August 2011

GAINS FOR CHILDREN:

Increased Participation in Medicaid and CHIP in 2009

Genevieve M. Kenney, Victoria Lynch, Jennifer Haley, Michael Huntress, Dean Resnick and Christine Coyer

Robert Wood Johnson Foundation

Urban Institute

I. INTRODUCTION

The expansion of Medicaid coverage to individuals with incomes below 138 percent of the federal poverty level (FPL) is a key component of the Affordable Care Act (ACA). Under full implementation of the ACA, Medicaid enrollment is projected to increase by 39 percent overall.[1] However, even with that increase in Medicaid enrollment, an estimated 38 percent of the uninsured under the ACA would be eligible for Medicaid or the Children's Health Insurance Program (CHIP), but not expected to enroll.[2] Given how many uninsured have incomes below 138 percent of the FPL, success in improving coverage will depend critically on achieving high participation in Medicaid.[3]

Current patterns of participation in Medicaid/CHIP among children could provide insights to help guide state and federal action under the ACA. Dating back to the inception of CHIP in 1997 and continuing with the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, there has been considerable policy focus on increasing coverage in Medicaid/CHIP among eligible children.[4] This brief updates an earlier analysis that assessed how well Medicaid/CHIP programs were performing at enrolling eligible children by examining patterns in 2009 and monitoring change relative to 2008; in 2008, Medicaid/CHIP participation rates were over 80 percent nationally, but with notable variation across states.[5,6] The analysis uses the American Community Survey (ACS), which includes a public use sample of approximately 700,000 children each year and which began including a question on health insurance coverage in 2008. The following section describes the data source and methods underlying the analysis; subsequent sections present the results and discuss the policy implications of the findings.

II. DATA AND METHODS

Data Source. These estimates are derived from the 2008 and 2009 ACS, an annual survey fielded continuously over a 12-month period by the United States Census Bureau.[7] We use an augmented version of the ACS prepared by the University of Minnesota Population Center – the Integrated Public Use Microdata Series (IPUMS).[8] In 2008, the ACS had a reported response rate of 97.9 percent, ranging from 91.4 in Washington, DC to 99.4 in Wisconsin.[9] The ACS uses an area frame that includes households with and without telephones (landline or cellular). It is a mixed-mode survey that starts with a mail-back questionnaire (56.6 percent of the sample is completed by mail); non-responders are followed-up by telephone and a sub-sample of remaining non-responders are interviewed in person.[10] The estimates presented here focus on children age 18 and under in the civilian non-institutionalized population, which includes children living in private residences as well as college students living in dorms and other children living in group quarters such as outpatient treatment facilities.

In 2008, a question was added to the ACS to ask the respondent about coverage of each individual in the household by any of the following types of health insurance or health coverage plans at the time of the survey:

a. Insurance through a current or former employer or union
    (of this person or another family member)

b. Insurance purchased directly from an insurance company
    (by this person or another family member)

c. Medicare, for people 65 and older, or people with certain disabilities

d. Medicaid, Medical Assistance or any kind of government-assistance
    plan for those with low incomes or a disability

e. TRICARE or other military health care

f. VA [Department of Veterans Affairs] (including those who have ever
    used or enrolled for VA health care)

g. Indian Health Service

h. Any other type of health insurance or health coverage plan – specify

We classify children as uninsured if they do not have coverage under categories a through f (including those recoded from the write-in option, category h) and they are not classified as having coverage based on other information collected on the survey.[11,12,13] Since the data are collected continuously over a 12-month period, the coverage estimates represent an average day in the calendar year.

Research suggests that the ACS may understate Medicaid and CHIP coverage for children.[14] In addition to the known underreporting of public coverage on household surveys, the ACS, unlike other national, federally-funded surveys such as the Current Population Survey (CPS) and the National Health Interview Survey (NHIS), does not specifically mention CHIP, provide respondents with the state-specific names for the Medicaid and CHIP programs in their state or indicate that nongroup coverage is independent of former and current employers. In addition, relative to other surveys, the ACS overstates nongroup coverage.[15]

Data Adjustments. To address the underreporting of Medicaid and CHIP on the ACS, we make adjustments to the microdata, drawing on findings with respect to the covariates of measurement error in the reporting of coverage and approaches that have been applied to other surveys.[16,17] We apply refinements to the set of logical edit rules that the Census Bureau began applying to the ACS in 2010, as well as additional edits that take advantage of other coverage-related information collected in the ACS. The edit rules used to adjust the data are based on eligibility rules and enrollment procedures for Medicaid and CHIP, and evidence of misreported nongroup coverage and other types of coverage, along with other information suggesting that the survey's Medicaid/CHIP enrollment indicator may not be accurate.[18] Our derived estimates of the number of uninsured children are 7.2

million in 2008 and 6.6 million in 2009, both of which are slightly lower than the NHIS uninsured estimates of 7.4 and 6.7 million for 2008 and 2009 (Urban Institute tabulations of 2008 and 2009 NHIS), respectively.[19,20,21]

We make no further adjustments to the ACS coverage indicators beyond the edits described above, even though the resulting Medicaid/CHIP coverage estimates are slightly below the administrative counts, because we believe that the administrative counts could overstate the number of children enrolled in Medicaid/CHIP coverage on a given day.[22,23,24,25] Available administrative data suggest that 25.9 and 28.3 million children were enrolled in full benefit Medicaid/CHIP coverage and not also enrolled in private coverage as of June 2008 and June 2009, respectively.[26] Our edits increase the estimated number of children with Medicaid/CHIP as their primary coverage relative to the levels released by Census by roughly 2.8 million in both 2008 and 2009 to a level that, in 2008, is about 1.4 percent lower than the comparable administrative count for June 2008 and, in 2009, is about 0.7 percent lower than the comparable administrative count for June 2009.[27]

Eligibility Simulation. This analysis relies on the Urban Institute Health Policy Center's ACS Medicaid/ CHIP Eligibility Simulation Model, which builds on the model developed for the CPS by Dubay and Cook.[28] The model simulates eligibility for Medicaid and CHIP using available information on eligibility guidelines, including the amount and extent of income disregards, for each program and state in place as of approximately June 2008 and 2009.[29,30,31,32,33,34] Between mid-2008 and mid-2009, six states[35] expanded their income thresholds under CHIP.

In addition to estimating the number of eligible children and their rates of participation in each year, we assess changes in these indicators from 2008 to 2009. Furthermore, by applying the 2008 Medicaid/CHIP eligibility rules to the 2009 ACS, we calculate the relative contributions of (a) changes in the income distribution due to the economic downturn and (b) Medicaid/CHIP eligibility expansions to changes in the number of eligible children. When we apply the 2008 eligibility rules to the 2009 ACS, we attribute increases in the number of eligible children to the economic downturn and attribute the remaining increase in the number of eligible children to the expansions in Medicaid/CHIP programs.

Family-level characteristics used in determining eligibility, such as income, are based on the family grouping (i.e., the child's health insurance unit (HIU)) that states define during the eligibility determination process. For non-citizen children, the model also takes into account length of residency in the United States in states where this is a factor in eligibility; 17 states covered documented immigrant children with less than five-years U.S. residency in both 2008 and 2009.[36] Because the ACS does not contain sufficient information to determine whether an individual is an authorized immigrant and therefore potentially eligible for Medicaid/CHIP coverage, we impute documentation status for non-citizens based on a model developed using CPS data.[37,38]

According to our ACS estimates, 10.4 percent (2.7 million) of all children in 2008 and 8.6 percent (2.4 million) of all children in 2009 who are enrolled in Medicaid/CHIP do not appear to meet

eligibility requirements for this coverage.[39] It is likely that the presence of Medicaid/CHIP coverage among children for whom we cannot establish an eligibility pathway is due in part to the lack of monthly household and income information on the ACS. Without this information, it is not possible to determine changes in eligibility status over the course of the year, which introduces measurement error in the population we identify as Medicaid/CHIP eligible. Additional measurement error in estimates of Medicaid and CHIP eligibility may result from misreporting of income or other information used in determining eligibility, our adjustment for immigration status, lack of specificity of state-level eligibility requirements or imprecision in the editing of reported coverage by the Census Bureau or the Urban Institute.

Despite the differences between the ACS and the CPS, model results from the two surveys produce comparable results for the same time frame, suggesting that the ACS eligibility simulation is robust compared to that developed and evaluated over many years for the CPS.[40,41] The numbers and characteristics of children according to their eligibility for Medicaid/CHIP and their eligibility pathway (i.e., Medicaid vs. CHIP, etc.) are also quite similar in 2008 for the two surveys (data not shown).

