full Buy-In	>400%	NA	$176/child/month; no family max	
Texas	CHIP	151-185%	$35/family	NA	Children cannot enroll or renew coverage until the annual enrollment fee is paid
	CHIP	186-200%	$50/family	NA	
Utah	CHIP Plan B	101-150%	NA	$30/family/quarter	30 days; Families who do not pay their premium on time are charged a $15 late fee
	CHIP Plan C	151-200%	NA	$75/family/quarter	

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

Table VI.3. Copayment and Deductible Amounts for Selected Services, 2012

State	Program	% FPL	Medical Office Visits Amount (Non-Preventive)	Generic Prescription Drug	Brand Prescription Drug	ER	Deductible
Alabama	ALL Kids	101-150%	$3	$1	$5	$6	NA
		151-300%	$13	$5	$25	$60	NA
California	Healthy Families	all eligible	$10	$10	$15	$15	NA
Florida	Healthy Kids	all eligible	$5	$5	$5	$10 (if inappropriate)	NA
Louisiana	LaCHIP Affordable Plan	all eligible	Enrollees pay 10% of the fee-for-service rate in-network and 30% out-of-network	Enrollees pay 50% of costs or a maximum of $50 for a 30 day supply		$150 (waived if admitted)	$200 for mental health/substance abuse services
Texas	CHIP	0-100%	$3	$0 generic	$3	$3 nonemergency	NA
		101-150%	$5	$0 generic	$5	$5 nonemergency	NA
		151-185%	$20	$10 generic	$35	$75 nonemergency	NA
		186-200%	$25	$10 generic	$35	$75 nonemergency	NA
Utah	CHIP Plan A	<100%	$3	$1 generic	$1	$3	None
	CHIP Plan B	101-150%	$5	$5 generic	5% of approved amount	$5 $10 nonemergency	$40/family
	CHIP Plan C	151-200%	$25	$15 generic	25% of approved amount	$300 after deductible	$500/child; $1500/family max
Virginia	FAMIS	134-150%; ages 6-18	$2	$2	$2	$2 ($10 nonemergency)	NA
		151-200%; ages 6-18	$5	$5	$5	$5 ($25 nonemergency)	NA

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

B. Changes to Cost Sharing Policies

Despite recent MOE restrictions on premium increases, cost sharing for families with children enrolled in CHIP in the study states has steadily increased over the last several years. Indeed, as illustrated in Figures VI.1-3, the majority of the study states increased their premiums between 2006 and 2009. Six states—Alabama, California, Florida, Michigan, New York, and Utah—raised premiums or annual enrollment fees at least once between 2006 and 2009—when MOE rules were enacted. While some of these increases were made to keep premiums in line with inflation and rising incomes, others were made to help raise revenue for the state. Notably, California raised premiums on three separate occasions before 2009; and although the last increase did not change the costs for families with the lowest incomes, it more than doubled premiums for families in between 150 and 300 percent of FPL.

Only one study state successfully increased its premiums or annual enrollment fees after MOE rules were put in place. In 2012, Alabama attempted to raise its annual enrollment fee to help offset severe budget challenges that could have required significant changes to the state's successful separate CHIP program. However, because of MOE standards, CMS limited the increase to an inflation-related adjustment of $2 per child for families under 150 percent of FPL and $4 per child for families under 300 percent of FPL.

Since the passage of MOE rules, states have increasingly looked to copayments as the best way to address budget pressures—as a means of discouraging inappropriate utilization. During the study period, most of the seven states using copayments increased them for families in CHIP. For example, officials in Texas reported that the state raised copayment amounts several times to help offset the costs of CHIPRA mandates regarding mental health parity and dental requirements. Similarly, California raised copayments for families in 2010 in response to a severe budget deficit in the state.

Figure VI.1. Effective Monthly Premiums for a Two-Child Family at 150% FPL, 2006-2010

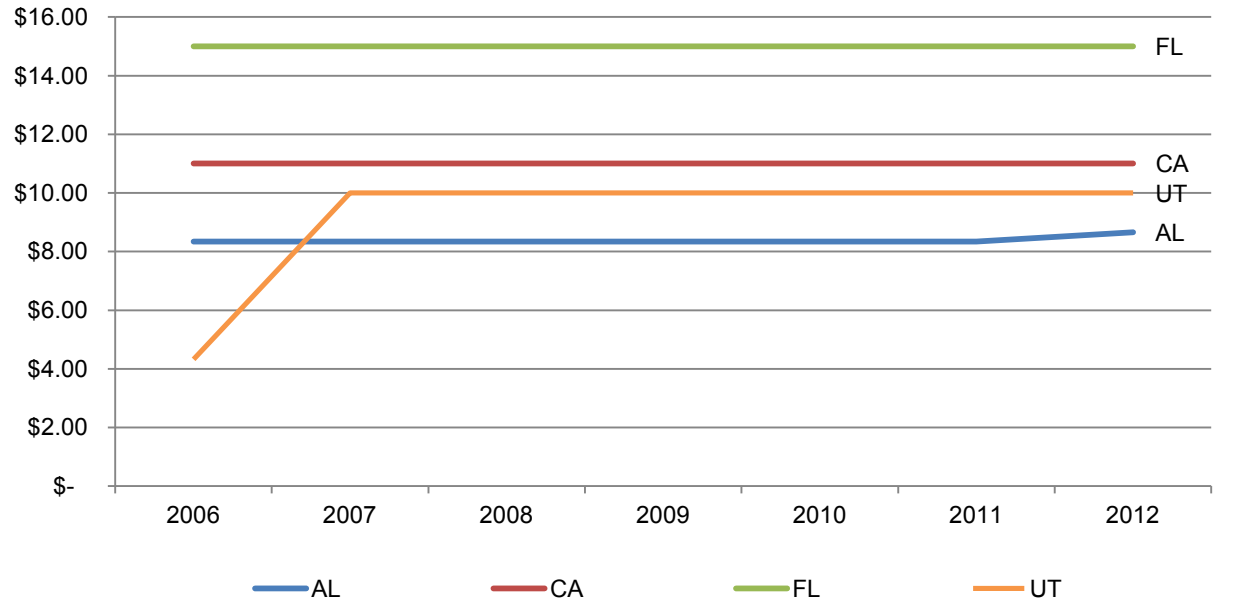


Figure VI.2. Effective Monthly Premiums for a Two-Child Family at 200% FPL, 2006-2010

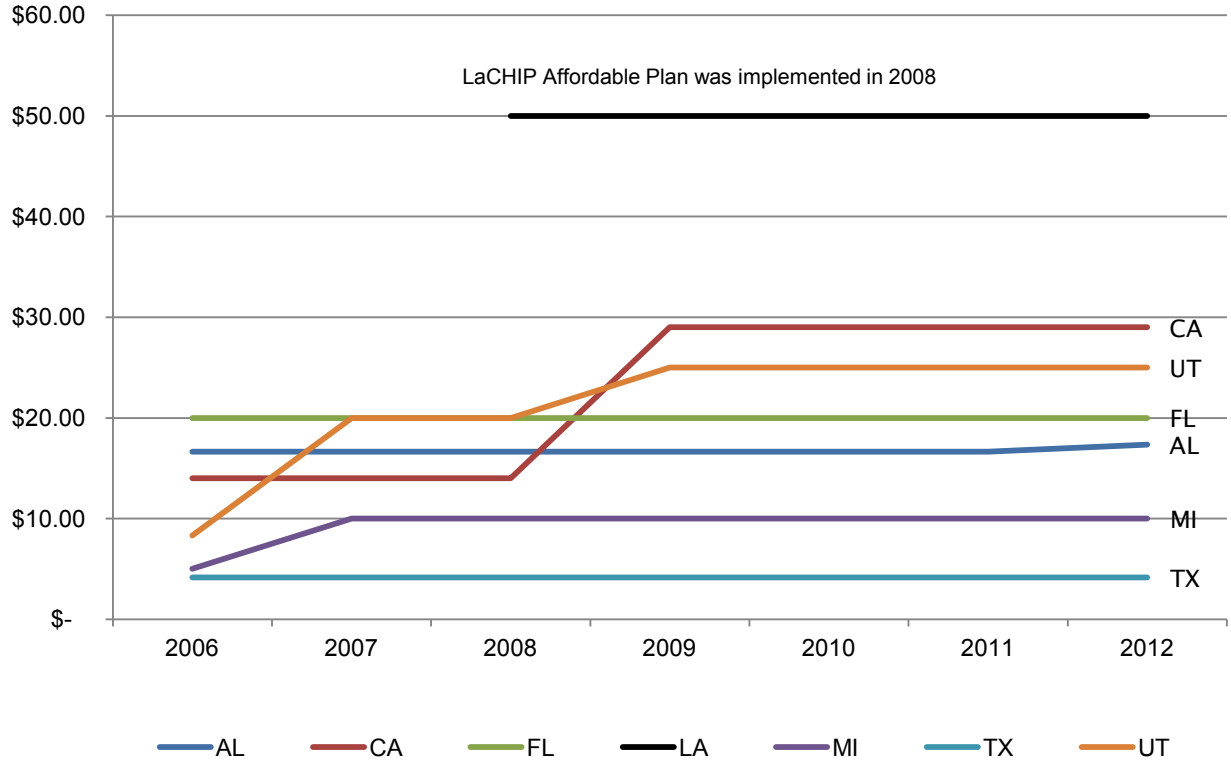
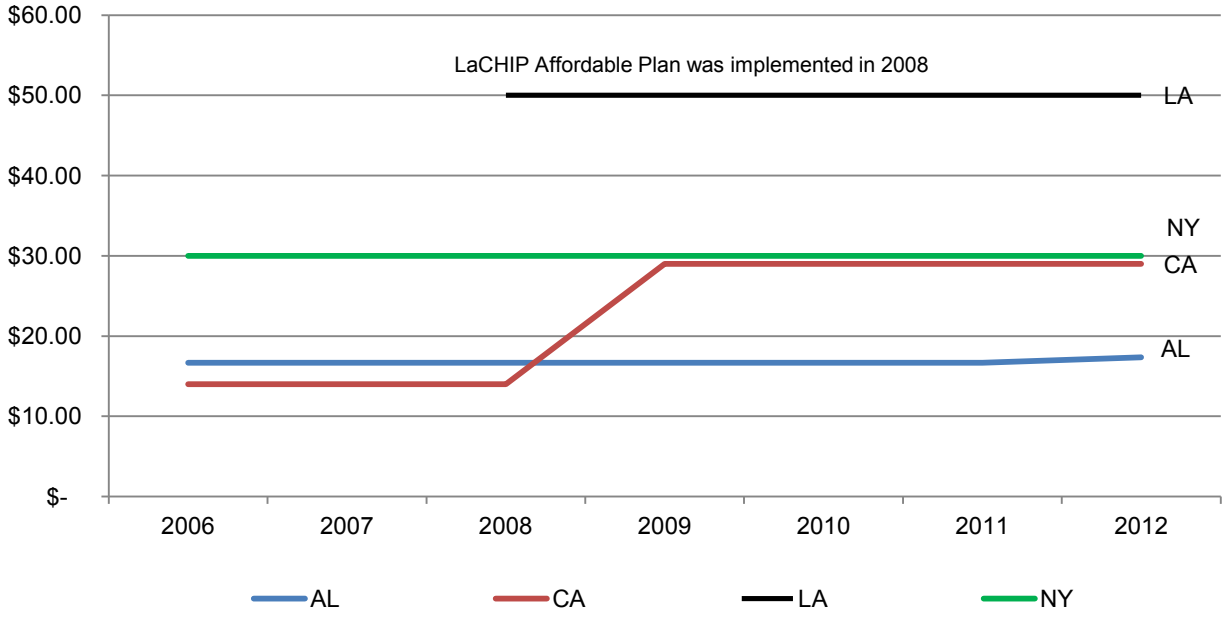


Figure VI.3. Effective Monthly Premiums for a Two-Child Family at 250% FPL, 2006-2010



Sources: 2006-2010 CARTS Reports, Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

C. Implementation of Cost Sharing Policies

The recent increases in cost sharing levels have not been without controversy. While some state legislators believe that increasing cost sharing was the last, best option for preserving CHIP, advocates and other policymakers interviewed for the case studies warned that such increases might deter families from enrolling their children in CHIP, maintain coverage in the program, or utilizing services. Informants in several states reported notable concern regarding the cost sharing burden being placed on families. In Louisiana, high premiums were blamed for low enrollment in *LaCHIP Affordable Plan*, while informants in Utah worried that premiums perceived as expensive were leading to adverse selection where families with healthy children drop coverage. Similarly, some informants in Texas worried that higher copayments were preventing families from seeking care.

