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Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?

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ABSTRACT **Kathleen Sebelius, secretary of health and human services, has issued a challenge to enroll the millions of uninsured children eligible for public insurance in Medicaid or the Children's Health Insurance Program (CHIP). This paper provides estimates of the rates at which children in the various states participated in these programs in 2008 as well as the number who were eligible for them but uninsured. According to our coverage estimates, an estimated 7.3 million children were uninsured on an average day in 2008, of whom 4.7 million (65 percent) were eligible for Medicaid or CHIP but not enrolled. Participation rates varied across states from 55 percent to 95 percent, and ten states had participation rates close to or above 90 percent. Thirty-nine percent of eligible uninsured children (1.8 million) live in just three states—California, Texas, and Florida—and 61 percent (2.9 million) live in ten states. Meeting Secretary Sebelius's challenge means achieving success in these populous states, in part through tools and resources available under the 2009 CHIP reauthorization law.**

In early 2010, the secretary of health and human services (HHS), Kathleen Sebelius, issued a challenge to find and enroll the approximately five million uninsured children who were estimated to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) and outlined strategies for achieving that goal.[1] This new initiative, called Connecting Kids to Coverage, builds on the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.[2]

Background On Children's Coverage

RISING RATES OF COVERAGE SINCE 1997 The reauthorization took place against a backdrop of coverage gains for children following the enactment of CHIP in 1997. A number of studies found declines in the number of low-income uninsured children. This occurred at a time when uninsurance was rising for adults.[3–6] The increased coverage among children eligible for Medicaid and CHIP was likely to have been attributable to states' outreach and enrollment efforts. Despite this progress, when CHIP was reauthorized, close to two-thirds of all uninsured children appeared to be eligible for, but not enrolled in, Medicaid or CHIP. Moreover, there was much variation across states with respect to enrollment and retention policies.[7–9]

NEW TOOLS TO INCREASE PARTICIPATION CHIPRA provides states with new tools to address shortfalls in participation in Medicaid and CHIP. These include outreach and enrollment grants and bonus payments to states that adopt five of eight enrollment and retention strategies and states that experience Medicaid enrollment increases that exceed target growth rates.[10] States also were given "Express Lane" options, which allow them to use administrative data from other programs such as the Special Supplemental Nutrition Program for Women,

Infants, and Children (WIC) to facilitate enrollment.

The law also gave states new options to meet citizenship requirements for child enrollees. In addition, it allowed states to use federal dollars to cover legal immigrant children who had been in the United States fewer than five years, and it provided states with additional federal funds to cover more children.

OUTCOMES By February 2010, one year after CHIPRA became law, a number of states had either expanded eligibility for coverage or introduced improvements to their enrollment and retention processes.[2] By April 2010, the federal government had awarded $50 million in outreach grants, including $40 million to organizations in forty-two states and an additional $10 million for targeting Native American children. These policy changes are expected to change the composition of the population of children enrolled in public coverage and raise participation rates among children who are already eligible.

At the same time, however, the ongoing recession and state budget shortfalls could reduce state-level efforts to promote greater enrollment and retention among eligible children. Ultimately, policy changes to be implemented in 2014 under the Patient Protection and Affordable Care Act of 2010 will introduce major changes to Medicaid and CHIP coverage for children and parents.

NEW DATA SOURCE To assess progress covering uninsured children under CHIPRA and, ultimately, through health reform, information on nationwide participation and coverage is needed. Data from the state and local levels, and for different subgroups of children, are also needed. Research suggests that participation in Medicaid/CHIP—that is, the ratio of eligible children enrolled in the programs to that number of children plus uninsured eligible children—varies across regions of the country.[8] To date, however, it has not been possible to produce robust estimates for each state, because of limitations in the available data.

The situation has now changed. The American Community Survey, which includes an annual sample of approximately 700,000 children nationwide, began asking about health insurance coverage in 2008.[11] The availability of health insurance data from this survey, along with accompanying household and income data, allowed us to develop a Medicaid/CHIP eligibility model for the survey that produces more precise state and local estimates than had been possible previously.

NEW ESTIMATES This paper provides national and state-level estimates of Medicaid/CHIP participation rates and of the number of uninsured children who are eligible for the programs, based on 2008 data from the American Community Survey. We found substantial variation in participation rates across states and among subgroups of children. We also found that the majority of uninsured children who are eligible for Medicaid/CHIP but not enrolled are concentrated in a small number of the most populous states.