The 2008 estimates contained in this report were derived using a slightly different methodology than was applied in our prior analysis of the 2008 data.[42] In particular, because the 2009 Census Bureau ACS release contained coverage edits whereas the original 2008 ACS release did not, we modified procedures for 2008 so that the edit rules would be identical in both years. In addition, in some cases, we used different income disregards or other rules in our eligibility model, based on new information that became available since our initial analysis. We also refined our methods for grouping family members into the units that are used to measure income, family need and other factors states use to determine eligibility for Medicaid and CHIP. In addition, we applied a new approach to identify likely undocumented immigrants; we continued to use CPS estimates as the basis for the imputation, but we refined the CPS model. We are now using external control totals of unauthorized immigrants nationally and in a subset of large states (California, Florida, Illinois, New Jersey, New York and Texas) in the model and, with few exceptions, these new estimates classify almost none of the non-citizen children with Medicaid/CHIP coverage as being undocumented. The combined effect of these methodological changes resulted in only very small impacts on our national participation and eligible but uninsured estimates.[43] In addition, there was very little change in the relative participation rates among states (just six states changed quintile group and were reclassified in an adjacent quintile).[44] The one subgroup for which the estimates were affected by the changes in the underlying methodology were those for non-citizen children, where our new estimates show higher participation rates (76.0 percent vs. 69.1 percent). For all other groups, the difference in participation rates between the original and revised estimates was no more than two percentage points.

We define participation rates as the ratio of Medicaid/CHIP eligible enrolled children to Medicaid/CHIP eligible enrolled children plus Medicaid/CHIP eligible uninsured children. We exclude from

these counts children with both Medicaid/CHIP and employer/union-based or military coverage and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Estimates are presented nationally and by Census region and division, age, presence of English-speaking parents, family income, race/ethnicity and citizenship status.

Statistical Analyses. All the estimates use weights provided by the Census Bureau. Standard errors are calculated using replicate weights that take into account the complex nature of the sample design.

III. RESULTS

Nationally, the number of children eligible for Medicaid/CHIP increased by an estimated 2.5 million between 2008 and 2009, from 40.2 million to 42.7 million (Exhibit 1). This increase was due to a combination of the downward shift in the income distribution and the expansion of Medicaid/CHIP programs in a number of states.[45] An estimated 50.5 percent was due to the eligibility expansions and 49.5 percent was due to the economy, although this mix varied across states. For example, almost all (98.9 percent) of the increased number of eligible children in New York was due to an eligibility expansion, while the reverse was true in states like Texas, California and Florida (data not shown).

Despite the increased number of eligible children, participation in Medicaid/CHIP rose among children between 2008 and 2009, increasing from 82.1 to 84.8 percent (Exhibit 2). Children who were made newly eligible due to expansions in coverage between 2008 and 2009 had a participation rate of 76.5 percent in 2009, while children who met the eligibility rules in place in 2008 had a participation rate of 84.9 percent in 2009 (data not shown).

Medicaid/CHIP participation rose in each of the four census regions, increasing by 1.7, 1.6, 2.8 and 4.0 percentage points for states in the Northeast, Midwest, South and West regions, respectively. Additionally, the increases in participation were statistically significant in every census division with the exception of the West North Central division (Exhibit 3).

There were statistically significant increases in Medicaid/CHIP participation rates in 30 states, ranging from 11.4 percentage points in Colorado to 1.2 percentage points in New York; no state had a statistically significant decline in their Medicaid/CHIP participation rate for children between 2008 and 2009 (Exhibit 4). States with participation rates in 2008 that were at or above 90 percent had smaller absolute increases in participation, while states with the very lowest participation rates in 2008 tended to have larger absolute increases in participation (Exhibit 5). For example, Colorado, Idaho, Montana and Utah – all in the group of states with the lowest participation rates in 2008 – had increases in Medicaid/CHIP participation that were above 8 percentage points. While there were statistically significant increases in participation for states in each quartile grouping of states with respect to participation in 2008, the increase was 4.6 percentage points for states in the bottom quartile compared to 1.6 percentage points for states in the top quartile (data not shown). Thus, the cross-state variation in Medicaid/CHIP participation narrowed for children between 2008 and 2009.

Medicaid/CHIP participation rates also increased for children of different ages, language groups, income levels and races/ethnicities (Exhibit 6).[46] Non-citizen children were the only group shown in Exhibit 6 that did not experience a statistically significant increase in Medicaid/CHIP participation; the participation rate among non-citizen children was 76.3 percent in 2009, well below the national average.

The net effect of the increased number of eligible children and the increased participation rate was to reduce the number of eligible but uninsured children by about 340,000, to an estimated 4.3 million, and to reduce the uninsured rate among eligible children, from 11.7 to 10.2 percent (Exhibit 7). Although the uninsured rate among children ineligible for Medicaid/CHIP was fairly stable (6.6 percent in 2008 and 6.3 percent in 2009), the decline in uninsurance among Medicaid/CHIP-eligible children contributed to an overall decline in the uninsured rate among all children, from 9.2 percent to 8.4 percent (data not shown).

Thus, in 2009, roughly two-thirds of the total 6.6 million uninsured children in the U.S. were eligible for Medicaid/CHIP. Of those 4.3 million uninsured children eligible for Medicaid/CHIP in 2009, 2.8 million (41.6 percent of the total uninsured or about two-thirds of the eligible uninsured) had incomes below 133 percent of the FPL, and 1.6 million (23.8 percent of the total uninsured or about one-third of the eligible uninsured) had incomes above 133 percent of the FPL (Exhibit 8). Thus, a majority of eligible uninsured children are in families targeted by the Medicaid expansions in the ACA (the ACA uses an income threshold of 133 percent, but a standard 5 percent disregard will also apply, bringing the effective threshold to 138 percent). An additional 2.3 million children (about a third of all uninsured children) were not eligible for Medicaid/CHIP either because their family incomes were too high to qualify for coverage or because of their immigration status.

Three large states account for 39.9 percent of the 4.3 million eligible but uninsured children in the nation: 15.9 percent live in Texas, 15.2 percent live in California and 8.8 percent live in Florida (Exhibit 9). Altogether, 62.1 percent of the nation's uninsured children who are eligible for Medicaid or CHIP live in one of 10 states (Texas, California, Florida, Georgia, New York, Ohio, Arizona, Illinois, Pennsylvania and Indiana). Among these 10 large states, Arizona, California, Florida, Georgia, Indiana and Texas have participation rates that are below the national average; Florida and Texas were both in the lowest quintile in terms of state-level participation, with participation rates of 77.0 and 77.1 percent respectively.

In 2009, 16 states (Arkansas, Connecticut, Delaware, DC, Hawaii, Illinois, Kentucky, Maine, Massachusetts, Michigan, Nebraska, New York, Rhode Island, Tennessee, Vermont and West Virginia) had Medicaid/CHIP participation rates of 90.0 percent or higher.[47] In contrast, six states (Florida, Montana, Nevada, North Dakota, Texas and Utah) had participation rates below 80.0 percent. Nevada, with a participation rate of 62.9 percent, remained substantially below the other states in terms of its Medicaid/CHIP participation rate; the next lowest participation rates were found in North Dakota and Utah, at 74.5 percent and 76.1 percent, respectively (Exhibit 10).

The number of eligible uninsured children could be reduced considerably if states with low participation rates could reach the participation levels of higher-ranking states. Of the 4.3 million eligible uninsured children in 2009, only 3.7 million would remain uninsured if every state with a participation rate below the mean increased to the mean (84.8 percent). If every state increased to 90 percent participation, just 2.8 million eligible uninsured children would remain; and if every state reached 95 percent participation, the number of eligible uninsured children would be only 1.4 million (Exhibit 11).

IV. CONCLUSIONS

The key findings from this analysis are that:

- The share of children without health insurance coverage fell between 2008 and 2009, despite the ongoing economic downturn;

- Nationally, the rate of Medicaid/CHIP participation among children rose by 2.7 percentage points to 84.8 percent and cross-state variation in Medicaid/CHIP participation rates narrowed, as larger improvements occurred on average for states that had the lowest participation rates in 2008;

- Increases in Medicaid/CHIP participation rates occurred in 30 states, with 16 states (Arkansas, Connecticut, Delaware, DC, Hawaii, Illinois, Kentucky, Maine, Massachusetts, Michigan, Nebraska, New York, Rhode Island, Tennessee, Vermont and West Virginia) having participation rates of 90.0 percent or higher in 2009, and six states (DC, Hawaii, Maine, Massachusetts, Michigan and Vermont) having participation at or above 90.0 percent in both years;

- Six states (Florida, Montana, Nevada, North Dakota, Texas and Utah) had participation rates below 80.0 percent, with the lowest rate found in Nevada in both 2008 and 2009 at 57.0 and 62.9 percent, respectively;

- Participation gains occurred between 2008 and 2009 for children in each race/ethnicity, language, income and age group examined;

- The increase in Medicaid/CHIP participation was associated with a decline in the number of children eligible for Medicaid/CHIP but uninsured of about 340,000;

- Just three states (California, Florida and Texas) account for 39.9 percent of the eligible but uninsured children and all three have participation rates that fall below the national average;

- If participation rates nationally could reach at least 95 percent in every state, the number of eligible uninsured children would be reduced by almost 3 million, to just 1.4 million.