Despite these concerns, cost sharing in CHIP remains relatively modest compared to the private sector. In 2006, premiums for employer-sponsored insurance, on average, constituted 28 percent of a family income at 200 percent of FPL (Kenney and Pelletier 2009). Conversely, the original CHIP legislation specified that total annual cost sharing in separate programs cannot exceed five percent of a family's income, to help ensure that CHIP remains affordable for enrollees. In Alabama, California, Florida, Texas, Utah, and Virginia, families are responsible for keeping track of their out-of-pocket costs by saving all of their receipts (the so-called "shoe box" method). In Louisiana, the five percent limit is monitored by a third party administrator, which automatically changes families to a "no cost sharing" status when the annual maximum is reached. In Michigan and New York, premiums were set to ensure that no family would pay more than 5 percent of their income. Overall, very few families reportedly reach the maximum out-of-pocket limit—in 2011, there were 30 families in Louisiana, 110 in Utah, and just under 400 in Texas who reached the five percent threshold. But officials in several states reported that, in addition to being administratively difficult to track, many families are unaware of the five percent limit. As a result, several informants believe that many more families reach the five percent limit annually without recourse.

In conjunction with the 5 percent federal limit, many states also set annual maximum copayment amounts for some or all services—California caps copayments at $250 per year for all services; Louisiana reduces copayments to $15 for brand name drugs and $0 for generics after families reach an annual cap of $1,200/person; while Virginia limits copayments to $350 per year. During the study period, several states implemented new provisions to offset the cost sharing burden on families. For example, Florida recently began a small program that the state hopes to expand called "CHIP In" which collects donations from businesses and relatives to help families pay for their *Healthy Kids* premiums.

In addition to being concerned about the affordability of CHIP cost sharing, officials also reported that processes for collecting premiums and annual fees can be burdensome for families. Informants in a majority of the states described how nonpayment of premiums is one of the most common reasons for case closure, but asserted that this often appeared to have less to do with the affordability of those premiums than it did with premium payment processes. As summarized in Table VI.4, the study states have instituted a variety of payment options, beyond mailing in the payment, to respond to this problem. In particular, Florida has been especially innovative in recent years. Specifically, families enrolled in *Healthy Kids* have the ability to have premiums automatically deducted from paychecks or checking and savings accounts; to pay several months

at once; or to pay online, by telephone, or in cash. The state is even looking to create an application for smartphones as another payment option for families.

Table VI.4. Methods of Enrollment Fee or Premium Collections, 2012

State	Mail	Online	Phone	Automatic Draft From Checking or Savings Account	Money Transfer Locations (e.g. Western Union)	Text Message	Payroll Deduction	In-Person Drop-Off at Local Benefits Office
Alabama	X	X	X					
California	X	X	X	X	X			
Florida	X	X	X	X	X	X	X	
Louisiana	X	X		X				X
Michigan	X							
New York	X							
Texas	X	X						
Utah	X	X	X					

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

Some states also have incentives to encourage families to pay their premiums on time or early. In California, for example, families that set up monthly automatic payments receive a 25 percent discount on their premiums, while those who pay three months at a time receive a fourth month for free. To decrease churning due to non-payment of premiums, CHIPRA legislated that all states offer families a 30-day grace period, during which families can pay their premiums to avoid having their children's cases closed. Officials in New York reported that a 30-day grace period, implemented in October of 2005 before CHIPRA, had significantly reduced the number of families dropped from *CHPlus* due to unpaid premiums.

C. Conclusions

Cost sharing, in the view of most key informants, continues to be seen as an important and positive component of CHIP that bridges the gap between public and private coverage, gives families a sense of responsibility and ownership for their children's coverage, and distinguishes CHIP from Medicaid. Despite some concerns with affordability and issues with premium collection, informants generally were satisfied with the levels of cost sharing in state's separate programs. As illustrated in the Focus Group Box V-1, parents were overwhelmingly of the opinion that cost sharing was fair and affordable. Many compared CHIP quite favorably to private coverage, noting that CHIP is much less expensive and offers a better value, since it covers equal or more comprehensive benefits at a lower cost. Some families even expressed that they would be willing to pay more for CHIP or in some instances, that they would be willing to pay premiums to stay in CHIP rather than being enrolled in the free Medicaid program.

Focus Group Box VI-1 Cost Sharing

Parents appreciated being able to pay something toward the cost of coverage for their children, and viewed cost sharing in CHIP as affordable, particularly compared to private insurance.

"It's not bad compared to [private] insurance." (Alabama)

"[Copays] are not a problem…I don't have to think twice." (California)

"We understand that our premium is not even close to what they are paying for the care. We really appreciate it." (Florida)

"I liked paying just $10 a month…to get the care. You can't get medical for $10 a month." (Michigan)

"This is so affordable…you almost feel guilty that it is what it is." (New York)

"CHIP is more affordable than the insurance at my job." (Texas)

"I think when you have to pay for it; it makes you more grateful for it, instead of something that you just get [for free]." (Utah)

However, parents in some states reported that increases in cost sharing had created barriers to enrollment and service utilization.

"The $15 for me is very difficult, because I don't have an extra dime." (Florida)

"I had to take my two girls in the same week, you are looking at $50 in one week…it is okay if you just have one well-child visit for one child, but if you have to bring them in together, it adds up." (Texas)

"The $250 for us to go up to the [emergency room] is a little bit much…that one hurt." (Utah)

VII. CROWD OUT

During the initial development of CHIP, policymakers debated whether the program would "crowd out" the private market by encouraging families to substitute government-sponsored health insurance for existing employer-sponsored coverage for their children. Moreover, many were also concerned that employers would stop offering dependent health coverage for their employees if their children became eligible for public coverage. In response to these concerns, the original CHIP legislation mandated that all states have "reasonable procedures" in place to protect against crowd out despite warnings that such provisions could act as a barrier to enrollment. Although key informants interviewed for this evaluation reported that crowd out is not a major concern today, nine of the 10 study states currently employ crowd-out prevention strategies, including:

- Imposing waiting periods between dropping private coverage and enrollment;
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases;
- Imposing cost sharing in approximation to the cost of private coverage;
- Preventing employers from changing dependent coverage policies to induce parents to shift their children's coverage to public coverage; and/or
- Imposing other measures, such as premium assistance.

A. State Crowd Out Policies

From 2005 to the present, very few changes were made to states' crowd out policies; none of the 10 states chose to eliminate their anti-crowd out measures completely, and only a few implemented new measures. Of the 10 study states, only Ohio has no specific anti-crowd out policies (although it is not required to, as its' upper income limit is 200 percent of FPL). Per federal regulations, however, Ohio has always monitored the presence of crowd out and has procedures in place if crowd out is identified as a problem.

As shown in Table VII.1, nine of the 10 study states currently impose waiting periods and monitor health insurance status at the time of application to prevent crowd-out. Only three of the nine states that utilize waiting periods modified them during the study period; Florida decreased its waiting period from four to two months in 2009, while both New York and Louisiana implemented new waiting periods when they increased their eligibility limits to 400 percent and 250 percent of FPL, respectively (data not shown).

Table VII.1. CHIP Substitution and Crowd Out Policies, FFY 2010

State	Waiting Period (Yes Indicated by Length in Months)	Health Insurance Status Monitored	Database Match to Private Insurance Status	Cost-Sharing	Other
Alabama	3	X	X		
California	3	X	X		
Florida	2	X	X		X[b]
Louisiana	12[a]	X	X	X	
Michigan	6	X	X		
New York	6	X	X		
Ohio	--				
Texas	3	X		X	
Utah	3	X	X	X	X[c]
Virginia	4	X			
Number of States Using Policy:	**9**	**9**	**7**	**2**	**2**

Source: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012

[a] Louisiana's waiting period is for families in the separate CHIP component only (200-250 percent of FPL).

[b] In the FFY 2010 CARTS report, Florida identified the buy-in option as a crowd out prevention policy

[c] In the FFY 2010 CARTS report, Utah identified its premium assistance program as a crowd out prevention policy.

In response to concerns that waiting periods can create barriers to covering children, states have created exceptions that allow families to be exempt entirely from the waiting period given certain circumstances. These exceptions often target children who have lost coverage for reasons beyond their families' control or children who currently have health insurance that is very limited in scope or beyond their families' means. By utilizing these exceptions, states can effectively eliminate the waiting period for many of the children in need. For example, families in New York are exempt from the waiting period if any of the following circumstances apply to them:

- Involuntary job loss resulting in loss of health insurance;
- Death of a family member resulting in termination of child's health insurance;
- Changed jobs and new employer does not provide health benefits coverage;
- Moved and no employer-based coverage is available;
- Employer stopped offering health benefits to all employees;
- Health benefits terminated due to long-term disability;
- COBRA coverage expired;
- Child applying for *CHPlus* coverage is pregnant;
- Cost of the child's portion of employer-based coverage is more than five percent of the family's gross income; or
- Child applying for *CHPlus* coverage is at or below the age of five.

Although no other state in this study has as many exceptions as New York, all nine states with waiting periods include exceptions for involuntary loss of coverage and termination of COBRA coverage. In addition, five of the states—Florida, Louisiana, New York, Texas, and Virginia—include formal exceptions for affordability, allowing families to avoid the waiting period if the cost of employer-based coverage is more than a certain percentage of a family's gross income. While Michigan does not have an official exemption for affordability, caseworkers there can exempt families from the waiting period due to affordability on a case-by-case basis.

To determine whether a child qualifies for an exception from the waiting period, all nine states monitor an applicants' health insurance situation by including questions on the application about current and past coverage. The questions generally try to determine if the child already has health insurance, if they have had coverage in the past certain number of months (the number of months differ from state to state) and if so, why the child might have lost this coverage. In many states, the questions serve as a screening mechanism for the waiting period. For instance, in Virginia, applicants must indicate the reason a child's health insurance ended from a list of choices that correspond with the approved exceptions to the state's waiting period.

In addition to monitoring health insurance at the point of application, seven of the states also chose to match prospective enrollees to a database that details private insurance status. In Alabama for example, where approximately 85 percent of the state is covered by Blue Cross Blue Shield, all new applications are compared with the Blue Cross Blue Shield membership database.

Officials in Louisiana and Utah reported that the use of cost-sharing in approximation to the cost of private coverage creates an economic disincentive for families to substitute coverage. For example, in 2011, the national average copayment for families in the private sector was $21.53 (Davis 2009), while children in Utah's *CHIP* Plan C (the highest income coverage group with incomes between 151 and 200 percent of FPL) saw high copayments of $25 per office visit. Additionally, similar to the private market, families eligible for Utah's *CHIP* Plan C and Louisiana's *LaCHIP Affordable Plan*—which has an upper income limit of 200 percent of FPL—face premiums, deductibles, copayments, and coinsurance set at much higher levels than for families in lower income groups (see Table VI.3).

In addition, two of the study states offer premium assistance as an alternative for working families who cannot afford employer-sponsored insurance, which could prevent families from substituting public coverage due to affordability. Both Utah and Virginia offer such assistance to families:

- The *Utah Premium Partnership* (*UPP*) offers premium assistance to children under 200 percent of FPL and adults under 150 percent of FPL. All applicants are required to complete the universal application to be screened for Medicaid, CHIP, and *UPP* eligibility. If a child is found to be CHIP eligible and has access to employer-sponsored insurance (ESI), the family can choose to receive premium assistance to support participation in the ESI coverage. Families in *UPP* receive between $100 and $120 per child per month to use toward their children's premiums.
- In Virginia, children under 200 percent of FPL are eligible to receive premium assistance under *FAMIS Select*. Before applying, a child must be enrolled in *FAMIS*

before completing a separate application for *FAMIS Select.* Families in *FAMIS Select* can receive $100 per child per month towards their ESI insurance coverage.

Policymakers have lauded premium assistance programs for their potential to increase coverage, attain cost savings, and prevent crowd out, although state officials noted that both *UPP* and *FAMIS Select* remained underutilized in 2011 with enrollments of just 393 and 350 children, respectively. As a result of low utilization, informants interviewed for this report were noncommittal on whether premium assistance is an effective tool in preventing substitution. Nevertheless, officials maintained that premium assistance programs were important creative components of their CHIP programs.