Study Data And Methods

DATA SOURCE These estimates are derived from the 2008 American Community Survey, an annual survey fielded continuously over a twelve-month period by the U.S. Census Bureau.[12] We used an augmented version of the survey prepared by the University of Minnesota Population Center.[13] The survey has a reported response rate of 97.9 percent (range: 91.4 percent in Washington, D.C., to 99.4 percent in Wisconsin).[14]

The survey uses an area frame that includes households with and without telephones (landline or mobile). A mixed-mode survey, it starts with a mail-back questionnaire (56.6 percent of the sample is completed by mail). Nonresponders receive a follow-up phone call, and a subsample of remaining nonresponders is interviewed in person.[15] The estimates presented here focus on children age eighteen and younger in the civilian noninstitutionalized population, including college students in dorms and a small number of other children living in group quarters, such as residential treatment facilities.

In 2008 a question was added to the survey that asked about coverage status in different types of insurance plans for each individual in the household at the time of the survey (Exhibit 1). We classified children as uninsured if they did not have coverage under categories A through F (including those recoded from the write-in option, category H) and if they were not classified as having coverage based on other information collected in the survey.[16–18] (See the Appendix for a description of further adjustments made to the coverage data.)[19] Because the data are collected continuously over a twelve-month period, the coverage estimates represent an average day in the calendar year.

Research suggests that with the exception of direct-purchase coverage, the survey coverage estimates are generally valid, with estimates about the same for other coverage categories as those from two other federally funded surveys, the Current Population Survey and the National Health Interview Survey.[16] However, there is concern that the survey may understate Medicaid and CHIP coverage because, in addition to the known underreporting of public coverage on

EXHIBIT 1

American Community Survey Question On Health Insurance

Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? *Mark "Yes" or "No" for EACH type of coverage in items A–H.*

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 (of this person or another family member)
C. Medicare, for people age 65 and over, 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 (including those who have ever enrolled in or used VA health care)
G. Indian Health Service
H. Any other type of health insurance or health coverage plan—*specify*

SOURCE U.S. Census Bureau, American Community Survey, 2008. **NOTES** TRICARE is the program formerly known as CHAMPUS; it covers uniformed service members, retirees, and their families worldwide. VA is Department of Veterans Affairs.

household surveys, the American Community Survey—unlike the other surveys cited above—does not specifically mention CHIP or give respondents names for their state's particular Medicaid and CHIP programs.

ADJUSTMENTS To address the underreporting of Medicaid and CHIP, we made adjustments based on approaches that have been applied to other surveys.[18,20] We applied a set of logical edit rules that the Census Bureau has developed for this survey, as well as additional edits that take advantage of other information collected in the survey (see the Appendix).[19] The edits reduced the estimated number of uninsured children in the survey from 8.2 million to 7.3 million, which is slightly lower than the National Health Interview Survey estimate of 7.4 million uninsured children for the same period.[21] Our edits increased the estimated number of children with Medicaid/CHIP as their primary coverage by roughly 4.4 million to a level that is just about 7 percent lower than the comparable administrative count for June 2008.[22]

ANALYTIC MODEL This analysis relied on the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, which builds on the model developed for the Current Population Survey by Lisa Dubay and Allison Cook.[23,24] Despite the differences between surveys, the American Community Survey eligibility simulation for 2008 appears robust compared to that developed for the Current Population Survey. For example, the numbers and characteristics of children according to their eligibility for Medicaid/CHIP and their pathway to eligibility—that is, Medicaid versus CHIP—are similar for both surveys.[25]

We defined *participation rates* as the ratio of eligible children enrolled in Medicaid/CHIP to those children plus uninsured children who are eligible for Medicaid/CHIP. In our core estimates, we excluded from these counts children enrolled in one of the programs who also have other coverage (such as private or military coverage) and those with Medicaid/CHIP coverage who do not have a known eligibility pathway.[26] We do not currently have a method for including in the denominator of the participation rate those uninsured children who may similarly be eligible for Medicaid/CHIP coverage but don't appear to be, based on the information that is available on the survey.

Variation in participation within states can be assessed using Public Use Microdata Areas. These areas, numbering more than 2,000, are usually defined in terms of counties: A microdata area can cover a single county, a combination of whole counties, or a part of a large county. Estimates are presented by census region and division, age, race or ethnicity, citizenship status, presence of English-speaking parents, family income (defined in terms of the child's health insurance unit), participation in the Supplemental Nutrition Assistance Program (formerly known as food stamps) at some point in the prior twelve months, and the presence of a telephone (either landline or mobile) in the household.