At nearly 85 percent, the Medicaid/CHIP participation rate that was found among children in 2009 is very high in absolute terms and relative to participation rates found in other means-tested programs.[48] In fact, CPS data show that in 2008 the percentage and number of children without health insurance were at their lowest levels since 1987.[49] The high Medicaid/CHIP participation rate for children is likely a consequence of the considerable federal and state policy efforts devoted to increasing and maintaining participation in Medicaid/CHIP among children over the past two decades.

Moreover, the passage of CHIPRA in early 2009 gave states new policy options and resources to increase Medicaid/CHIP participation for children. CHIPRA included outreach and enrollment grants, new enrollment options and bonus payments to states that adopt five of eight enrollment and retention strategies and that have Medicaid enrollment increases that exceed target levels. More than half of states introduced enrollment or retention simplifications or other improvements in Medicaid or CHIP coverage for children since CHIPRA was enacted.[50] In 2010, 15 states qualified for bonus payments, up from 10 in 2009.[51] While it is not possible to attribute the improvements in Medicaid/CHIP participation found here to CHIPRA, it is likely that it was a contributing factor, since not only did it stimulate policy changes aimed at increasing participation, it also served to raise the profile of the issue at federal, state and local levels.[52] More work is needed to understand the underlying reasons for the patterns of cross-state variation in Medicaid/CHIP participation rates that are observed and for the patterns of changes found between 2008 and 2009 in participation rates across states and subgroups of children.

The broad-based increases in Medicaid/CHIP participation in 2009 and the associated decreases in uninsured rates among eligible children suggest that states have not hit a ceiling in terms of Medicaid/CHIP participation among children. To achieve further improvements, the key will be to raise enrollment among the states that have low participation rates by national standards, particularly among the states that have a large share of the nation's eligible but uninsured children.

The prospects for achieving progress in the three largest states (California, Florida and Texas) or the seven other large states (Arizona, Georgia, Illinois, Indiana, New York, Ohio and Pennsylvania) that altogether account for 62.1 percent of the total eligible but uninsured children in this country are not clear. Only Illinois qualified for bonus payments[53] in 2009 and only California, Florida, New York and Ohio introduced enrollment or retention simplifications since CHIPRA was passed.[54,55] Variation in participation across states is likely a function of many factors, such as the subpopulations eligible for their programs, the expansiveness of their eligibility rules for both children and parents and the characteristics of their state's population. Nevertheless, a number of policy steps, such as continuous eligibility, express lane eligibility and streamlined renewal processes, could be undertaken that have been found to increase enrollment and retention in Medicaid and CHIP. [56] For example, Florida and Texas do not have 12-month continuous eligibility for all children in their programs and California and Texas require paper documentation of income.[57] Moreover, both California and Arizona have proposed limiting CHIP coverage in response to budget issues in the past two years which could have a chilling effect on enrollment in Medicaid and CHIP; in the case of California, CHIP enrollment

was frozen between July and September of 2009, while in Arizona, an enrollment freeze among children was instituted in January 2010 for CHIP, which is still in effect.[58]

At present, no state can introduce a cap or freeze on CHIP or Medicaid enrollment or erect barriers to enrollment or retention for children due to the Maintenance of Effort (MOE) requirement under the ACA. However, congressional proposals to remove the MOE could lead to more restrictive policies, particularly in light of the reduction in federal matching rates for Medicaid that was effective July 1, 2011.

Whether states will be able and willing to maintain or further raise Medicaid/CHIP participation levels for children in the midst of ongoing state budget shortfalls is not known. However, to the extent that all states could raise their participation rates to 90 percent, the number of uninsured children would decrease by over a million and a half. Administrative data suggest that Medicaid/CHIP enrollment continued to rise for children between 2009 and 2010,[59] which may or may not translate into another increase in Medicaid/CHIP participation at least in 2010, depending on how private coverage and the number of eligible children changed. In addition, a number of states have expanded eligibility since mid-2009; in fact, three states (Colorado, Kansas and Oklahoma) expanded income eligibility for children in 2010.[60] However, the recent decrease in federal matching rates, which had been temporarily increased as part of the American Recovery and Reinvestment Act of 2009 to help states cope with the economic downturn and resulting increased Medicaid enrollment, may make states less willing to aggressively seek to enroll and retain eligible children in Medicaid and CHIP.

Preliminary analysis of the ACS suggests that Medicaid/CHIP participation rates for adults fell short of those for children in 2009 (data not shown). An important question for the future is the extent to which states will be able to achieve comparable Medicaid participation rates for adults under the ACA as they have for children, which will be critical to reducing overall uninsurance. The ACA includes a Medicaid expansion to 133 percent of the FPL, which targets coverage gaps among poor and near-poor adults. Currently, federal funds are slated to cover all of the costs associated with enrolling these newly eligible adults in Medicaid through 2019, which could stimulate greater efforts to enroll this population, particularly as the Medicaid expansion should allow states to cut back on state-funded programs that have historically supported health services for them.[61] Given that Medicaid programs for adults do not include as many enrollment and renewal simplifications, by transferring and adapting the strategies that have worked for children to adult enrollment procedures, states may be able to achieve higher rates of Medicaid participation for adults as well.[62]

Finally, while this paper has focused attention on the question of how successfully Medicaid and CHIP programs are reaching their target populations of children, also important is the care that is available to children once they enroll, both in terms of its access and quality. Currently, no consistent, timely or comprehensive information is available to monitor access to care for children in Medicaid and CHIP at the state level.[63] While there are a number of efforts underway that could address some of these gaps,[64,65,66] additional efforts will certainly be needed to provide the information required to guide effective policy change and support improved health outcomes for children.
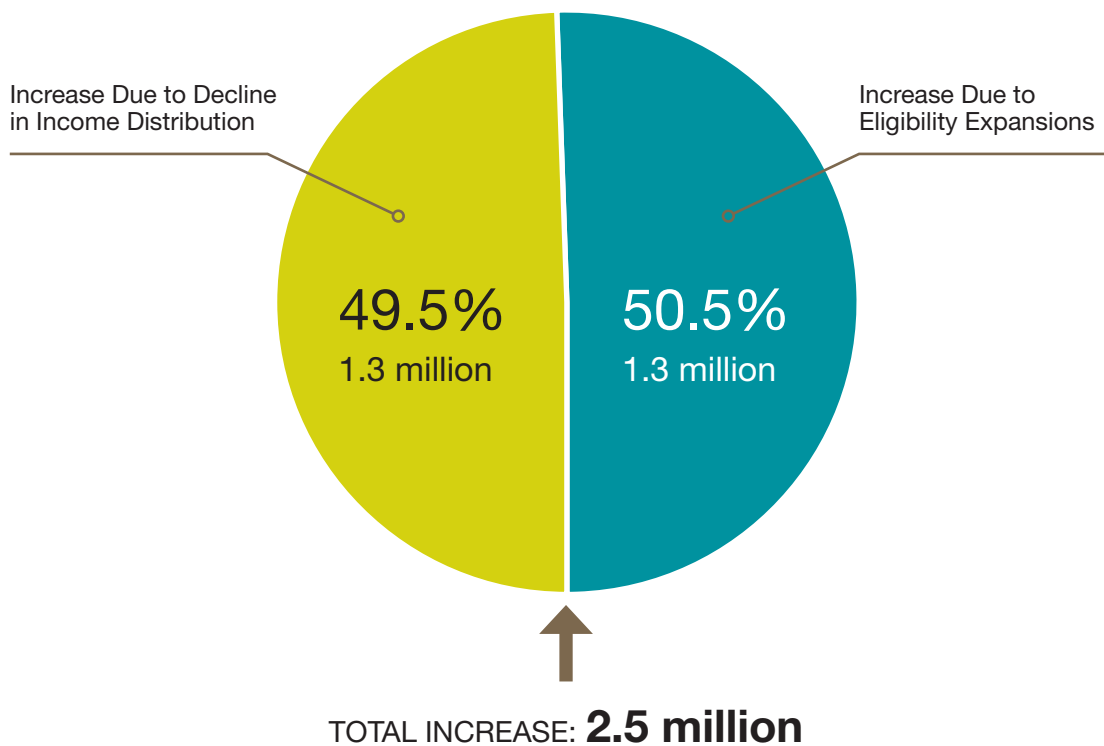
(Endnotes)

[1] Holahan, J. and I. Headen. 2010. "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL." Washington, DC: Kaiser Family Foundation.

[2] Buettgens, M., B. Garrett, and J. Holahan. 2010. "America Under the Affordable Care Act." Washington, DC: The Urban Institute.

[3] The Kaiser Commission on Medicaid and the Uninsured. 2010. "The Uninsured: A Primer." Washington, DC: The Kaiser Family Foundation.