Several of the study states also employ other, less commonly used strategies to prevent substitution from occurring. For example, in California, the Managed Risk Medical Insurance Board (MRMIB) has had legal obligations in place since the program's inception that prohibit employers from dropping or altering dependent coverage in response to CHIP.

B. State Experiences with Crowd Out

In general, officials in all 10 states believed the anti-crowd out provisions were effectively deterring families and employers from dropping coverage, and thus reported little concern about the matter. Several of the states had data to support these perceptions. For example, in FFY 2009, Michigan reported that only 0.01 percent of applicants indicated on the application that they had dropped health insurance to qualify for *MIChild.* Similarly, only 1.9 percent of families in Florida indicated on their application that they had coverage in the previous two months, potentially confirming the effectiveness of the state's two month waiting period (Nogle and Shenkman 2011).

Program administrators in many of the states believed that the waiting period was the most effective strategy in preventing crowd out because parents are afraid of foregoing coverage for their children , even for a short period of time. Other states reported that crowd out is not even a concern, as the majority of families eligible for CHIP are not believed to have much access to private insurance. In particular, officials in Virginia and Florida noted that their CHIP programs target low-income families who often work in industries where private insurance is almost never offered by their employer.

Because crowd out was not perceived to be a significant concern, the majority of states had not substantially modified their anti-crowd out policies during the study period, even as income eligibility limits expanded in many of our study states. For example, no changes were made to Alabama's crowd out policy when coverage was expanded from 200 percent to 300 percent of FPL in 2009. Similarly, officials in New York did not feel it necessary to impose a waiting period when the income threshold for *CHPlus* was expanded from 250 percent to 400 percent of FPL in 2009. Federal officials, however, disagreed and per federal regulations the state was required to adopt its first-ever waiting period (which is for six months) for applicants above 250 percent of FPL. Moreover, during the study period, many of the states minimized the impact of their waiting period, either by decreasing the length (Florida), or by adding new exceptions. Louisiana was the only state that opted to enhance its anti-crowd out measures by adding a 12-month waiting period for its separate CHIP program component when it expanded eligibility to 250 of FPL under the new *LaCHIP Affordable Plan* in 2007.

Despite little evidence of crowd out, we heard from legislators and health plan representatives in a couple of states that crowd out does still occur in specific instances. In Utah, for instance, one informant insisted that families go without coverage to enroll their children in *CHIP*, while another claimed crowd out was a constant concern in the state. Notably, Utah tried to increase its waiting period to six months in 2008, but this change was not approved by CMS as it was determined to violate MOE rules.

C. Conclusions

At the time of this study, none of the 10 study states were planning to modify their current crowd out provisions. In fact, the majority of informants in all 10 study states reported that they were satisfied with their current crowd out provisions, as they saw no evidence of crowd out occurring in their states. However, the implementation of the Affordable Care Act has created new uncertainty in some states, as officials question whether the option to expand Medicaid or extend coverage to state employees will possibly lead to crowd out.

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VIII. FINANCING AND FISCAL ENVIRONMENT

CHIPRA played an important role in increasing and stabilizing federal funding available to states during a period of considerable economic stress at both the federal and state levels. The onset of the Great Recession led to a doubling of the national unemployment rate to a high of over 12 percent in 2010 and put severe pressure on state budgets (which generally are required by state constitutions to be balanced). Passage of CHIPRA, however, ended a period of uncertainty concerning future federal funding for CHIP by committing $44 billion in new federal funding for the program through 2015. CHIPRA also amended the funding formula for states, rectifying long-standing inefficiencies by shifting to an allocation that is based on actual CHIP expenditures. Finally, the popularity and small relative size (compared to Medicaid) of CHIP resulted in continued strong support for the program among state policymakers.

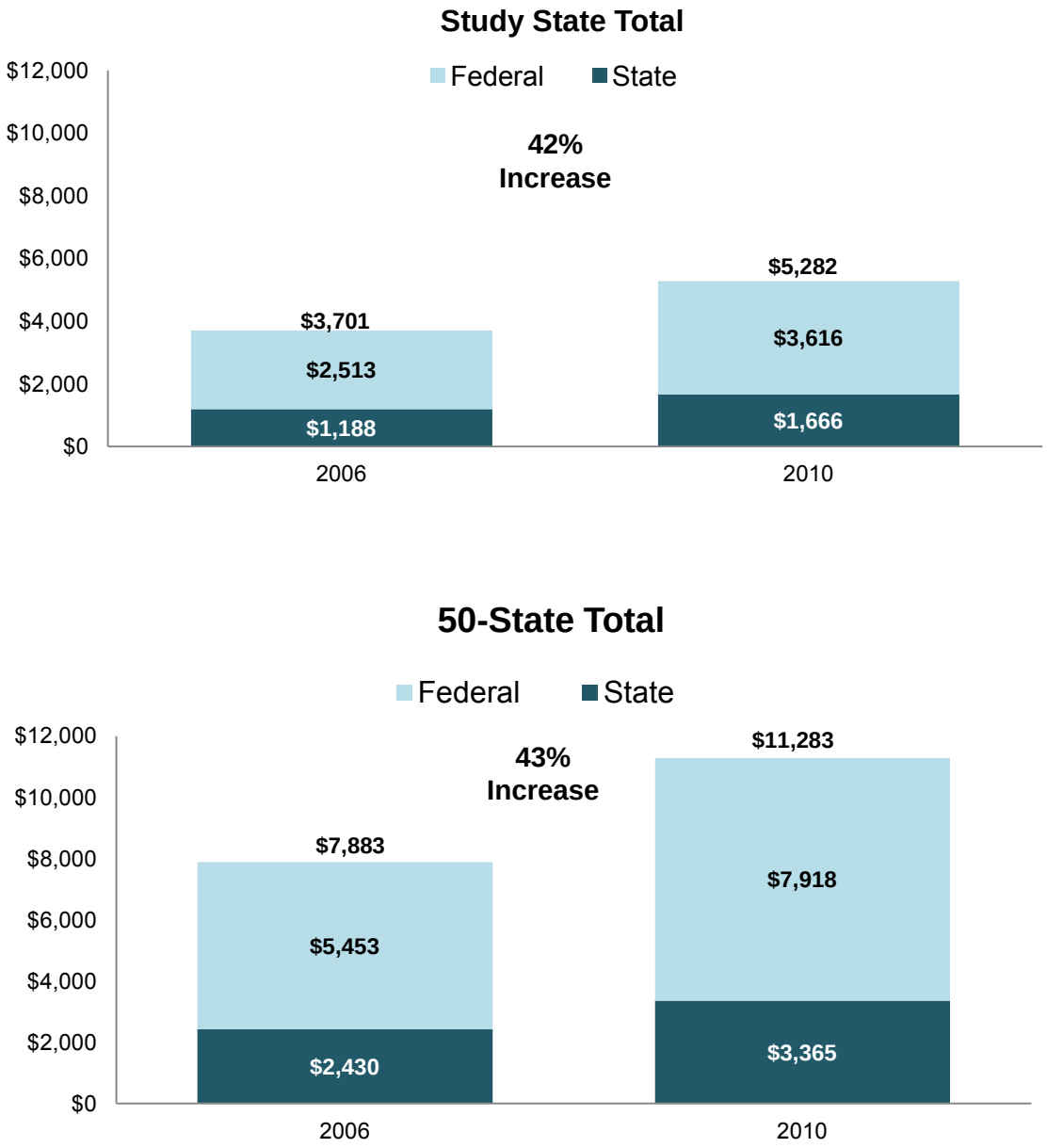
A. Federal Financing Issues

CHIP is a block-grant program, with annual fixed federal allotments to states. State expenditures are matched at a rate that is higher than Medicaid's—generally about 15 percentage points—but is capped at a fixed state allotment. Prior to CHIPRA, the allotment formula—which determines how much money each state could receive—was based on the number of low income uninsured children in the state, among other factors. During CHIP's early years, this formula often allocated some states more money than they could spend and others with less than they needed. As a result, complex reallocations of funds across states were often required. CHIPRA's new allocation approach, based on actual state expenditures on CHIP enrollees, thus made funding for states more predictable and responsive to state needs.

Other federal legislation that affected CHIP financing included the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act. As discussed in previous chapters of this report, maintenance of effort (MOE) rules established by ARRA and that were both broadened and extended by the Affordable Care Act stipulate that states are not allowed to lower their income eligibility limits for CHIP and Medicaid or otherwise place restrictions on eligibility (for example, by imposing more onerous enrollment procedures or by increasing premiums more than the rate of inflation) beyond those included in their program rules as of March 2010. This provides additional financial protection for CHIP programs, one that affects state as well as federal financing. Another important effect of the Affordable Care Act was to extend authorization of CHIP from 2015 through 2019 (though additional federal legislation will be required to fund CHIP beyond fiscal year 2015).

Figure VIII.1 shows trends in spending growth for CHIP in the 10 study states and nationally. It illustrates that spending grew 42 percent between 2006 and 2010 in the study states and at a similar rate nationally (43 percent).

Figure VIII.1. Trends in CHIP Spending, 2006-2010 (in Millions)



Source: Federal Expenditures and Total Expenditures 2006-2009: Kaiser "Total CHIP Expenditures"; Federal Expenditures and Total Expenditures 2010: Rowland, 2011; State Expenditures calculated from subtracting federal expenditures from total expenditures.

Appendix Table C.1 provides more detail on federal and state expenditure trends from 2006 to 2010 for CHIP, as well as trends in federal allotments and matching rates, for all 10 study states—separately and combined. The tables, together, illustrate the following points:

- Federal allotments for the 10 study states more than doubled between 2006 and 2010 (from $2.1 billion to $4.5 billion). The rate of increase in the allotment was even greater at the national level (from $4.0 to $10.5 billion).
- While total spending for the program nationally (federal and state combined) grew from $7.9 billion to $11.3 billion between fiscal years 2006 and 2010 (a 43 percent increase), spending per child grew by only 24.5 percent—about the rate of health care inflation over the same five years. The difference in these rates is due to substantial enrollment growth in the period.
- There was considerable state variation in spending patterns. For example, total CHIP spending declined in Michigan and stayed flat in California during the period, while spending almost doubled in Louisiana and tripled in Texas. Once again, these differences are likely driven by varying rates of enrollment growth in the study states. (For example, enrollment levels in California were high to begin with, while Texas redoubled its outreach efforts during the study period to address declining enrollment trends.)
- In the first part of the study period (2006-2008) most study states either overspent their allotment or were close to spending it all. The exceptions are Michigan and Texas, which spent substantially less than their allotments. Following the CHIPRA changes, which now base allotments on prior spending patterns, New York was the only state to overspend its allotment by 2010, while all other study states underspent their federal allotments.
- Consistent with historic patterns, the same trend is evident for the 10 state average and for the nation as a whole. Indeed, for FY 2010 only about three-quarters of the entire federal allotment was spent due to underspending by states.
- There was little change in matching rates in the period. The federal match rate increased—and the state match declined—in Michigan, Ohio, and Utah due to poor economic circumstances in the states. However, changes were not substantial.

B. State Financing Issues

All states faced fiscal strain during the study period for the evaluation. This led states increasingly to examine all sources of spending—including Medicaid, in particular, but also the smaller CHIP program. In spite of this, total state spending increased for CHIP in all study states but Michigan, likely due to enrollment growth. The study states in the south—Alabama, Florida, Louisiana, Texas, and Virginia—increased their state CHIP spending substantially during the study period, despite having generally conservative governors and legislatures. This pattern may be explained in part by eligibility expansions (e.g. Alabama), renewed marketing efforts to boost declining enrollment (e.g., Texas), and innovative enrollment simplification efforts (e.g., Louisiana and Virginia) coupled with the general popularity of CHIP. CHIP is often viewed as a less stigmatized alternative to Medicaid that serves many working and middle class families in low income states, and as an important safety net during the economic recession.