All estimates used weights provided by the Census Bureau. Standard errors were calculated using replicate weights that took into account the complex nature of the sample design.

Study Findings

CHARACTERISTICS OF UNINSURED CHILDREN According to our revised coverage estimates, some 7.3 million children were uninsured on an average day in 2008, of whom 4.7 million (65 per-

cent) were eligible for Medicaid or CHIP but not enrolled (Exhibit 2).[26] Of these 4.7 million children, 3 million had family incomes below 133 percent of the federal poverty level,[27] 1.2 million had family incomes of 133–200 percent of poverty, and 500,000 had incomes above 200 percent of poverty.

Although 64 percent of uninsured children eligible for Medicaid/CHIP had family incomes below 133 percent of poverty, children in this income group participated in Medicaid/CHIP at higher rates relative to higher-income children (see the discussion below). Most of the remaining 2.5 million uninsured children did not qualify for Medicaid/CHIP because their family incomes exceeded income eligibility thresholds in 2008.

PATTERNS AMONG STATES The number of uninsured children who were eligible for Medicaid/CHIP but not enrolled was heavily concentrated in a relatively small number of populous states (Exhibit 3). Just three states combined—California, Texas, and Florida—contained 38.6 percent of all eligible uninsured children in the country. Moreover, an estimated 61 percent (about 2.9 million) of all eligible uninsured children lived in the ten states shown in the exhibit.

The main reason these states accounted for such a large share of the eligible uninsured children is that they also contained a disproportionate share of children: 52 percent of all children and 56 percent of eligible children in the nation (data not shown). However, Florida, Texas, and Arizona also had participation rates that were well below the national average (Exhibit 4)—69.8 percent, 74.7 percent, and 76.6 percent, respectively.

PARTICIPATION RATES Overall, we estimated that the national rate of Medicaid/CHIP participation for children was 81.8 percent in 2008 (Exhibit 4).[28] The median rate across states was even higher, 83.3 percent (Appendix Exhibit A.1).[19] Although not exactly comparable, the Medicaid/CHIP participation rate we estimated for children was much higher than the participation rates typically found in other government programs. This is probably due to concerted efforts to improve Medicaid/CHIP eligibility, enrollment and retention processes, and outreach.[3,29] We found higher participation rates for states in the Northeast (87.7 percent) and Midwest (85.3 percent) census regions and lower rates for states in the West (78.8 percent) and South (79.8 percent) regions (Exhibit 5).

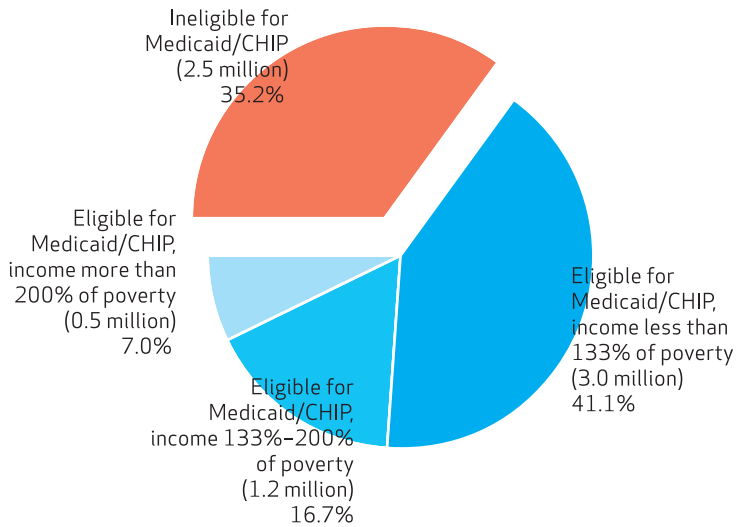
▶ **STATE VARIATIONS:** Participation rates varied greatly across states, from lows of 55.4 percent in Nevada and 66.2 percent in Utah to highs of 95.4 percent and 95.2 percent in the District of Columbia and Massachusetts, respectively. Hawaii, Maine, Massachusetts, Vermont, and the District of Columbia had participation rates of 91 percent or higher, and Arkansas, Kentucky, Louisiana, Michigan, New York, and West Virginia had rates of 88–90 percent. A total of thirteen states had participation rates under 80 percent (Alaska, Arizona, Colorado, Idaho, Florida, Montana, Nevada, North Dakota, Oregon, South Carolina, Texas, Utah, and Wyoming).