[4] Sebelius, K. 2010. "Rising to the Challenge: Tools for Enrolling Eligible Children in Health Coverage." *Health Affairs,* 29(10): 1930-1932.

[5] Estimates from an earlier analysis of the 2008 ACS indicated that six states (DC, HI, MA, ME, MI and VT) had participation rates over 90 percent and 13 states (AK, AZ, CO, FL, ID, MT, ND, NV, OR, SC, TX, UT and WY) had participation rates below 80 percent. Kenney G., V. Lynch, A. Cook and, S. Phong. 2010. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" *Health Affairs*, 29(10):1920-1929.

[6] Kenney, G., V. Lynch, A. Cook, and S. Phong. 2010. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" *Health Affairs*, 29(10): 1920-1929.

[7] U.S. Census Bureau. "American Community Survey." http://www.census.gov/acs/www/.

[8] Ruggles S., T.J. Alexander, K. Genadek, R. Goeken, M. Schroeder, and M. Sobek. 2010. "Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]." Minneapolis, MN: University of Minnesota.

[9] U.S. Census Bureau. "American Community Survey: Accuracy of the Data (2009)." http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/ACS_Accuracy_of_Data_2009.pdf.

[10] Griffin, D. and T. Hughes. "Mixed mode data collection in the American Community Survey." American Association of Public Opinion Research Conference Proceedings: 2010 May 13-16; Chicago, IL.

[11] Turner, J., M. Boudreaux, and V. Lynch. 2009. "A preliminary evaluation of health insurance coverage in the 2008 American Community Survey." Suitland, MD: U.S. Census Bureau, Housing and Household Economic Statistics Division.

[12] The Indian Health Service (IHS) is not typically counted as health insurance coverage because of limitations in the scope of available services and geographic reach of IHS facilities. In 2008, approximately 141,000 children were estimated to have IHS and no insurance coverage. In 2009, approximately 134,000 children were estimated to have IHS and no insurance coverage. For most states in 2009, the participation rates do not change in a meaningful way when IHS was considered a source of health insurance coverage; however, in six states—Alaska, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota, the participation rate increased by more than two percentage points when IHS was reclassified as insurance coverage, but the difference in North Dakota and Montana was not statistically significant at the 0.10 level. The impact on the participation rate was particularly noticeable in Alaska, where the rate increased from 80.1 to 90.3 percent. The other estimate that was sensitive to how IHS was treated was the participation rate among American Indian/Alaska Native children, which increased from 74.5 percent to 91.8 percent when the IHS was classified as health insurance coverage.

[13] Lynch, V., M. Boudreaux, and M. Davern. 2010. "Applying and evaluating logical coverage edits to health insurance coverage in the American Community Survey." Suitland, MD: U.S. Census Bureau, Housing and Household Economic Statistics Division.

[14] Turner, J., M. Boudreaux, and V. Lynch. 2009. "A preliminary evaluation of health insurance coverage in the 2008 American Community Survey." Suitland, MD: U.S. Census Bureau, Housing and Household Economic Statistics Division.

[15] Lynch, V. and M. Boudreaux. 2010. "Estimates of Non-Group Coverage in the American Community Survey: Evaluation and Post-Collection Adjustments." Presented at the Joint Statistical Meetings. August 2010.

[16] Davern, M., J.A. Klerman, J. Ziegenfuss, V. Lynch, D. Baugh, and G. Greenberg. 2009. "A Partially Corrected Estimate of Medicaid Enrollment and Uninsurance: Results from an Imputational Model Developed Off Linked Survey and Administrative Data." *Journal of Economic and Social Measurement*, 34(4):219-240.

[17] Division of Health Insurance Statistics. 2010. "NHIS Survey Description." Hyattsville, MD: National Center for Health Statistics. ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2009/srvydesc.pdf.

[18] See Lynch, V. 2010. Memo on Applying Logical Coverage Edits for Analyzing Medicaid/CHIP Participation and Coverage in the 2008 ACS. Washington, DC: Health Policy Center, Urban Institute; June 4, 2010. The edits we use have the effect of reducing the estimated number of uninsured children on the ACS by 400,000 in both 2008 and 2009, relative to the estimates released by Census.

[19] Our edits increase the estimated number of children with Medicaid/CHIP coverage on the ACS by almost three million in each year, bringing the Medicaid/CHIP totals to just about 350,000 and 200,000 below the comparable administrative count for both 2008 and 2009.

[20] The ACS included 2.2 million children who were reported to have both Medicaid/CHIP and employer-sponsored coverage at the time of the survey in 2008 and 2.1 million in 2009.

[21] Available administrative data suggest that the total number of children enrolled in full benefit Medicaid and CHIP coverage but not also enrolled in private coverage in June of 2008/2009 was 25.9/28.3 million. We derive this total by adjusting the reported Medicaid enrollment counts for children with restricted benefits and for those classified as having Medicaid and private coverage and for double counting of children who move across state lines and by adding in the reported CHIP enrollment count for the same period. The 2008/2009 administrative data indicate that there were a total of 28.4/31.0 million children enrolled in Medicaid and CHIP, including children with restricted benefits like Emergency Medicaid services or Family Planning Services, as well as private coverage (e.g. Medicaid wrap-around coverage) and children who moved and re-enrolled in another state. Medicaid Statistical Information System (MSIS) data representing Title 19 Medicaid full-year equivalency enrollment totals were used to develop state-level adjustments for the exclusion of enrollment in restricted benefit Medicaid programs (e.g. family planning waivers) or private coverage (Urban Institute Analysis of the 2007 Medicaid Statistical Information System). The adjustment for across- and within-state duplicate enrollment is based on information from the U.S. Census Bureau ("Phase III Research Results: Refinement in the Analysis of Examining Discrepancies between the National Medicaid Statistical Information System (MSIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)." December 2008, Research Project to Understand the Medicaid Undercount). These adjustments were applied to June 2008/2009 MSIS Title 19 Medicaid data for children, 0-18, by state to produce Medicaid enrollment counts that reflect non-duplicated full benefit enrollment and exclude private coverage. (June 2008/09 data from Medicaid Statistical Information System (MSIS) State Summary Datamart, retrieved March 2011). CHIP enrollment counts came from the SCHIP Enrollment Data System (SEDS) for the third quarter of 2008/09.

[22] While the derived administrative counts are considered to be more consistent than baseline administrative totals with respect to the Medicaid/CHIP coverage estimates from the ACS, they may still overstate this coverage on a given day because the adjustments do not take into account potential duplication in CHIP records. In addition, some people may remain on the administrative data after they have obtained another type of coverage, and families may not be aware that their child is enrolled in public coverage, due, for example, to misunderstandings about continuous eligibility periods or to automatic re-enrollment/enrollment, and thus may behave as though the child is uninsured. Finally, both retroactive and presumptive eligibility may produce an over-count of enrollees relative to survey respondents' beliefs regarding their coverage.

23 Call, K.T., G. Davidson, A.S. Sommers, R. Feldman, P. Farseth, and T. Rockwood. Winter 2001. "Uncovering the missing Medicaid cases and assessing their bias for estimates of the uninsured." *Inquiry,* 38(4): 396-408.

24 Call, K.T., G. Davidson, A. Hall, J. Kincheloe, L.A. Blewett, and E.R. Brown. 2006. "Sources of Discrepancy between Survey based Estimates of Medicaid Coverage and State Administrative Counts." Minneapolis, MN: State Health Access Data Center.

25 Additional imprecision in the administrative totals may be introduced by the adjustment method, which relies on multiple years of administrative data.

26 We derive this total by adjusting the reported Medicaid enrollment counts downward to account for children with restricted benefits and for those classified as having Medicaid and private coverage and to account for the double counting of children who move across state lines; we then add the reported CHIP enrollment count for the same period. Medicaid Statistical Information System (MSIS) data were used to develop state-level adjustments to exclude children in restricted benefit Medicaid programs (e.g. family planning waivers) or private coverage (Urban Institute Analysis of the 2007 Medicaid Statistical Information System). The adjustment for across and within state duplicate enrollment is based on information from the U.S. Census Bureau ("Phase III Research Results: Refinement in the Analysis of Examining Discrepancies between the National Medicaid Statistical Information System (MSIS) and the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)" December 2008, Research Project to Understand the Medicaid Undercount). These adjustments were applied to June 2008/2009 MSIS Title 19 Medicaid data for children, 0-18, by state to produce Medicaid enrollment counts that reflect non-duplicated full benefit enrollment that excludes those who also have private coverage. (June 2008/2009 data from Medicaid Statistical Information System (MSIS) State Summary Datamart, retrieved on March 2011). CHIP enrollment counts came from the SCHIP Enrollment Data System (SEDS) for the third quarter of 2008/2009.

27 The difference between our adjusted state Medicaid/CHIP total and the respective administrative total ranges across states. In over half of states, the difference is less than 10 percent in both years, and for 10 states, the difference is less than 5 percent in both years.