While there were some threats of state cuts to CHIP funding described by key informants in the study states, the Affordable Care Act's MOE requirement dramatically limited states' options for trimming CHIP (and Medicaid) expenditures. In years past, states experiencing budget shortfalls could cap enrollment and establish a waiting list for separate CHIP programs. (Only California did this during the study period, for two months in 2009.) As the recession progressed and pressure on state budgets intensified, key informants in several states reported that Governors and legislatures had considered this and other strategies for constraining enrollment, including in Alabama, New York, Virginia, and Utah. In each case, however, MOE requirements prevented the proposed changes from occurring.

States did adopt some strategies to control costs, according to state officials interviewed for this study. These included eliminating marketing budgets and limiting outreach to constrain enrollment growth (discussed further in Chapter III of this report), moving more enrollees into risk-based managed care (a step taken by Louisiana, Ohio, Utah, and Virginia and discussed further in Chapter V), increasing co-payments (as seen in Alabama, California, Louisiana, Texas, and Utah, as discussed in Chapter VI), and cutting benefits (as seen in Utah and discussed in Chapter IV). None of these actions on the part of states were prohibited by MOE protections.

C. Conclusions

The onset of the Great Recession put severe pressure on state and local budgets. In spite of dire fiscal circumstances at the state level, federal funding for the CHIP program stabilized and indeed increased substantially during the study period as a result of passage of CHIPRA. In addition, the popularity (and small relative size compared to Medicaid) of the CHIP program led to continued support at the state level.

IX. PREPARATION FOR HEALTH CARE REFORM

The Affordable Care Act has far-reaching consequences for CHIP and for children's coverage overall. As a practical matter, CHIP officials have devoted significant time over the past several years preparing their programs for the changes needed to comply with the law and—to varying degrees—in assisting their state with preparing for health reform implementation more generally. Moreover, the Affordable Care Act has played a prominent role in states' discussions about the future of CHIP. Though the Act extended CHIP funding through September 2015, increased federal matching funds for CHIP from FFY 2016- FFY 2019, and required states to maintain CHIP and Medicaid coverage for children until October 2019, federal funding after 2015 is not assured and substantial uncertainty exists about the future of CHIP once federal health reform is implemented. This section examines the implications of the federal health reform law for CHIP programs, including a review of the Affordable Care Act's provisions that are most relevant for CHIP, a summary of the study states' progress in implementing the law, and a discussion of CHIP's role in a post-reform world.

A. Relevant Affordable Care Act Provisions

Expanding access to affordable coverage is a keystone of federal health reform. The Affordable Care Act's Medicaid expansion provision targets adults, and would extend coverage to an estimated 15.1 million uninsured adults if fully implemented by all the states (Kenney et al. 2012a) However, the law also has several important implications for children's coverage under CHIP and Medicaid. Besides the maintenance of effort (MOE) and CHIP financing provisions described above and elsewhere in this report, additional provisions with the greatest potential to affect CHIP programs include:

- A requirement that CHIP enrollees with family incomes below 133 percent of FPL transition to Medicaid. Since state Medicaid programs are already mandated to cover children through age five in that income range, this provision only affects children ages six and up. It takes effect in 2014, regardless of whether a state opts to adopt the broader Medicaid expansion.
- A new option for states to cover children of public employees in CHIP if minimum agency contributions and other requirements are met.
- A new definition for income—called Modified Adjusted Gross Income, or MAGI—that states must use to determine eligibility for most nonelderly Medicaid and CHIP beneficiaries, as well as for the subsidies that will be available to purchase coverage through the exchange, beginning in 2014. As states transition to MAGI, they must make two major changes to the way they calculate income for Medicaid and CHIP:
  - Assets tests for all Medicaid and CHIP enrollees subject to MAGI are to be eliminated. Few states currently use an asset test to determine children's eligibility. Among the 10 study states, only Utah has an asset test for children in Medicaid (applicable to children age six and older) and only Texas has an asset test for CHIP (applicable for those with net incomes above 150 percent of FPL).
  - Most income disregards in Medicaid and CHIP must also be eliminated. A standard 5 percent disregard will be applied to everyone, raising the effective income thresholds for Medicaid and CHIP by 5 percentage points.

- Logistically speaking, MAGI implementation requires the reconfiguration of the business rules used by states' eligibility and enrollment systems. Further, family income will be counted differently under MAGI and as a result income for some children will be higher than it is under current methodology, meaning that some children currently in Medicaid may transition to CHIP.[33]

The Affordable Care Act also includes requirements that states' processes for determining Medicaid and CHIP eligibility (and renewal) are highly automated and streamlined, allowing eligibility decisions to be made in real-time. Moreover, the Affordable Care Act stipulates that Medicaid and CHIP programs coordinate processes behind the scenes with the exchange to ensure that applicants are directed, seamlessly, to the right program. States must adopt a single application that can be used for all health coverage programs, and which is accessible through multiple pathways (i.e., phone, online, in-person, mail). Exchanges will employ Navigators, or individuals that will assist consumers with enrolling in health coverage (including Medicaid and CHIP). The federal government has made significant funding available on a temporary basis to assist states with the cost of establishing Affordable Care Act-compliant eligibility and enrollment systems.[34]

Another relevant provision of the Affordable Care Act involves the Basic Health Program (BHP), an optional public coverage program with income eligibility levels that are similar to those of many states' CHIP programs. Specifically, the federal health reform law allows states to use federal tax subsidy dollars to offer subsidized coverage through the BHP for individuals with incomes between 133 and 200 percent of FPL who would otherwise be eligible to purchase coverage through the exchange.[35] The BHP is typically envisioned as a Medicaid or CHIP-like program with lower cost sharing than plans available through the exchange. In states that choose to establish a BHP, parents and other adults as well as children—including former CHIP enrollees (given the overlap in eligibility levels) in a state that elects to eliminate CHIP—could potentially be covered through the program.

There are a number of additional Affordable Care Act provisions related to Medicaid which will have a direct influence on states with Medicaid expansion CHIP programs and an indirect influence on separate CHIP programs. These include requirements to cover new benefits (such

[33] For a more detailed discussion of how this would work in California see: Stan Dorn. The future of Healthy Families: Transitioning to 2014 and beyond, The Urban Institute, February 2012, http://www.urban.org/uploadedpdf/412508-The-Future-of-Healthy-Families-Transitioning-to-2014-and-Beyond.pdf

[34] Primary among these funding opportunities is a 90 percent federal matching rate for Medicaid eligibility and enrollment system modernization. States must meet certain conditions, including seamless coordination with the exchanges, to qualify for the enhanced match rate. They are also eligible for an enhanced 75 percent matching rate for system maintenance and operations. The 90 percent matching rate is available for eligibility systems until December 31, 2015, and the 75 percent match is available beyond that date, assuming the conditions continue to be met. More information can be found at http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf. For states choosing to create a single integrated eligibility system for Medicaid and the exchange, other critical sources of funding include exchange planning and establishment grants (available 2010–13) and the Early Innovator grants awarded to a handful of states in 2011.

[35] In addition, BHP coverage would be available to legal immigrants with incomes below 133 percent of FPL whose immigration status disqualifies them from federally matched Medicaid.

as tobacco cessation services for pregnant women) or providers (such as freestanding birth centers); a temporary increase in Medicaid reimbursement rates for primary care services in 2013-14; and, enhanced federal funding for providing health home services (such as comprehensive care management) to beneficiaries with chronic diseases.

B. Progress in Implementing the Affordable Care Act

Responses to the Affordable Care Act have been varied among the study states, reflecting the same diversity in implementation approaches taken by states across the country. California and New York have largely embraced the law and taken a proactive stance towards implementation. Policymakers in other study states have been generally opposed to or divided over whether (and how) to implement the Affordable Care Act, impeding progress and prompting concern among key informants about meeting the law's aggressive deadlines. Even the most recalcitrant study states have taken steps to implement at least some portion of the Affordable Care Act, however, as demonstrated in Table IX.1 showing responses to selected Affordable Care Act provisions. Moreover, states' positions related to federal health reform implementation are constantly evolving. At the time of the evaluation site visits, key informants in all but the two most proactive states (California and New York) suggested that policymakers were in a "wait and see" mode about most implementation decisions, waiting first for the result of the June 2012 Supreme Court decision on the constitutionality of the Affordable Care Act and then for the outcome of the November 2012 federal elections. As each of these events has passed—and with the federal health reform law still in place—state policymakers' stance towards implementation appears to be shifting in some states.[36] And with the coverage expansions and other 2014 reforms looming larger every day, study states that are still undecided about how they will approach various provisions in the law—principally the Medicaid expansion and exchange establishment—are expected to begin making concrete decisions.

[36] Just days after President Obama was re-elected, for instance, Florida Governor Rick Scott—one of the Affordable Care Act's most outspoken critics who had formerly declared that Florida would not actively implement the law—issued a press release indicating that his position towards implementing the law had softened. See: http://www.miamiherald.com/2012/11/10/3091758/scott-may-shift-stance-on-health.html

Table IX.1. State Responses and Progress towards Implementation of the Affordable Care Act (as of December, 2012)

State	Participation in the Federal Lawsuit to Overrule the Affordable Care Act	Pursued Enhanced Federal Funding for Medicaid Eligibility System Modernization	Planning to Expand Medicaid in 2014	Health Insurance Exchange Establishment	
				Received Federal Grants for Exchange Planning or Establishment	Type of Exchange
Alabama	Yes	Yes	No	Yes	Federally-facilitated
California	No	Yes	Yes	Yes	State-based
Florida	Yes	Yes	Undecided	Yes, but returned funds	Undecided
Louisiana	Yes	Yes	No	Yes, but returned funds	Federally-Facilitated
Michigan	Yes	Yes	Undecided	Yes	Federal-facilitated Partnership
New York	No	Yes	Undecided (Leaning Yes)	Yes	State-based
Ohio	Yes	Yes	Undecided	Yes	Federal-facilitated Partnership
Texas	Yes	Yes	No	Yes, but returned funds	Federally-Facilitated
Utah	Yes	No	Undecided	Yes	Undecided
Virginia[a]	No	Yes	Undecided (Leaning No)	Yes	Undecided

Sources Participation in the federal lawsuit, Pursued Enhanced Federal Funding: Case Study Reports prepared by the Urban Institute and Mathematica Policy Research for the CHIPRA-mandated evaluation of CHIP, 2012; Planning to expand Medicaid: The Advisory Board Company, 2012; Health Insurance Exchange: Kaiser Family Foundation, 2012.

[a] Virginia did not participate in the 26-state federal lawsuit to overrule the Affordable Care Act, but did file its own lawsuit separately in 2010. A federal appeals court dismissed the case as the state lacks the jurisdictional authority to challenge the law.

CHIP officials in many of the study states have had an important role in federal health reform implementation. For instance, California's CHIP administrator (MRMIB) has been actively involved with discussions and planning for the state's new eligibility system, and with selecting a contractor to lead statewide outreach efforts. A legislator on Utah's CHIP Advisory Board is chair of the state taskforce responsible for making decisions about Affordable Care Act implementation. Other CHIP officials suggested that while they did not have a prominent leadership role in implementation activities, they were invited to discussions and could provide meaningful input to the process. States' past and current experiences with designing and operating separate CHIP programs are directly relevant to many of the implementation-related decisions they are now faced with, such as designing a benefit package, developing an eligibility and enrollment system, conducting outreach, and coordinating across separate coverage programs.[37]

1. Expanding Medicaid and the BHP

Even more study states are still undecided about whether they will take up the Affordable Care Act's Medicaid expansion. As of December 2012, officials in one state (California) had publicly stated that they will pursue the expansion, while governors in three other study states (Alabama, Louisiana, and Texas) have indicated that they will not, and more than half remain undecided (Table IX.1). Given that the bulk of the evaluation site visits occurred before the June 2012 Supreme Court decision that made this provision optional, the research team was not able to examine key informants' opinions on the expansion choice. Officials in a number of states, however, expressed concern about the state costs of expansion, even with an unprecedented level of federal support for expansion enrollees' coverage.[38] Regardless of whether they opt to expand Medicaid, states are preparing for enrollment increases in their public coverage programs because a number of residents who are currently eligible for Medicaid or CHIP but not enrolled are expected to apply when they learn about the exchanges (and related subsidies) and associated requirements to obtain coverage.

A few of the study states reported that they were considering the Affordable Care Act's BHP option, though none had a firm decision yet about whether to pursue this, which is not surprising given that states are awaiting federal guidance on the BHP. California and New York both engaged external experts to study the feasibility of a BHP in their state, and in Michigan a bill to establish a BHP (which some key informants described as premature) was introduced in the 2012 legislative session.