Participation rates for the states in the top quintile, or 20 percent of states, ranged from 88.4 percent to 95.4 percent, while participation rates for the states in the bottom quintile ranged from 55.4 percent to 75.2 percent (Appendix Exhibit A.1).[19] The top quintile included states of different sizes, racial and ethnic composition, and income levels (data not shown), and at least one state from each census region. However, neither the Mountain nor the West North Central census division had a state in the top quintile. Five of the six states in the New England census division were in the top two quintiles, and three were in the top quintile.

Seven of the ten states with participation rates in the lowest quintile were in the West census region, and five of these states were in the Mountain division. All eight states in that division had participation rates in the bottom two quintiles. No state in the lowest quintile was in the Middle

EXHIBIT 2

Eligibility Of Uninsured Children For Coverage Through Medicaid Or The Children's Health Insurance Program (CHIP), 2008



SOURCE Authors' analysis using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey. **NOTES** Estimates reflect an adjustment for the underreporting of Medicaid/CHIP coverage on the survey. Of the 7.3 million uninsured U.S. children, 4.7 million are eligible for Medicaid or CHIP. Percentages shown here are percentages of the 7.3 million children. Cumulative percentages might not total 100 because of rounding.

EXHIBIT 3

Number Of Eligible Uninsured Children In Selected States, 2008

State	Distribution of eligible uninsured children			Cumulative share of total U.S. uninsured (%)
	Number	Percent	90% CI	
United States	4,708,000			
California	695,000	14.8	14.2–15.3	14.8
Texas	693,000	14.7	14.3–15.1	29.5
Florida	429,000	9.1	8.8–9.4	38.6
Georgia	193,000	4.1	3.8–4.4	42.7
New York	164,000	3.5	3.3–3.7	46.2
Arizona	155,000	3.3	3.1–3.5	49.5
Illinois	146,000	3.1	2.8–3.4	52.6
Ohio	144,000	3.1	2.8–3.3	55.6
Pennsylvania	129,000	2.7	2.5–3.0	58.4
North Carolina	125,000	2.7	2.4–2.9	61.0

SOURCE Authors' analysis using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey. **NOTES** Estimates of uninsured children reflect an adjustment for the underreporting of Medicaid and Children's Health Insurance Program (CHIP) coverage on the survey. Numbers of uninsured children are rounded to the nearest thousand. Cumulative percentages might not total 100 because of rounding. CI is confidence interval.

Atlantic, New England, East North Central, or East South Central division.

▶ **INDIAN HEALTH SERVICE:** As indicated above, state-level participation rates treated as uninsured all children reporting Indian Health Service but no other source of coverage. When we recalculated the participation rates by not counting these children as uninsured, the national participation rate remained the same. However, the estimated rates rose by three percentage points or more in six states (Alaska, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota), with the largest increase (14.5 percentage points) occurring in Alaska (data not shown).

Thus, the lower Medicaid/CHIP participation rates in some western states may be linked to the relatively larger shares of Native American children in those states. New higher federal matching rates are now available to states to cover these children, which may increase their enrollment in Medicaid and CHIP.

▶ **VARIATION WITHIN STATES:** Participation in the programs also appeared to vary considerably across areas within a given state (data not shown). For example, rates in Florida, a state in the bottom quintile of participation, varied across areas in the state from a low of 45.8 percent to a high of 92.3 percent.

▶ **VARIATION ACROSS SUBGROUPS:** We also found substantial variation in participation rates across different subgroups of children who were eligible for coverage (Exhibit 6). Overall, adolescents were about seven to nine percentage points less likely than younger children to participate in Medicaid/CHIP. African American children and those in the "other/multiple race" category had the highest participation rates among eligible children, at around 87 percent; Hispanic and Asian/Pacific Islander children had participation rates of 78.8 percent and 79.4 percent, respectively.

Although American Indian/Alaska Native children appeared to have the lowest participation rates (68.0 percent), their participation rate rose to 91.6 percent if we did not treat as uninsured the children reported as covered only through the Indian Health Service. We found higher participation rates among citizen children with citizen parents and among those who had at least one English-speaking parent than among citizen children with no parents who were citizens or with no English-speaking parent.