28 Dubay, L. and A. Cook. 2009. "How Will the Uninsured be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

29 Ross D.C., A. Horn, R. Rudowitz, and C. Marks. 2008. "Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

30 The model takes into account disregards for childcare expenses, work expenses, and earnings in determining eligibility, but does not take into account child support disregards. Since we do not have family income for sample children living apart from their families in group quarters (primarily college students) we do not count any of those cases as eligible unless the ACS shows they are an enrollee.

31 Heberlein, M., T. Brooks, S. Artiga, and J. Stephens. 2011. "Holding Steady, Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

32 Cohen Ross, D., Jarlenski, M., Artiga, S., Marks, C. 2009. "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

33 Kaiser Commission on Medicaid and the Uninsured. 2009. "New Options for States to Provide Federally Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

34 National Immigration Law Center. 2010. "Table: Medical Assistance Programs for Immigrants in Various States." Available at: http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf.

35 We applied the eligibility rules in place in the middle of each year. The following changes in Medicaid/CHIP eligibility thresholds from 2008 to 2009 were applied: in Indiana, eligibility changed from 200 to 250 percent of FPL in October 2008; in Iowa, eligibility increased from 200 percent to 300 percent in July 2009; in New York, a limited state program for children in the 250-400 percent range was shifted to CHIP effective September 2008; in North Dakota, eligibility increased from 150 to 160 percent in July 2009; in Washington, eligibility increased from 250 to 300 percent in January 2009; and in West Virginia, eligibility increased from 220 to 250 percent in January 2009.

36 California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Pennsylvania, Texas, Virginia, and Washington covered documented immigrant children with less than five-years U.S. residency. See: Kaiser Commission on Medicaid and the Uninsured, 2009. "New Option for States to Provide Federally Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/upload/7933.pdf.

37 In this model, documentation status is imputed to immigrant adults in two stages using their individual and family characteristics, based on an approach that was developed by Passel (See: Passel, J. and D. Cohn. 2008. "Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow," Washington, DC: Pew Hispanic Center.). Documentation status for children is imputed based on the status of co-residing adults (typically the child's parents). The imputations provided by this process are designed to match, in the aggregate, published summary estimates of the U.S. undocumented population, nationally and in a subset of large states.

38 Passel J. and D. Cohen. 2008 "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center.

39 In comparison, an estimated 3.9 million children reported to have Medicaid/CHIP on the CPS in 2008 are not found to be eligible (Kenney et al. 2010).

40 Kenney G., V. Lynch, A. Cook and, S. Phong. 2010. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" *Health Affairs*. 29(10): 1920-1929.

41 An estimated 4.9 million (68 percent) uninsured children were eligible for Medicaid or CHIP in 2008 according to the CPS (Kenney et al. 2010).

42 Kenney, G., V. Lynch, A. Cook, and S. Phong. 2010. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" *Health Affairs*. 29(10): 1920-1929.

43 In both instances, our estimate was that there were 4.7 million eligible but uninsured children in 2008 and the national participation rate rose by a small amount from 81.8 to 82.1 percent for 2008.

44 Alabama moved from 3rd quintile to 2nd, moving from 21st overall to 18th; New Hampshire moved from 2nd quintile to 3rd, moving from 18th overall to 21st; New Jersey moved from 4th quintile to 3rd, moving from 31st overall to 29th; Mississippi moved from 4th quintile to 3rd, moving from 32nd overall to 30th; Oklahoma moved from 3rd quintile to 4th, moving from 30th overall to 32nd; and California moved from 3rd quintile to 4th, from 29th overall to 34th.

45 There was also a small increase in the size of the population of non-institutionalized civilian children from 78.4 million children in 2008 to 78.9 million children in 2009.

46 See Endnote 11 for a discussion of how the treatment of IHS coverage affects participation estimates for American Indian/Alaskan Native children.

[47] Nebraska's participation rate is 89.957 percent, but we include it among states with participation rates of 90 percent or higher due to rounding.

[48] Dorn, S., B. Garrett, C. Perry, L. Clemans-Cope, and A. Lucas. 2009. "Nine in Ten: Using the Tax System to Enroll Eligible, Uninsured Children into Medicaid and SCHIP." Washington, DC: Urban Institute.

[49] DeNavas-Walt, C., B.D. Proctor, and J.C. Smith. 2008. "Income, Poverty, and Health Insurance Coverage in the United States: 2008." Current Population Reports, P60-236. Suitland, MD: U.S. Census Bureau.

[50] Department of Health and Human Services. 2010 "Children's Health Insurance Program Reauthorization Act: One Year Later: Connecting Kids to Coverage (2009 CHIPRA Annual Report)." Washington, DC: Department of Health and Human Services.

[51] Department of Health and Human Services. 2011. "Connecting Kids to Coverage: Continuing the Progress (2010 CHIPRA Annual Report)." Washington, DC: Department of Health and Human Services.

[52] Department of Health and Human Services. 2011. "Connecting Kids to Coverage: Continuing the Progress (2010 CHIPRA Annual Report)." Washington, DC: Department of Health and Human Services.

[53] Department of Health and Human Services. 2011. "Connecting Kids to Coverage: Continuing the Progress (2010 CHIPRA Annual Report)." Washington, DC: Department of Health and Human Services.

[54] Heberlein, M., T. Brooks, S. Artiga, and J. Stephens. 2011. "Holding Steady, Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[55] Cohen Ross, D., Jarlenski, M., Artiga, S., Marks, C. 2009. "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[56] Wachino V. and A. Weiss. 2009. "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children." Portland, ME: National Academy for State Health Policy.

[57] Heberlein, M., T. Brooks, J. Guyer, S. Artiga, and J. Stephens. 2011. "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[58] Also, coverage in Arizona for parents between 100 and 200 percent of the FPL was eliminated in October 2009 (Cohen Ross, D., M. Jarlensk, S. Artiga, and C. Marks. 2009. "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009." Washington, DC: Kaiser Commission on Medicaid and the Uninsured).

[59] Department of Health and Human Services. 2011. "Connecting Kids to Coverage: Continuing the Progress (2010 CHIPRA Annual Report)." Washington, DC: Department of Health and Human Services.

[60] Heberlein, M., T. Brooks, J. Guyer, S. Artiga, and J. Stephens. 2011. "Holding Steady, Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[61] Bovbjerg, R., B, Ormond, and V. Chen. 2011. "State Budgets Under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[62] Heberlein, M., T. Brooks, J. Guyer, S. Artiga, and J. Stephens. 2011. "Holding Steady, Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[63] Kenney G. 2010. "Access to Care in Medicaid and CHIP for Children and Nonelderly Adults." Presented to the Medicaid and CHIP Payment and Access Commission, September 2010.

[64] Sebelius, K. 2010. "Report to Congress: HHS Secretary's Efforts to Improve Children's Health Care Quality in Medicaid and CHIP." Washington DC: Department of Health and Human Services. https:// www.cms.gov/MedicaidCHIPQualPrac/Downloads/ ChildHealthImprovement.pdf.

[65] Mann, C. 2011. "CMCS Informational Bulletin, Update on Medicaid/ CHIP." Washington, DC: Center for Medicaid, CHIP, and Survey & Certification. https://www.cms.gov/CMCSBulletins/ downloads/6-1-11-Info-Bulletin.pdf.

[66] "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services." Federal Register vol. 76 no. 88 (6 May 2011): 26342-26362.

EXHIBIT 1

Increase in Number of Children (0-18) Eligible for Medicaid/CHIP Between 2008 and 2009

Increase Due to Decline in Income Distribution

Increase Due to Eligibility Expansions

49.5%
1.3 million

50.5%
1.3 million

TOTAL INCREASE: **2.5 million**

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS. Numbers may not sum to total due to rounding.