2. Modernizing Eligibility and Enrollment

Without question, the area of health reform implementation where the study states reported the most activity was in establishing modern, coordinated eligibility and enrollment system(s) for

[37] Notably, the information on CHIP program experiences related to Affordable Care Act implementation is limited to just the 10 case study states in this report; the evaluation's upcoming survey of state program administrators will provide more extensive information on progress in all the states.

[38] States will receive an enhanced federal match rate for the cost of providing Medicaid to newly-eligible expansion populations. From 2014 to 2016, coverage for the newly-eligible will be fully federally-funded (100 percent match) and the match rate will then gradually decline until it reaches 90 percent in 2019 and beyond.

all health insurance subsidy programs (i.e., Medicaid, CHIP, and the exchange). As shown in Table IX.1, all states but one—Utah—have actively pursued the enhanced federal Medicaid funding to upgrade or overhaul their existing Medicaid eligibility system. Utah officials reported that they will update their system—which (as described earlier in the Eligibility and Enrollment section) is already more automated and streamlined than that of many other states—so that it is compliant with the Affordable Care Act, but the state had not made any plans to use the temporary enhanced funding for this purpose. The other study states are in various stages of system modernization. At least two (California, New York) have vendor contracts in place, for instance, while others (Florida, Louisiana, Ohio, Virginia) have solicited proposals from vendors though no awards have been announced.[39]

With the exception of Utah and Louisiana, all the study states with separate CHIP programs currently have different eligibility systems for those programs and Medicaid.[40] The separate CHIP systems are coordinated to varying degrees. Key informants in California reported that the Medicaid and CHIP programs had worked hard to align their eligibility and enrollment processes and to make sure that transitions between the programs are smooth, but this is still a challenge. Key informants in Florida described disjointed Medicaid and CHIP systems that cause confusion and problems for families, and expressed concern about how state agencies would meet the Affordable Care Act's requirements for behind the scenes seamlessness between Medicaid, CHIP, and the exchange. It appears that this issue will be largely addressed in the future, since the replacement Medicaid eligibility system that Florida is building will eventually be an integrated system that serves all health coverage programs. Though the system will initially focus on Medicaid eligibility (to meet Affordable Care Act-related deadlines), additional programs—including CHIP—can be added in later phases. New York is taking a similar approach. The new system California is building (and expects to launch by 2014) will determine eligibility for Medicaid, CHIP, and the exchange, and Texas will have an integrated system even sooner. In September 2013, Texas will migrate CHIP eligibility functions into its Medicaid system.

Key informants shared several examples of how different elements of their state's CHIP program could be useful in an implementation context. Like many other states with separate CHIP programs, Florida's CHIP administrator (Florida Healthy Kids Corporation) has experience collecting premiums and working with community groups on application assistance, prompting some to suggest that the entity is well-positioned to play a role in exchange operations. In Alabama, officials decided to build their new eligibility and enrollment system using lessons learned from the existing CHIP system. And both New York's Facilitated Enrollment and California's Certified Application Assistor programs could provide a strong foundation of community-based organizations, health care providers, and health plans to play a

[39] Alabama also contracted with a vendor for its Medicaid eligibility system upgrade, but subsequently retracted the award when the state was unwilling to front the $5 million needed for the state share of the project even with the enhanced 90/10 federal/state match. The state will still use the enhanced funding to build a new system, but plans to use state agency staff (rather than an outside vendor) for the effort, thus saving costs.

[40] Ohio, as a Medicaid expansion CHIP model uses the same system for Medicaid and CHIP. Louisiana is a combination state but uses the same system for Medicaid and CHIP (both the Medicaid expansion and separate program components). Utah has only a separate CHIP program, but uses the same system for CHIP and Medicaid.

role in providing hands-on application assistance (including through the state's Navigator program, potentially) after implementation of reform.

C. CHIP in a Post-Reform World

As the Affordable Care Act is implemented, states' coverage landscapes will change considerably—Medicaid programs will grow, and many low- and moderate-income individuals will become eligible for federal subsidies to purchase private coverage through the new exchanges. Many of the parents in the evaluation's focus groups had heard about the Affordable Care Act, and understood that there would be some major changes in store, but were uncertain about the details or how their family's coverage might change (see Focus Group Box IX-1). Indeed, in most of the study states, is not yet clear how CHIP will fit into this post-reform environment. In the near-term, state officials must consider the implications of current CHIP policies as the Affordable Care Act is being implemented—for instance, whether CHIP enrollees with subsidy-eligible family members may be subject to premium stacking (meaning that they may need to pay premiums for CHIP as well as for the health plan they select in the exchange) or whether CHIP crowd out policies (like the common requirement of a waiting period) should be reexamined in the context of the near universal coverage envisioned by the Affordable Care Act (Hess et al. 2012). And, with expansions and new coverage options on the horizon and uncertainty about federal CHIP funding after 2015 (and authorization after 2019), however, there has been ongoing dialogue among CHIP officials and other stakeholders about the program's future.

Focus Group Box IX-1: Health Reform

Many parents reported that they were either currently uninsured, or had long periods of uninsurance in the past.

"In my adult working life, I've only had insurance for two years…I've worked several part time jobs and they did it so they wouldn't have to offer insurance." (Ohio)

"It would be great [to get what our children get]….since I have diabetes, every time I go to the doctor, it is $100…I would be glad to get insurance." (Texas)

"It's scary because I'm 60, you know, and I have no insurance, and I just don't go to the doctor." (Louisiana)

There were mixed findings in the focus groups regarding what parents had heard and understood about health care reform.

"I heard about it, but I really don't know how it's going to work." (California)

"I've heard about it. If they do something like [Healthy Families], you know, I'm willing to pay for that kind of coverage." (California)

"[I] heard there are going to be stipends and more of a sliding scale for people who are like me who don't have an option through work and we can buy in." (Ohio)

"I heard that it was going to cover people that don't have health insurance, which I was excited to hear. But I don't know if that's…going to happen." (Utah)

"I worry that we'll have a lot less options of [providers]" (Utah)

"One of the things that caught my attention during the health reform was…making plans more inclusive so that individual that have pre-existing conditions…[don't] have to go through a waiting period before they could start receiving care." (Alabama)

"I think the plan as a whole is a wonderful plan…I think we do need to have something to help us as a whole…I just feel like there's other ways that maybe we could go about paying for it." (Alabama)

Across the study states, there were two predominant and opposing sentiments among key informants about whether (and how) CHIP would operate in 2014 and beyond. On the one hand, some expected their state's CHIP program to continue into the foreseeable future. Given CHIP's popularity and wide bipartisan support, these key informants found it hard to imagine that policymakers would choose to eliminate the program. This was particularly true in states like New York and Florida, which—notably—had children's coverage programs that predated CHIP.

On the other hand, some key informants suggested that, as a practical matter, it may make sense for their state to dismantle CHIP and transfer program enrollees into other coverage options. They reasoned that, from a consumer's perspective, it may be more advantageous for children to obtain coverage via the exchange (or the BHP, if relevant) since many of their parents are likely to be covered that way and the entire family could be enrolled in the same plan, with the same provider network. Moreover, it may be administratively inefficient to continue operating separate CHIP programs, especially in light of the fact that CHIP enrollment in some states will shrink when certain Affordable Care Act provisions are implemented—primarily the requisite transfer of CHIP enrollees with family incomes under 133 percent of FPL to Medicaid. The likely impact of this provision depends on the income distribution of each state's current CHIP population—states with a greater proportion of CHIP enrollees in the lowest income band will experience a larger shift. For instance:

- Florida officials estimated that about a quarter of the state's CHIP enrollees would transition to Medicaid.
- New York—which has already begun to implement this provision ahead of the 2014 deadline (described in greater detail below)—also expected roughly a quarter of its CHIP population to transition.
- Utah expects the most dramatic enrollment changes (among the study states), with CHIP officials reporting that their program could shrink from around 38,000 to roughly 10,000 enrollees as a result of the under-133 percent provision and the elimination of the state's asset test for Medicaid.

California is the only study state that has made a definitive decision about the future of its CHIP program. After intense debate, and in what key informants described as a very difficult decision driven primarily by concerns about the state budget, California policymakers decided earlier this year to eliminate CHIP by phasing its enrollees into Medicaid. This transition will begin in January 2013 and be complete within a year. Key informants in the state shared concerns about the transition proposal—which has not yet been approved by CMS—particularly that it would adversely affect CHIP beneficiaries' access to care. California's CHIP program is perceived to offer better access than Medicaid, in part due to lower provider reimbursement rates (and consequent lower provider participation rates) in the latter program. Other study states reported that they too have considered transitioning their entire CHIP population to Medicaid, but were generally reluctant to do this for several reasons. A foremost concern is potentially negative consequences for enrollees' access to care, but key informants in Utah were also skeptical that policymakers would support moving children from a program with considerable cost sharing (i.e., enrollees in Utah's highest income tier pay premiums and copayments that are similar to that of commercial coverage) into Medicaid, where cost sharing is strictly limited. And in Florida, key informants worried that CHIP enrollees would experience more challenges with eligibility and enrollment processes if they were transitioned to Medicaid; noting, for instance, that the average wait time for a customer service call is 45 minutes for Medicaid versus 19 seconds for CHIP.

New York's experience with transferring CHIP enrollees in families with incomes below 133 percent of FPL into Medicaid reveals early lessons that may be useful for other states as they consider how to implement this particular Affordable Care Act requirement, or any other policies that states may adopt which could require the transfer of some or all CHIP enrollees into alternative forms of coverage (e.g., exchange-based or BHP plans). Though officials in other

study states reported that they had considered implementing the Affordable Care Act's under-133 transfer requirement ahead of 2014 (and California will do so starting in 2013), New York was the only state that started the effort prior to the evaluation site visit. In fact, New York had been planning to take this step even before passage of the Affordable Care Act. The state began to transition CHIP enrollees into Medicaid in November 2011 using a phased-in approach whereby children are transferred to Medicaid as they come up for their annual CHIP renewal. The state is using Express Lane Eligibility to assist in this transition so that the process is seamless. There is considerable overlap in managed care networks for the two programs, so service delivery arrangements were not expected to be significantly disrupted. Moreover, state officials noted that in those cases where a transferee's CHIP plan does not participate in Medicaid, they are taking extra steps aimed at ensuring provider continuity. Specifically, they compare the CHIP plan's provider network with that of the available Medicaid plans and assign the transferee to the Medicaid plan with the most similar provider network. Transferees who are auto-assigned in this manner also have the opportunity to switch plans if they are not satisfied. At the time of the evaluation site visit (February 2012), the policy change was fairly new and the impact on children and their families was described as minimal. Some New York informants anticipated that as more children are transferred to Medicaid, the state can expect greater resistance because CHIP is viewed by families somewhat more favorably than Medicaid; at the same time, some informants suggested that this discrepancy has decreased considerably in recent years.

In conclusion, there are still many unknown factors that will influence state decisions about CHIP's future. Primary among these is whether federal funding for the program will continue beyond 2015. In this time of economic recovery and ongoing state budget pressure, it seems unlikely that many states would choose to continue funding CHIP absent federal support when there is an opportunity to transition some enrollees to Medicaid or the exchange (where subsidies are 100 percent federally-funded). States' decisions about whether to implement the Medicaid expansion and/or create a BHP are also relevant to the conversation about CHIP's role in a post-reform world. The structure of each state's exchange is another important consideration—specifically whether the benefits and provider networks available under exchange plans will meet the health care needs of low-income children such as those currently enrolled in CHIP, and whether the exchange-based subsidies will be adequate to make coverage affordable. Eliminating CHIP programs may lower government outlays, but at the detriment of children's coverage levels. One study estimates, for instance, that if Congress does not continue funding CHIP—and if all states subsequently eliminate their separate CHIP programs—millions of additional children could be uninsured (when compared to a scenario where Medicaid and CHIP programs and eligibility levels for children are maintained). Further, if the federal MOE requirements are repealed and states are able to relax eligibility standards for children above 138 percent of FPL, children's uninsurance levels could actually increase.[41] (Notably, the evaluation's upcoming survey of state program administrators will provide more extensive

[41] The study suggests a number of reasons why so many children who would lose Medicaid and CHIP coverage would not gain employer-based or exchange coverage, such as the fact that some children would be ineligible for subsidies based on a parent's access to employer-based insurance (i.e., children in families whose parents are covered by employer-based single policies that cost less than 9.5 percent of family income would be ineligible for subsidized exchange coverage) and the fact that even with subsidies, exchange premiums and cost sharing will be higher than those in CHIP and Medicaid thus take-up is expected to be lower (Kenney et al. 2011).

information on how implementation of the Affordable Care Act has influenced, and will continue to influence, CHIP policy decisions.)