EXHIBIT 2

Medicaid/CHIP Participation Rates Among Children (0-18) by Region, 2008 and 2009
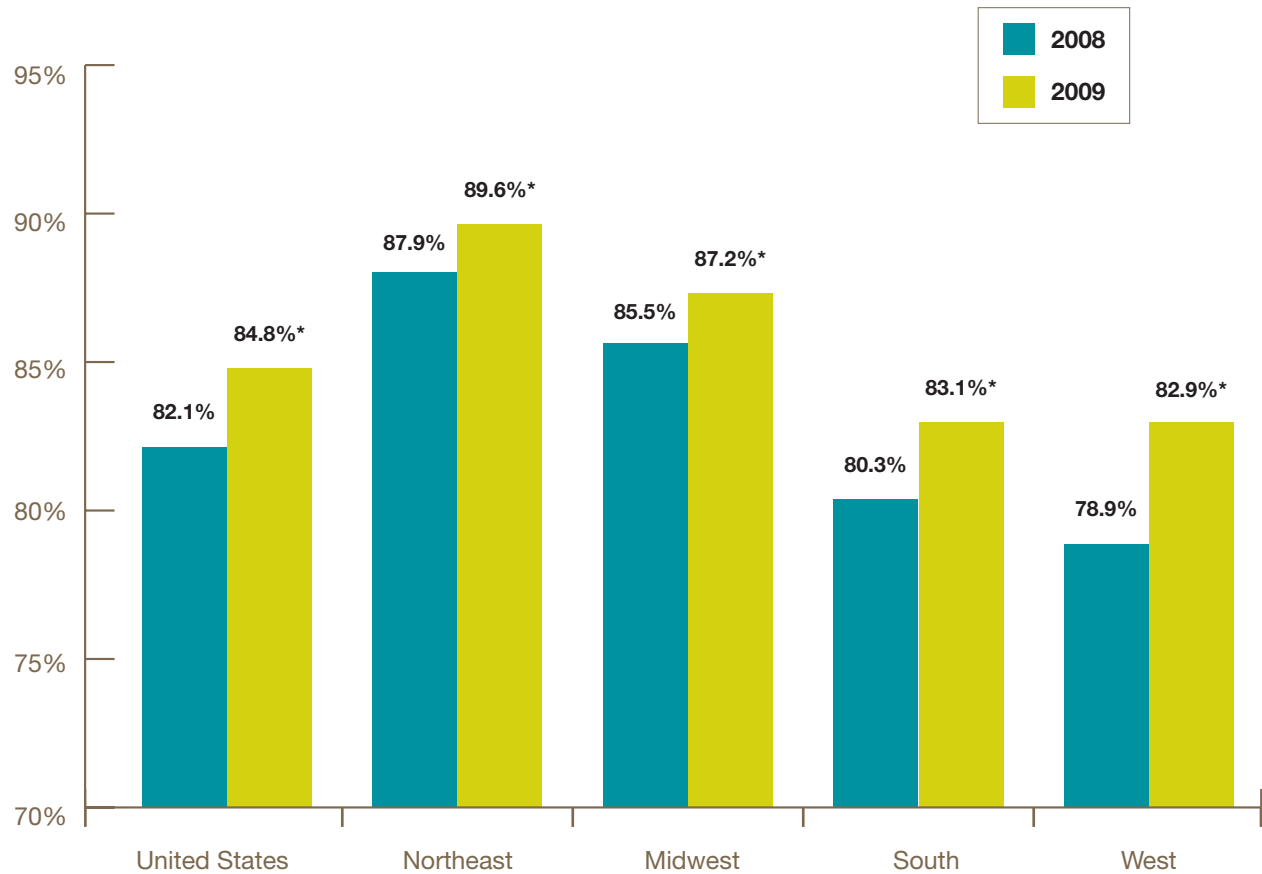
Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* indicates that the 2009 percentage is significantly different from the 2008 percentage at the (.10) level.

EXHIBIT 3

Medicaid/CHIP Participation Rates Among Children (0-18) by Census Region/Division, 2008 and 2009

	2008 Rate	2009 Rate	Difference
United States	**82.1%**	**84.8%**	**2.7%***
Northeast Region	**87.9%**	**89.6%~**	**1.7%***
New England division	90.8%	92.9%~	**2.1%***
Middle Atlantic division	87.1%	88.7%~	**1.6%***
Midwest Region	**85.5%**	**87.2%~**	**1.6%***
East North Central division	86.3%	88.4%~	**2.1%***
West North Central division	83.5%	84.0%	**0.5%**
South Region	**80.3%**	**83.1%~**	**2.8%***
South Atlantic division	79.3%	83.0%~	**3.7%***
East South Central division	86.0%	89.0%~	**3.0%***
West South Central division	79.1%	80.6%~	**1.5%***
West Region	**78.9%**	**82.9%~**	**4.0%***
Mountain division	72.7%	79.9%~	**7.2%***
Pacific division	81.4%	84.0%~	**2.6%***

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

~ indicates that the 2009 regional percentage is significantly different from the national percentage at the (.10) level.

* indicates that the 2009 percentage is significantly different from the 2008 percentage at the (.10) level.

EXHIBIT 4

Changes in Medicaid/CHIP Participation Rates Among Children (0-18) by State, 2008 to 2009

Changes in Participation Rates

2009 Not Significantly Different from 2008 at the (.10) level

2009 Significantly Different from 2008 at (.10) level

EXHIBIT 5

Medicaid/CHIP Participation Rates Among Children (0-18) by State, 2008 and 2009

Participation Rate			
Area	2008	2009	Difference
United States	**82.1%**	**84.8%**	**2.7%***
District of Columbia	96.1%	97.0%	0.9%
Massachusetts	95.2%	96.0%	0.8%
Vermont	93.4%	92.4%	-1.0%
Hawaii	92.0%	91.8%	-0.2%
Maine	91.2%	91.5%	0.3%
Michigan	90.8%	92.1%	1.3%
Kentucky	89.8%	90.0%	0.2%
West Virginia	89.8%	90.5%	0.7%
New York	89.2%	90.4%	1.2%*
Louisiana	88.6%	89.5%	0.9%
Arkansas	88.2%	92.8%	4.6%*
Illinois	87.9%	90.8%	3.0%*
Maryland	87.0%	89.4%	2.4%*
Tennessee	86.5%	90.0%	3.5%*
Wisconsin	86.5%	88.5%	2.0%
Pennsylvania	86.2%	88.4%	2.2%*
Connecticut	85.8%	90.7%	5.0%*
Alabama	85.7%	89.6%	3.9%*
Rhode Island	85.5%	90.9%	5.3%*
Missouri	85.4%	84.5%	-0.9%
New Hampshire	85.3%	87.1%	1.9%
North Carolina	85.2%	87.8%	2.6%*
Iowa	85.1%	87.0%	1.9%
Ohio	83.8%	86.6%	2.8%*
South Dakota	83.3%	84.5%	1.2%
Delaware	83.1%	91.7%	8.6%*
Washington	83.1%	85.9%	2.8%*
Nebraska	82.9%	90.0%	7.1%*
New Jersey	82.8%	84.3%	1.5%
Mississippi	81.9%	85.4%	3.6%*
Kansas	81.7%	82.5%	0.9%
Oklahoma	81.6%	84.5%	2.9%*
Minnesota	81.5%	80.5%	-1.0%
California	81.5%	83.8%	2.3%*
New Mexico	81.4%	85.3%	3.9%*
Virginia	81.1%	84.7%	3.7%*
Georgia	81.0%	82.2%	1.2%
Indiana	80.7%	80.5%	-0.2%
South Carolina	80.5%	84.1%	3.7%*
Wyoming	78.1%	85.1%	7.0%
Arizona	76.5%	82.5%	6.0%*
Oregon	76.2%	82.5%	6.3%*
North Dakota	75.8%	74.5%	-1.3%
Texas	75.8%	77.1%	1.3%*
Idaho	74.5%	83.9%	9.4%*
Alaska	73.1%	80.1%	7.1%*
Montana	70.3%	78.9%	8.6%*
Florida	70.1%	77.0%	7.0%*
Colorado	69.6%	81.0%	11.4%*
Utah	66.9%	76.1%	9.2%*
Nevada	57.0%	62.9%	5.9%*