Ultimately, it appears that federal support for CHIP will be the most influential factor in state decisions about whether or not to continue operating their programs in the years to come. At the same time, many key informants across the study states were committed to ensuring that their state's CHIP program design—which aimed to provide low-income children with reliable access to high-quality pediatric care—is not lost as implementation of the Affordable Care Act progresses, and that the lessons learned from operating their CHIP programs over the past decade are carried over to states' reformed health systems.

X. CONCLUSIONS

Case studies in 10 states find that CHIP programs continue to innovate and adapt to changing circumstances while providing comprehensive health coverage to a growing share of this nation's children. The CHIP Reauthorization Act (CHIPRA) provided much-needed federal financial stability to CHIP; not only did the Act commit $44 billion for the program through 2013, it critically amended the funding formula for states, rectifying long-standing inefficiencies by shifting to an allocation based on actual CHIP expenditures. CHIPRA also created new financial incentives for states to simplify and streamline enrollment and renewal, provided significant new funding support for outreach, and made a large investment of resources to improve the quality of care delivered to children. Beyond its financial effects, CHIPRA also broadened coverage of dental and mental health services, and gave states options to expand coverage to legally residing immigrant children, among others.

In response, as reflected in this evaluation's sample, some states expanded eligibility—even during the worst economic recession since the Great Depression—and most continued to adopt strategies that make it easier for families to apply for and maintain coverage for their children. States also fine-tuned benefit packages that were already described as generous and comprehensive, maintained cost sharing at levels most deemed fair and affordable, delivered services through managed care provider networks that extend good access to care, and intensified efforts to measure and report on child health quality. Meanwhile, passage of the Affordable Care Act just one year after CHIPRA meant extended authorization and funding, yet also raised fundamental questions about the future role of CHIP in a reformed health care system. While opinions are mixed on whether CHIP will survive in its current form over the long run, CHIP officials are committed to the principle that children should continue to be provided easy access to comprehensive, high-quality pediatric care, however health systems evolve in the years ahead.

Specific cross-cutting conclusions related to the key policy areas addressed in the evaluation appear below.

A. Eligibility, Enrollment, and Retention

- ***State CHIP programs continued to expand and innovate in the years preceding and following CHIPRA's passage, despite enduring a severe economic downturn***. More financial stability and flexibility after CHIPRA, among other factors, led the majority of the 10 study states to further expand eligibility for children—four raised upper income thresholds; three added federally funded coverage of legal resident immigrant children; and three added coverage of children of state employees. Critically important were maintenance of effort (MOE) rules, established by the American Recovery and Reinvestment Act of 2009 and extended and broadened by the Affordable Care Act, which protected these and other important gains by prohibiting states from cutting eligibility and enrollment policies for CHIP and Medicaid to levels more restrictive than those in place in March 2010. State officials in half the study states reported that these rules were crucial in safeguarding their programs from cuts in recent years, especially as state budgets came under pressure during the Great Recession.

- ***Enrollment simplification continued to be a major priority of CHIP programs and CHIPRA played a direct role in spurring additional action***. CHIPRA performance bonuses, made available to states that adopted at least five of eight simplification strategies and met Medicaid enrollment growth targets, were cited by state officials as a direct incentive for implementing further innovations. Six of the 10 study states qualified for bonuses during one or more years of the study periods—totaling nearly $27 million—by deploying such strategies as 12-month continuous eligibility, no assets test, no in-person interviews, joint CHIP/Medicaid applications, administrative renewal, presumptive eligibility, and Express Lane Eligibility, among others. Online applications, more integrated eligibility and information systems, and community- and health plan-based application assistance programs are also features of most states' eligibility processes.

- ***States also focused considerable attention on simplifying renewal processes, understanding that achieving high retention rates is crucial to reducing churn and maintaining reductions in the ranks of uninsured children***. In the early years of CHIP, policymakers focused the lion's share of their attention on getting children enrolled in the program. As CHIP programs matured, most states began to also focus on simplifying renewal processes, bolstered by evidence showing that children were losing coverage at renewal at alarmingly high rates (Hill and Westpfahl Lutzky, 2003), and that many children who lost coverage remained eligible (Kenney et al. 2011). Many states applied the same types of strategies to renewal as they did to enrollment, including: allowing families to submit renewal applications online; allowing parents to self-declare family income; pre-printing renewal forms with information already in states' eligibility systems; conducting administrative renewal whereby state officials could verify income, insurance status, and other factors through behind the scenes data matches; and permitting community-based application assistors to help parents renew their children's coverage. Also, adoption of 12 months continuous eligibility – in place in eight of the 10 states—buttressed these renewal simplifications by reducing the number of times families had to renew.

- ***While modest and steady enrollment gains were witnessed in most states, stakeholders reported that some barriers to enrollment remain***. While CHIP programs experienced modest and steady enrollment gains in the study period, stakeholders attributed some of this to the weak economy, while also noting that process barriers remain in many states. These include lack of full alignment between Medicaid and CHIP policies and procedures, multiple or outdated information systems that hinder efficient enrollment or transfer of children between the two programs, and ongoing disconnects between agencies responsible for Medicaid and CHIP eligibility.

B. Outreach

- ***In response to state budget constraints, CHIP outreach efforts have increasingly moved away from broad marketing campaigns to community-based efforts***. States' early investments in broad-based marketing and outreach succeeded in establishing well known and well regarded brands for state CHIP programs in most of the states. As marketing and outreach budgets dwindled over the years, state officials noted that the impacts of eliminating mass-media marketing efforts appear to have been

minimal. In turn, grass roots community-based outreach has played a more prominent role in most states, focusing on the challenging work of finding and enrolling uninsured children in hard to reach families. In states like New York, health plans have also played a major role in CHIP outreach and marketing, filling some of the void left as state funding was cut.

- ***CHIPRA outreach grants have played an important role in supplementing state outreach efforts***. CHIPRA outreach grants were very helpful in bolstering CHIP outreach at a time when many state outreach budgets were either severely cut or entirely eliminated. Stakeholders reported that CHIPRA grants enabled the continuation of existing efforts in some states, and the stimulation of new initiatives tailored to specific communities or health care settings in others.

C. Benefits

- ***States have continued to offer generous benefit packages in CHIP despite state budget pressures in recent years.*** Key informants and parents of children enrolled in CHIP overwhelmingly acknowledged the generosity of the CHIP benefit package, though a few deficiencies were noted, including lack of coverage of EPSDT and non-emergency transportation.
- ***CHIPRA's impact on benefits appears to have been limited, as many states already covered comprehensive dental and mental health care benefits in CHIP***. CHIPRA required states to offer dental coverage and to achieve parity for mental health benefits vis-a-vis medical services coverage. However, these provisions required minimal changes by states that already offered comprehensive benefit packages. Some of the study states reported having to add coverage of medically necessary orthodontia. To achieve mental health parity, states typically only needed to make small adjustments to their existing mental health benefits, often removing annual limits to certain behavioral health services. Utah was the only state that chose to reduce its medical benefits to bring it in line with less generous mental health coverage.

D. Service Delivery, Access, and Quality

- ***Risk-based managed care continues to be the dominant form of service delivery in separate CHIP programs, more so than Medicaid***. Among the 10 study states, Alabama is the only one that continues to use discounted FFS reimbursement with a single insurer for its separate program. State officials reported various reasons for choosing managed care—primarily they viewed the model as one that offers good access to care through provider networks that often bear a greater resemblance to commercial insurance networks than do those offered by Medicaid. Furthermore, despite substantial overlap between many Medicaid and CHIP managed care plans, some discontinuities remain, posing challenges for children who move between programs.
- ***The majority of CHIP (and Medicaid) managed care programs carve out behavioral health and dental care***. Usually, carved-out services are managed by a separate plan that also bears financial risk, though this is not always the case. There was widespread agreement that carve-outs for dental care work particularly well,

because specially designed dental plans have wider networks than traditional FFS. Opinions were more mixed for behavioral health carve-outs; most thought they resulted in more effective and specialized care for persons with mental health needs, but others were concerned that they fragmented care across health and behavioral health systems.

- ***CHIP programs are perceived as having achieved good access to high quality care, and have built strong reputations as a result***. Parents, advocates, and state officials alike consistently praised the CHIP program's ability to provide reliable access to high quality care. Access to primary care is particularly good due to high levels of participation by pediatricians. Parents also described mostly positive experiences with accessing specialty care for their children. The generally positive comments about access to care in separate CHIP programs were not as evident for Medicaid expansion CHIP programs. Provider reimbursement rates are lower, on average, in Medicaid; key informant suggested that, as a consequence, provider participation and access to care are general more limited. This was particularly true for dental care.
- ***States responded to CHIPRA incentives for enhanced quality monitoring and reporting under CHIP***. States reported more intensive efforts to consistently collect CHIP child quality measures according to uniform federal definitions and to contract with EQROs as a result of CHIPRA requirements. Two of the study states are also participating in the CHIPRA quality demonstration program. However, states still are struggling to report some of the federal CHIP quality measures due to a lack of ready access to data.

E. Cost Sharing

- ***Cost sharing remained a prominent and popular feature in separate CHIP programs during the study period.*** Most states increased cost sharing for families with children enrolled in CHIP during the study period, primarily due to worsening budget circumstances. However key informants interviewed for the case studies and parents participating in focus groups overwhelmingly viewed cost sharing as both fair and affordable, and much less expensive than private insurance. Many parents said they felt proud to be able to contribute to the cost of their children's coverage. Moreover, stakeholders and parents believe that cost sharing sets CHIP apart from Medicaid by structuring the program more like private insurance, instilling a sense of responsibility in families and encouraging the proper utilization of services.
- ***Maintenance of effort rules in the Affordable Care Act limited the extent to which states could increase cost sharing.*** Prior to MOE, 6 of the 10 study states increased premiums as a strategy for controlling CHIP costs. But after MOE rules were put in place, only one state—Alabama—received federal approval of an increase to its annual fee because $2 to $4 additions were viewed as nominal. Instead, after 2010, most states of the study states increased copayments as a lever to address budget pressures and discourage inappropriate utilization. Copayment increases did not come without controversy, however—some key informants worried that higher costs might create barriers to access and service use.

F. Crowd Out

- ***Crowd out was not a major concern in any of the study states, leading to few changes in crowd out policies during the study period***. Nine of the 10 study states employ a range of strategies to prevent or discourage the substitution of public insurance for private coverage, but primarily rely on waiting periods—ranging from 3 to 12 months—during which children must be uninsured before being allowed to enroll in CHIP. Only two states—Louisiana and New York—imposed new waiting periods under CHIP during the study period, doing so only after significantly expanding coverage to children in higher income families. More often, states reported loosening their anti-crowd out policies by either decreasing the length of waiting periods or adding more exceptions to waiting periods for families needing coverage for their children.

G. Financing

- ***CHIPRA increased and stabilized federal funding for the program during a period of considerable economic stress at both the federal and state levels***. CHIPRA ended a period of uncertainty for federal CHIP funding by committing $44 billion in new federal funding for the program through 2013. The law also amended the formula for determining how much funding states are to receive, rectifying long-standing inefficiencies by shifting to an allocation that is based on actual CHIP expenditures, rather than the number of low income uninsured children in the state.
- ***Largely because of enrollment growth and MOE requirements, states maintained or increased their CHIP spending between 2006 and 2010 despite state budget pressures resulting from the Great Recession***. While state fiscal strain was evident during the study period, total state spending increased for CHIP in all study states but one, likely due to enrollment growth. Although key informants described some threats of state cuts to CHIP, the Affordable Care Act's MOE requirements dramatically limited states' options for trimming CHIP and Medicaid expenditures. As the recession deepened and pressures on state budgets intensified, key informants reported that Governors and/or legislatures in several states proposed enrollment caps and other strategies for constraining growth. In each case, however, MOE protections prevented proposed cuts from being implemented.