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).
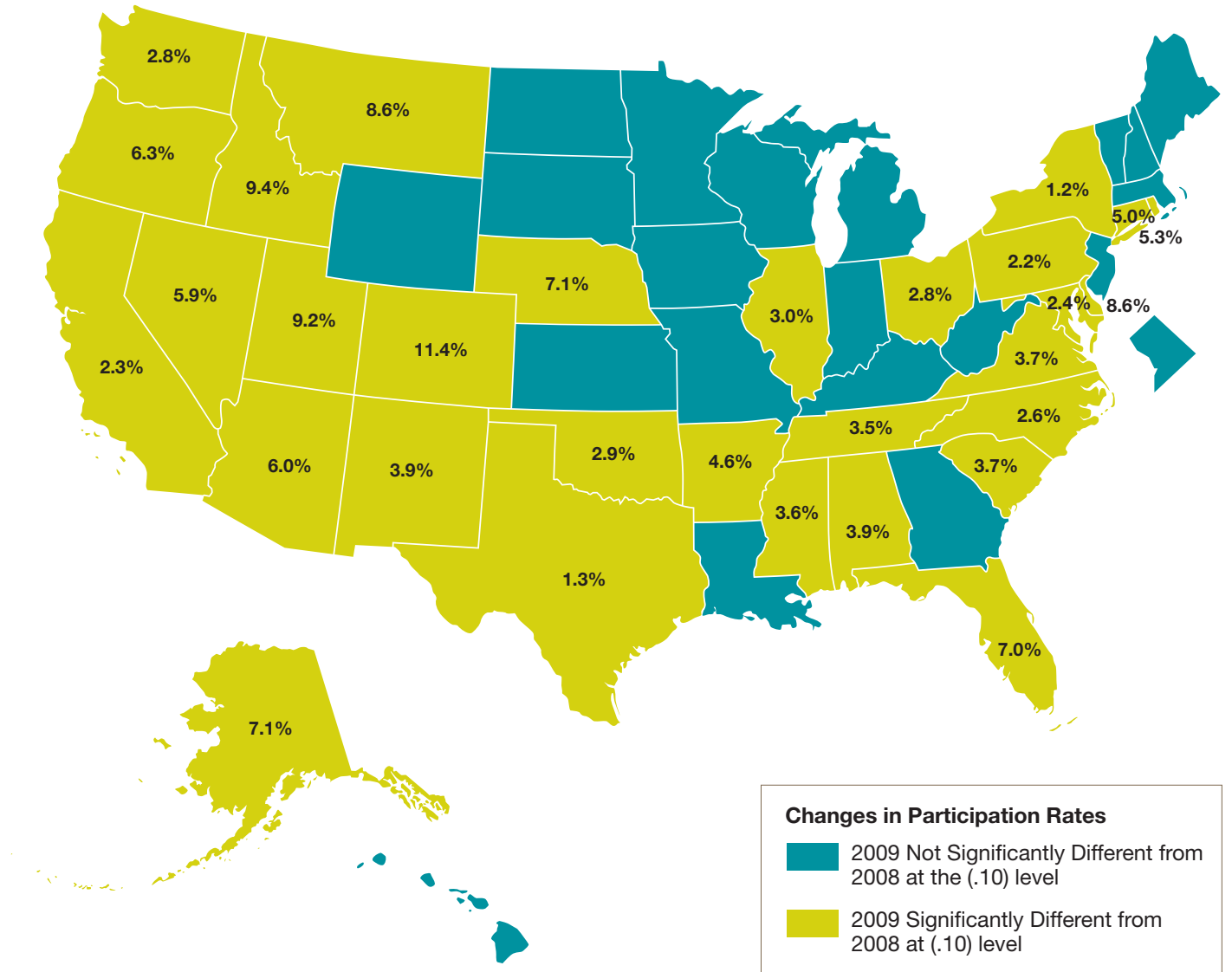
Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* indicates that the 2009 percentage is significantly different from the 2008 percentage at the (.10) level.

EXHIBIT 6

Medicaid/CHIP Participation Rates Among Children (0-18), 2008 and 2009

	United States		
	2008 Rate	**2009 Rate**	**Difference**
Total	**82.1%**	**84.8%**	**2.7%***
Age (years)			
0 to 5^	85.9%	88.9%	3.0%*
6 to 12	82.7%	85.6%~	2.9%*
13 to 18	76.3%	78.3%~	2.0%*
English Speaking Parent in Home			
At Least One^	83.3%	85.6%	2.3%*
None	78.3%	83.2%~	4.9%*
Child Not Living with Parents	77.1%	80.0%~	3.0%*
Family Income (As Percent of Poverty)			
0-132%^	84.5%	87.1%	2.5%*
133-199%	76.0%	79.6%~	3.6%*
200+%	72.0%	74.7%~	2.7%*
Ethnicity or Race			
Hispanic^	79.4%	82.6%	2.5%*
White	81.8%	84.4%~	2.6%*
Black or African American	87.2%	89.4%~	2.2%*
Asian/Pacific Islander	79.7%	82.7%	3.1%*
American Indian/Alaskan Native	68.8%	74.5%~	5.8%*
Other/Multiple	86.8%	88.7%~	1.8%*
Citizenship Status			
Citizen Child with No Citizen Parents^	78.3%	83.2%	4.9%*
Citizen Child with Citizen Parents	83.8%	86.1%~	2.3%*
Non-Citizen Child	76.0%	76.3%~	0.3%
Child Not Living with Parents	77.1%	80.0%~	3.0%*

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.
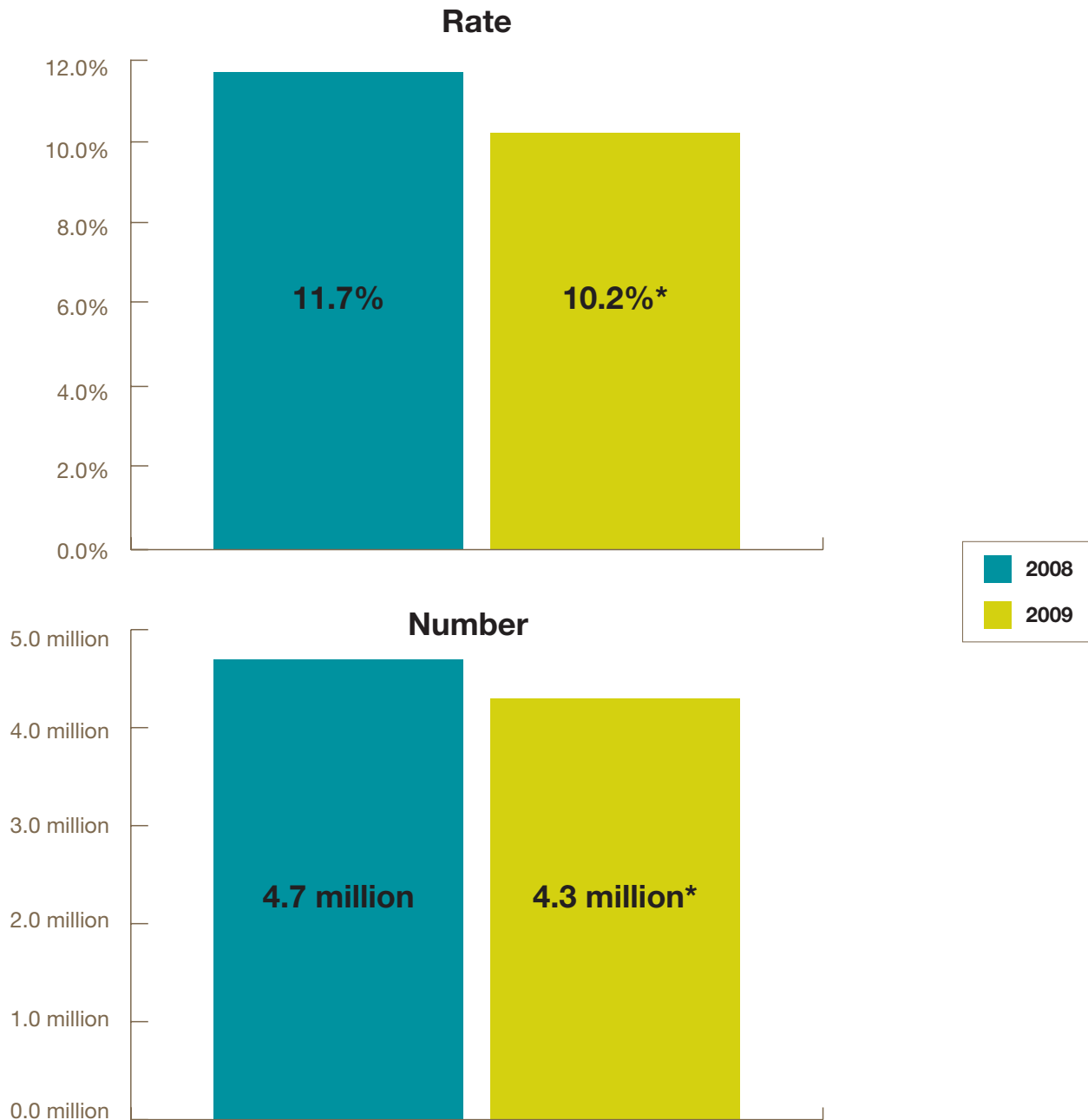
* indicates that the 2009 percentage is significantly different from the 2008 percentage at the (.10) level.

^ indicates reference group.

~ indicates that the 2009 estimate is significantly different form the reference group at the (.10) level.

EXHIBIT 7

Uninsurance Rate and Number of Uninsured Among Children (0-18) Eligible for Medicaid/CHIP, 2008 and 2009

Rate

- 11.7% (2008)
- 10.2%* (2009)

Legend:
- 2008
- 2009

Number

- 4.7 million (2008)
- 4.3 million* (2009)

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* indicates that the 2009 estimate is significantly different from the 2008 estimate at the (.10) level.