H. Health Reform

- ***The Affordable Care Act has far reaching implications for the future of CHIP and for children's coverage, generally.*** While the Affordable Care Act extended CHIP funding through September 2015, increased federal matching rates between 2015 and 2019, and required states to maintain CHIP and Medicaid coverage for children until October 2019, federal funding after 2015 is not assured.
- ***CHIP officials devoted significant time and effort preparing their programs for the changes needed to comply with the Affordable Care Act.*** Particularly relevant changes that the study states have focused on include (but are not limited to) the requirements that: CHIP enrollees with incomes below 133 percent of FPL transition to Medicaid; states adopt new methods for counting income—Modified Adjusted Gross Income—when determining CHIP and Medicaid eligibility; and eligibility

systems be upgraded to ensure that Medicaid, CHIP, and health insurance exchanges work together to create a coordinated, automated process for applying for and renewing health coverage.

- ***State CHIP programs' past and current experiences with designing and operating separate programs are directly relevant to many of the decisions states now face under the Affordable Care Act*** . For example, state CHIP officials have designed benefit packages to meet benchmark standards, designed and conducted marketing campaigns, provided application assistance to families, and coordinated coverage across public programs. As a result of these experiences, CHIP officials in most states have been "at the table" in their state's reform planning and implementation efforts.

It is not yet clear how CHIP will fit into states' post-reform environments. In the near-term, state officials must consider the implications of current CHIP policies (for example, those related to cost-sharing or crowd-out) as the Affordable Care Act is being implemented. In the longer-term, states must decide whether or not to continue operating their CHIP program at all, given the uncertainty of federal funding beyond 2015, expected reductions in program size, the availability of new alternative coverage sources for CHIP-eligible children, and considerations about whether families would be better served by an option that allows children and parents to enroll in the same programs and plans. What state stakeholders are committed to, however, is that the principles that formed the foundation of CHIP—that children should have broad access to comprehensive and high quality pediatric care—are not to be lost as implementation of health care reform progresses.

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APPENDIX A

CASE STUDY METHODS

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OVERVIEW OF THE EVALUATION'S CASE STUDY METHODS

This cross-cutting report is based on findings from site visits to 10 states conducted between February and August of 2012 (see Table A.1). The 10 study states were Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. The Urban Institute conducted six of the case studies, while Mathematica Policy Research conducted the remaining four. Each site visit was composed of interviews with key informants involved in CHIP implementation, as well as three focus groups with parents of children enrolled in CHIP.

Table A.1. CHIP-10 Case Study Schedule

State	Date of Site Visit
Alabama	June 2012
California	March, April 2012
Florida	March 2012
Louisiana	February 2012
Michigan	May 2012
New York	February 2012
Ohio	May 2012
Texas	June 2012
Utah	August 2012
Virginia	June, July 2012

A. Case Study Methods

Informants were recruited with the help of state CHIP administrators, who provided a list of key individuals in the state, and their contact information. Four to six weeks prior to the site visit, staff at the Urban Institute or Mathematica Policy Research contacted all potential informants by email, provided an overview of the CHIPRA Evaluation and requested a one- to two-hour interview. Follow-up calls and emails were made during the following weeks. Written consent was obtained at the beginning of each interview, after informants were given a project description and informed of how their interview would be used in the case study reports.

Protocols were developed during the design phase of the evaluation to ensure the systematic and consistent collection of information across the 10 study states. In total, five protocols were developed and tailored to the five types of respondents interviewed for the evaluation, including: CHIP and Medicaid administrators, high level policymakers and advocates, community level enrollment agencies, health care providers, and managed care plans. The "core" protocol, designed for use with CHIP and Medicaid administrators, focused on the recent history of the state's CHIP program and state policies and program characteristics related to:

- Eligibility, enrollment, and renewal;
- Outreach;
- Benefits;
- Service delivery and access to care;
- Cost sharing;

- Crowd out;
- Financing; and
- State preparations for health care reform.

The content of the protocol for high level policymakers and advocates was very similar to the "core" protocol, but was less detailed, and also inquired about the informant's satisfaction with current CHIP policy. The other three protocols were shorter in design, and more focused on a particular topic depending on the respondent type. For instance, the protocol for managed care organizations included specific questions on the adequacy of the CHIP benefits package and provider network, as well as payment arrangements. Providers were questioned about their payment arrangements with health plans, as well as their personal experiences treating children in CHIP. Finally, interviews with community level enrollment agencies predominantly concentrated on the enrollment and renewal processes, as well as outreach efforts.

Site visits lasted four days, and always began with an interview in the state capital with state CHIP and/or Medicaid administrators and their key staff. After the initial meeting, interviews continued over the next one or two days in the capital with such informants as: Governors' health policy staff, state legislator and/or their staff, state public health officials, providers and/or provider associations, health plan representatives, and advocacy groups. After conducting additional interviews in the capital with local level informants, case study teams would then spend one to two days in a local community where providers, child and family advocates, health plans, local eligibility staff, and staff of community-based organizations involved in outreach were interviewed. During the site visits, research teams conducted between 15 to 20 interviews with between 30-40 informants (see Table A.2)

During the interviews, staff took extensive notes and digitally recorded the proceedings with permission from the informants. At the conclusion of each site visit, interview notes were cleaned and organized in a standard style by the Urban Institute/Mathematica Policy Research team, before being coded using qualitative analytic software (atlas.ti).

B. Focus Group Methods

In addition to key informant interviews, case study teams also conducted three focus groups in each state with four different types of participants, including parents of children who were: enrolled in CHIP; parents of children who were eligible for, but not enrolled in CHIP; parents of children who were enrolled in employer-sponsored insurance; and parents of children disenrolled from CHIP.

Table A.2. CHIP-10 Interview Figures

State	Number of Interviews	Number of Interviewees
Alabama	16	30
California	21	44
Florida	20	31
Louisiana	13	24
Michigan	22	39
New York	13	25
Ohio	15	37
Texas	23	46
Utah	17	30
Virginia	17	29
Totals	177	335

Four moderator's guides were developed for each type of participant. The "core" moderator's guide for parents of children enrolled in CHIP was designed to determine how families found out about CHIP, as well as their experiences with eligibility, enrollment, and renewal processes; access to care; perceptions of the affordability of cost sharing; and adequacy of benefits. The guide concluded with questions focused on parents' familiarity with health care reform and overall satisfaction with CHIP.

The moderator's guide for parents of children with employer-sponsored insurance was structured almost identically to the core guide to create a comparison between the experiences of families in private and public coverage. Focus groups held with parents of children who were eligible for, but not enrolled in CHIP explored potential reasons why parents had not obtained coverage for their children, barriers to enrollment, and how their current insurance status affects access to care and service utilization. Lastly, the moderator's guide for parents of children disenrolled in CHIP was modified from the core guide to discern why coverage was dropped, current insurance status (if any), and their satisfaction with CHIP when their children were enrolled.

As summarized in Table A.3, there were 19 focus groups conducted with parents of children enrolled in CHIP, and three held with each of the other types of respondents. In addition, two of the groups with parents of children enrolled in CHIP included parents with children with special health care needs.

Focus group participants were recruited using a combination of methods. In several states, community-based organizations recruited from among their clients, using recruitment scripts and materials developed by the evaluation team. In the remaining states, staff at the Urban Institute and Mathematica Policy Research directly recruited participants by telephone using contact information provided by the state. To help with focus group recruitment, parents were offered a $50 incentive and light food and refreshments.

Written consent from parents was obtained at the start of each focus group, after the moderator described the evaluation and guaranteed the confidentiality of participants. During focus groups, research staff took extensive notes and digitally recorded the sessions. Notes and

digital transcriptions from the groups were coded by research staff at the Urban Institute and Mathematica Policy Research using qualitative analytic software.

Table A.3. Number of Focus Groups, by Type

States	Enrollee	Disenrollee	Eligible but not Enrolled	Employer-Sponsored Insurance	Children with Special Health Care Needs
Alabama	2	1			
California	2				1 (with some CSHCN)
Florida	1		1		1
Louisiana	3				
Michigan	1	1		1	
New York	2	1			
Ohio	2		1		
Texas	2			1	
Utah	2			1 (premium assistance)	
Virginia	2		1		
Totals	19	3	3	3	2

C. Reports

After each site visit, teams at the Urban Institute and Mathematica Policy Research developed individual state case study reports based on the information gathered from key informants during the site visit. Focus group findings, as well as material gathered from outside sources, including previous CHIP evaluations and current policy briefs, served as supplemental information in the reports. Each report followed a standard structure that was prospectively outlined to closely follow the interview protocols and address the key findings in each state. After internal review, the reports were shared with both state officials and ASPE before being finalized.

At the conclusion of the case study effort, this final cross-cutting report was developed, led by the Urban Institute with support from Mathematica Policy Research. After an initial cross-cutting outline was developed, individuals from the Urban Institute created more specific outlines for each section of the report. Several meetings were held between the two organizations to review each outline, discuss cross-cutting findings, and develop the tables and graphs used in the final cross-cutting report. The report underwent internal review by both the Urban Institute and Mathematica Policy Research before being sent to ASPE for further review and approval.

APPENDIX B

SELECT QUALITY MEASURES, AS REPORTED BY STUDY STATES, FY 2010

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Figure B.1. Percentage of CHIP and Medicaid Children with Six or More Well-Child Visits in the First 15 Months of Life, FFYs 2006 and 2010