EXHIBIT 8

Eligibility of Uninsured Children (0-18) for Medicaid/CHIP Coverage, 2009

Of the **6.6 million** uninsured children in the nation, **4.3 million** are eligible for Medicaid/CHIP

Eligible for Medicaid/
CHIP, income more than
133% of poverty

23.8%
1.6 million

Ineligible for
Medicaid/ CHIP

34.6%
2.3 million

41.6%
2.8 million

Eligible for Medicaid/
CHIP, income less than
133% of poverty

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).
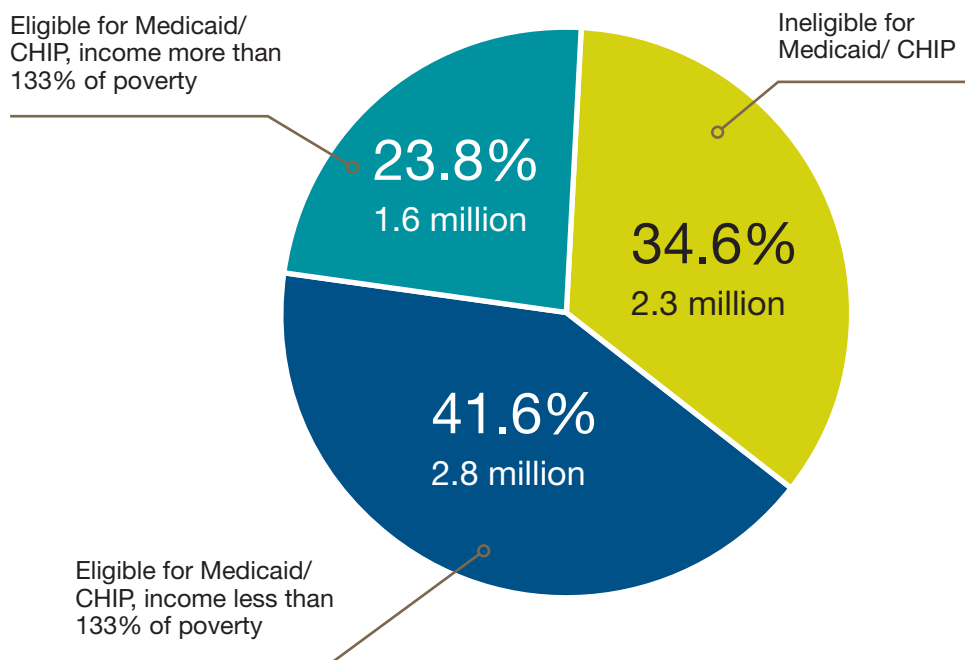
Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS. Numbers may not sum to total due to rounding.

EXHIBIT 9

Number of Eligible but Uninsured Children (0-18) in Selected States, 2009

	Number	Share of Total U.S. Eligible but Uninsured	Cumulative Share of Total U.S. Eligible but Uninsured
United States	**4,349,000**	-----	-----
Texas	693,000	15.9%	15.9%
California	661,000	15.2%	31.1%
Florida	381,000	8.8%	39.9%
Georgia	189,000	4.4%	44.3%
New York	175,000	4.0%	48.3%
Ohio	127,000	2.9%	51.2%
Arizona	125,000	2.9%	54.1%
Illinois	120,000	2.8%	56.8%
Pennsylvania	118,000	2.7%	59.5%
Indiana	113,000	2.6%	62.1%

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

EXHIBIT 10

## Medicaid/CHIP Participation and Uninsurance Rate Among Eligible Children (0-18) by State, 2009

Area	Participation Rate	Uninsured Rate Among Eligibles
United States	**84.8%**	10.2%
District of Columbia	97.0%~	2.3%~
Massachusetts	96.0%~	2.4%~
Arkansas	92.8%~	5.8%~
Vermont	92.4%~	5.0%~
Michigan	92.1%~	5.6%~
Hawaii	91.8%~	3.5%~
Delaware	91.7%~	6.3%~
Maine	91.5%~	6.5%~
Rhode Island	90.9%~	5.8%~
Illinois	90.8%~	5.1%~
Connecticut	90.7%~	5.5%~
West Virginia	90.5%~	6.1%~
New York	90.4%~	5.5%~
Tennessee	90.0%~	6.6%~
Kentucky	90.0%~	7.3%~
Nebraska	90.0%~	7.1%~
Alabama	89.6%~	7.7%~
Louisiana	89.5%~	8.1%~
Maryland	89.4%~	6.3%~
Wisconsin	88.5%~	6.1%~
Pennsylvania	88.4%~	6.8%~
North Carolina	87.8%~	9.1%~
New Hampshire	87.1%	6.8%~
Iowa	87.0%~	5.5%~
Ohio	86.6%~	9.2%~
Washington	85.9%	8.8%~
Mississippi	85.4%	11.4%
New Mexico	85.3%	11.6%
Wyoming	85.1%	9.5%
Virginia	84.7%	10.1%
Missouri	84.5%	9.2%
South Dakota	84.5%	10.6%
Oklahoma	84.5%	11.6%~
New Jersey	84.3%	8.6%~
South Carolina	84.1%	11.9%~
Idaho	83.9%	11.2%
California	83.8%~	11.5%~
Oregon	82.5%~	13.0%~
Kansas	82.5%	11.4%
Arizona	82.5%~	13.5%~
Georgia	82.2%~	12.5%~
Colorado	81.0%~	13.7%~
Indiana	80.5%~	11.8%~
Minnesota	80.5%~	10.3%
Alaska	80.1%~	12.7%
Montana	78.9%~	16.0%~
Texas	77.1%~	18.4%~
Florida	77.0%~	17.5%~
Utah	76.1%~	13.4%~
North Dakota	74.5%~	15.8%~
Nevada	62.9%~	24.1%~

Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS.

~ indicates that the 2009 estimate is significantly different from the national average at the (.10) level.

EXHIBIT 11

Simulated Effect of Increases in Participation Rates on the Number of Uninsured Children (0-18) Who Are Eligible for Medicaid/CHIP, 2009
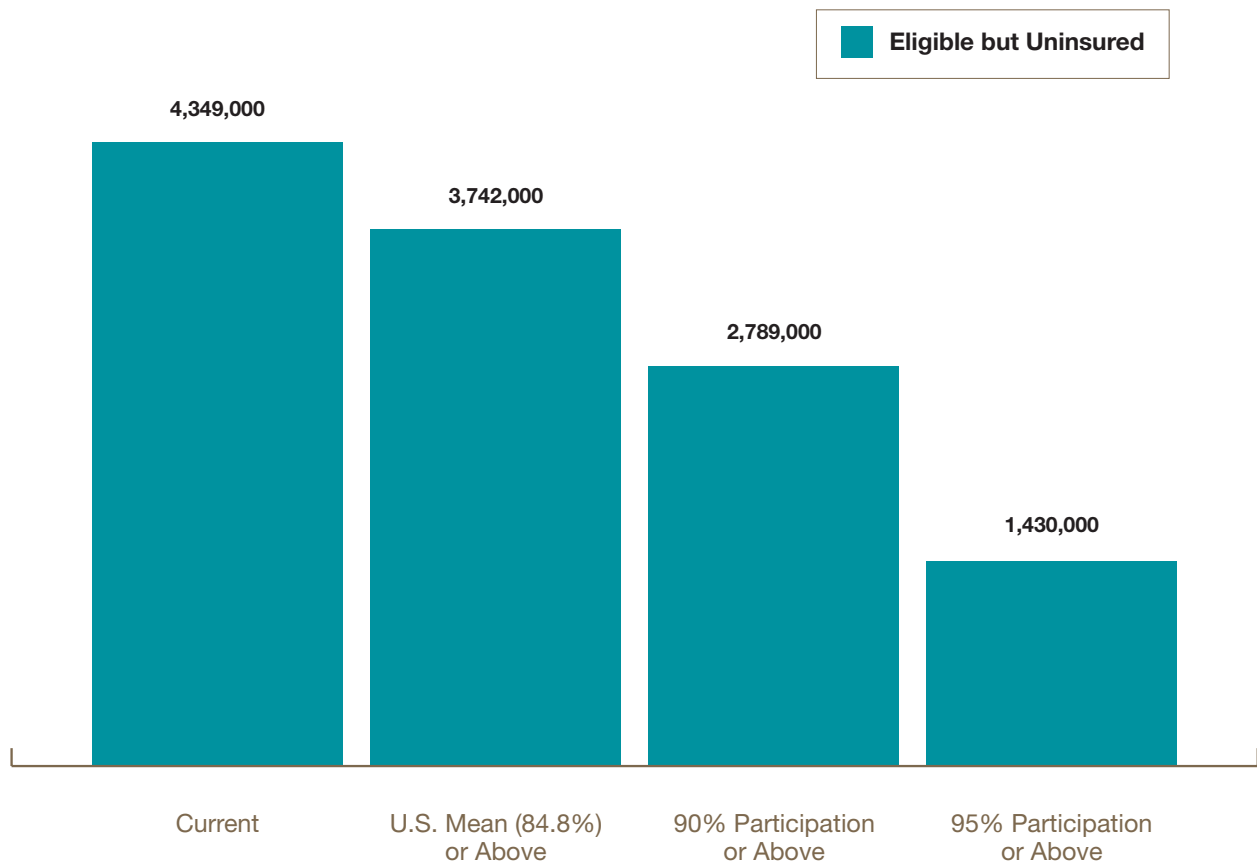
Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS).

Notes: Estimates reflect an adjustment for the misreporting of coverage on the ACS. Figure simulates the effects on the number of children who are eligible for Medicaid/CHIP but remain uninsured if states with participation rates below specified thresholds were to attain those thresholds.