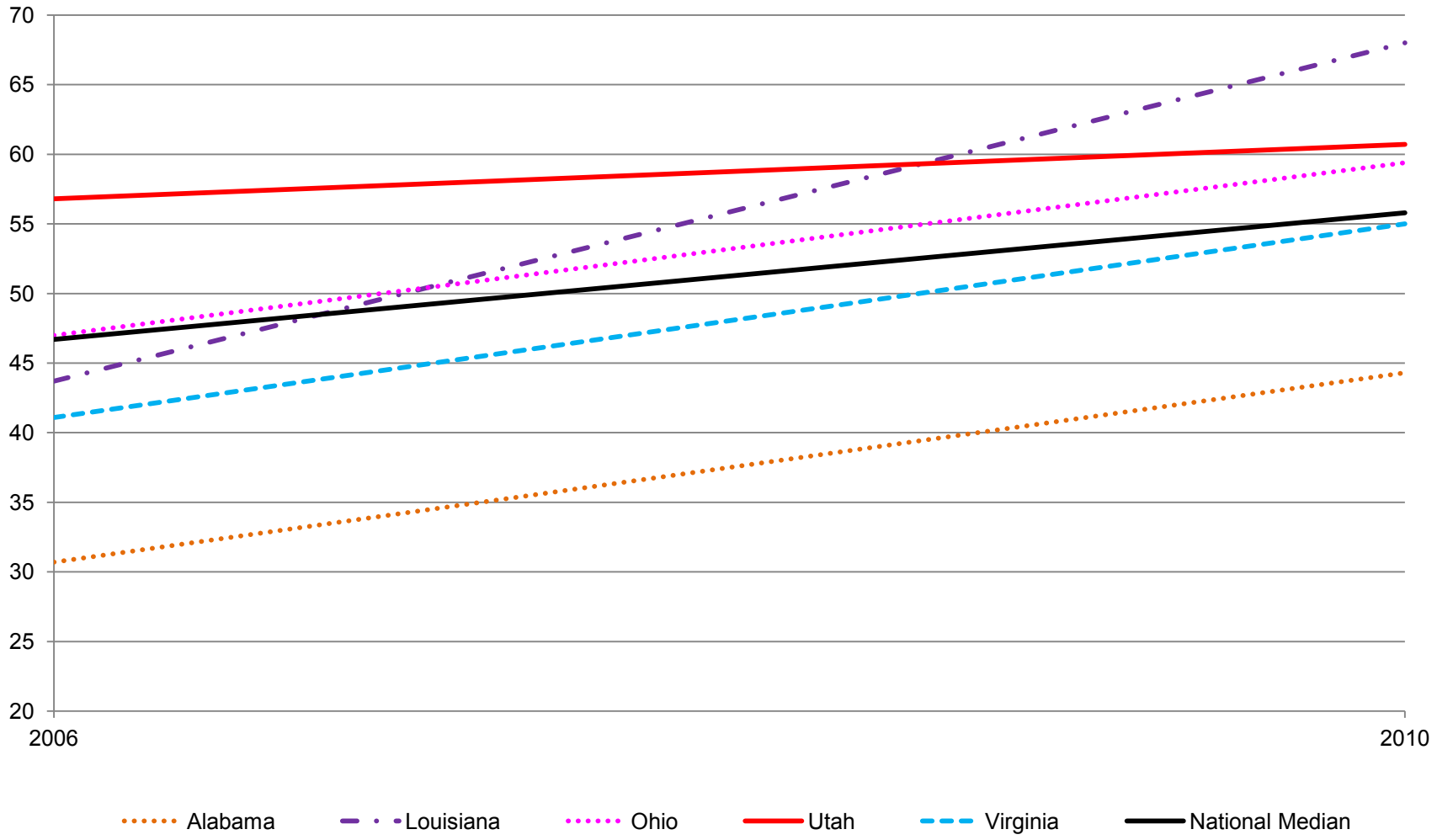
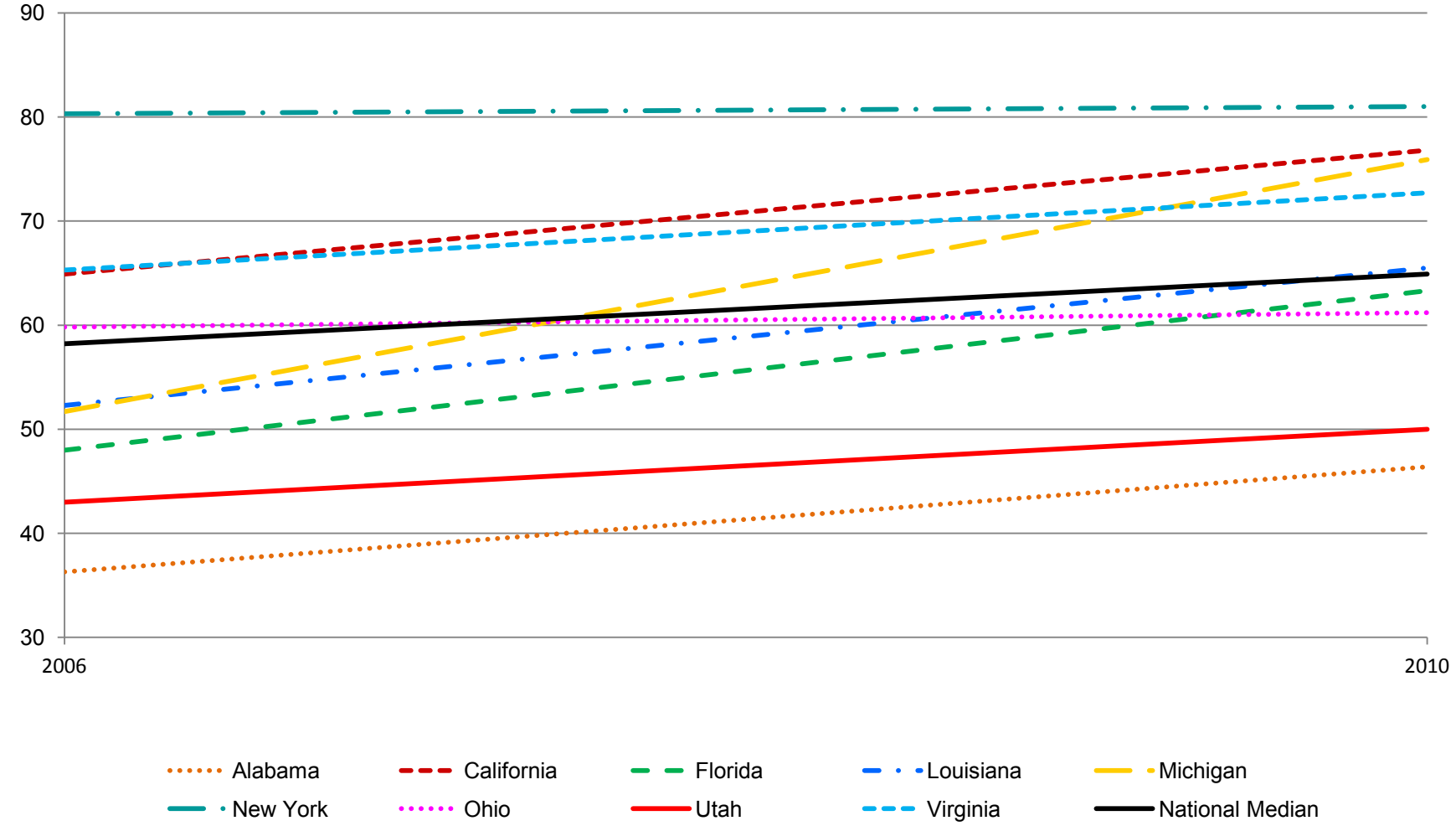


Figure B.2. Percentage of CHIP and Medicaid Children with One or More Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, FFYS 2006 and 2010



Sources: FFYs 2006 and 2010 CARTS Reports; Sebelius, 2011.

Notes: For comparison purposes, only states that reported this measure for both years are included in these graphs.

APPENDIX C

FEDERAL AND STATE CHIP FINANCING, 2006-2010

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Table C.1. Federal and State CHIP Financing, 2006-2010

State	Fiscal Year	Federal Expenditure (in Millions)	State Expenditure (in Millions)	Total Expenditure (in Millions)	Federal Allotment (in Millions)	Percent of Federal Allotment Spent	Federal Matching Rate	Unduplicated Enrollment	Total Expenditure per Child
Alabama	2006	$87	$24	$111	$64	136%	79%	84,257	$1,319
	2007	$95	$27	$122	$74	128%	78%	106,691	$1,142
	2008	$109	$32	$141	$72	151%	77%	110,821	$1,270
	2009	$116	$34	$150	$140	83%	78%	110,158	$1,361
	2010	$128	$37	$166	$147	87%	78%	137,545	$1,203
California	2006	$1,151	$620	$1,771	$647	178%	65%	1,391,405	$1,273
	2007	$981	$558	$1,538	$791	124%	65%	1,538,416	$1,000
	2008	$1,259	$707	$1,967	$789	160%	65%	1,692,087	$1,162
	2009	$1,147	$621	$1,767	$1,553	74%	65%	1,748,135	$1,011
	2010	$1,187	$639	$1,826	$1,629	73%	65%	1,731,605	$1,054
Florida	2006	$214	$87	$301	$249	86%	71%	303,595	$990
	2007	$262	$106	$368	$296	88%	71%	323,529	$1,137
	2008	$272	$118	$390	$302	90%	70%	354,385	$1,101
	2009	$286	$130	$416	$356	80%	69%	417,414	$997
	2010	$309	$142	$450	$373	83%	69%	403,349	$1,117
Louisiana	2006	$97	$26	$122	$77	125%	79%	142,389	$860
	2007	$120	$32	$152	$90	134%	79%	154,286	$986
	2008	$159	$38	$197	$84	189%	81%	164,998	$1,195
	2009	$190	$48	$237	$207	92%	80%	170,082	$1,396
	2010	$176	$52	$227	$229	77%	77%	157,012	$1,447
Michigan[a]	2006	$56	$ 23	$79	$117	47%	70%	66,440	$1,188
	2007	$44	$18	$62	$149	29%	70%	67,239	$ 919
	2008	$41	$18	$58	$147	28%	71%	66,737	$875
	2009	$41	$18	$59	$221	19%	72%	69,845	$845
	2010	$52	$ 18	$69	$232	22%	74%	63,925	$1,084
New York	2006	$329	$177	$505	$273	121%	65%	688,362	$734
	2007	$324	$175	$499	$341	95%	65%	651,853	$766
	2008	$327	$176	$503	$329	99%	65%	517,256	$972

Table C.1 *(Continued)*

State	Fiscal Year	Federal Expenditure (in Millions)	State Expenditure (in Millions)	Total Expenditure (in Millions)	Federal Allotment (in Millions)	Percent of Federal Allotment Spent	Federal Matching Rate	Unduplicated Enrollment	Total Expenditure per Child
	2009	$345	$186	$531	$434	80%	65%	532,635	$997
	2010	$499	$269	$768	$454	110%	65%	539,614	$1,424
Ohio	2006	$170	$66	$236	$125	136%	72%	221,643	$1,065
	2007	$187	$74	$261	$158	118%	72%	231,538	$1,125
	2008	$228	$86	$314	$158	144%	73%	251,278	$1,248
	2009	$252	$91	$343	$285	88%	74%	265,680	$1,291
	2010	$264	$91	$355	$299	88%	74%	253,711	$1,399
Texas[b]	2006	$269	$102	$372	$455	59%	73%	515,559	$721
	2007	$386	$146	$532	$558	69%	73%	623,705	$852
	2008	$698	$266	$964	$556	126%	72%	731,916	$1,317
	2009	$702	$279	$981	$867	81%	71%	869,867	$1,128
	2010	$776	$315	$1,092	$925	84%	71%	928,483	$1,176
Utah	2006	$45	$12	$57	$32	141%	80%	51,967	$1,095
	2007	$39	$10	$49	$41	96%	79%	44,785	$1,097
	2008	$50	$13	$63	$41	122%	80%	51,092	$1,227
	2009	$56	$14	$ 70	$65	85%	80%	59,806	$1,170
	2010	$60	$15	$74	$70	85%	80%	62,071	$1,195
Virginia	2006	$96	$52	$148	$72	133%	65%	137,182	$1,075
	2007	$111	$60	$170	$94	118%	65%	144,163	$1,182
	2008	$131	$71	$202	$90	145%	65%	155,289	$1,300
	2009	$148	$80	$228	$176	84%	65%	167,589	$1,362
	2010	$165	$89	$255	$185	90%	65%	173,515	$1,467
Total 10 Study States	2006	$2,513	$1,188	$3,701	$2,111	119%	N/A	3,602,799	$1,027
	2007	$2,548	$1,205	$3,753	$2,592	98%	N/A	3,886,205	$966
	2008	$3,274	$1,524	$4,798	$2,569	128%	N/A	4,095,859	$1,171
	2009	$3,284	$1,500	$4,784	$4,305	76%	N/A	4,411,211	$1,084
	2010	$3,616	$1,666	$5,282	$4,542	80%	N/A	4,450,830	$1,187

Table C.1 *(Continued)*

State	Fiscal Year	Federal Expenditure (in Millions)	State Expenditure (in Millions)	Total Expenditure (in Millions)	Federal Allotment (in Millions)	Percent of Federal Allotment Spent	Federal Matching Rate	Unduplicated Enrollment	Total Expenditure per Child
Total US, All States[c]	2006	$5,453	$2,430	$7,882	$4,040	135%	N/A	6,755,199	$1,167
	2007	$6,037	$2,659	$8,696	$4,988	121%	N/A	7,105,986	$1,224
	2008	$7,007	$3,038	$10,044	$4,988	141%	N/A	7,355,746	$1,365
	2009	$7,482	$3,146	$10,628	$9,373	80%	N/A	7,695,264	$1,381
	2010	$7,918	$3,365	$ 11,283	$10,476	76%	N/A	7,705,723	$1,464

Sources: Federal Expenditures and Total Expenditures 2006-2009: Kaiser "Total CHIP Expenditures"; Federal Expenditures and Total Expenditures 2010: Rowland, 2011; State Expenditures calculated from subtracting federal expenditures from total expenditures; Federal allotment 2005-2008: Georgetown "Original SCHIP Allotment"; Federal allotment 2009-2010: Georgetown "FY2009-FY2012 CHIP Allotment"; Percent Federal Allotment Spent calculated from dividing federal expenditures by federal allotment; Federal matching rate: Kaiser "Enhanced Federal Medical Assistance Percentage"; Unduplicated enrollment: CMS CHIP Statistical Enrollment Data System (SEDS); Total expenditures per child calculated from dividing total expenditures by unduplicated enrollment.

[a] In Michigan, financing and enrollment data from the State were determined to be more accurate estimates than publicly available data. Data was provided from personal communication with B. Keisling, DCH, November 29, 2012.

[b] The CHIP numbers for Texas include their Perinatal program for the year 2007 and beyond. Data was provided by Texas' Health and Human Service Commission Financial Services, November 5, 2012.

[c] Total US, All States numbers cite the original source data and do not include revisions to Michigan and Texas expenditures and enrollment numbers.

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