Participation rates were higher among children with family incomes below 133 percent of poverty (84.2 percent) and among those who were in households that received help through the Supplemental Nutrition Assistance Program (formerly known as food stamps; 93.5 percent), compared to higher-income children and children not living in households receiving food stamps.

Despite their relatively high participation rate, the poorest children made up a sizable majority (63.4 percent) of all children who were eligible but uninsured. Children living in homes without phones had participation rates that were almost ten percentage points lower than those of children who had phones in their homes.

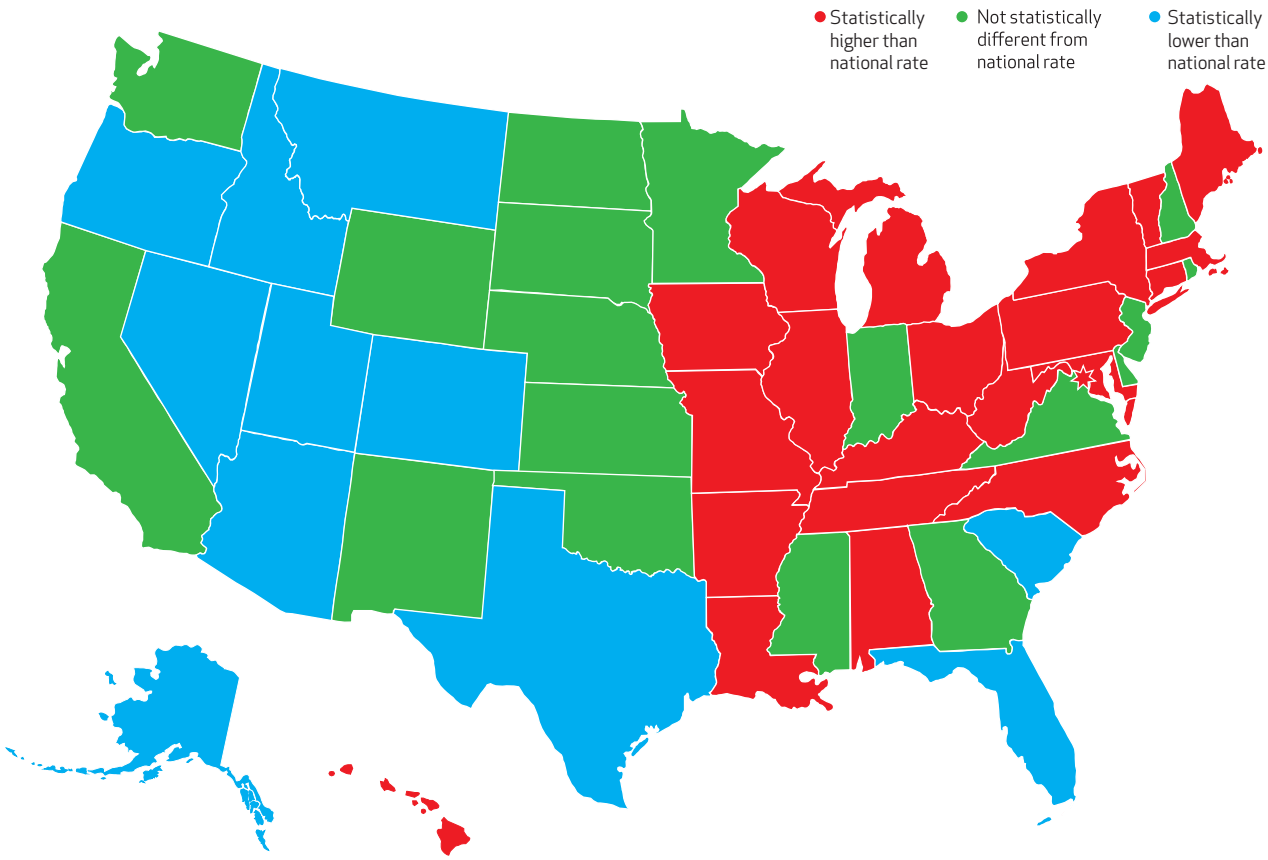
As seen in Exhibit 6, the remaining eligible uninsured children were heterogeneous along a number of different dimensions. For example, 39.1 percent were Hispanic; 36.9 percent were white; 15.8 percent were black; and the remaining 8.2 percent included Asian/Pacific Islanders, American Indian/Alaska Natives, and children in the "other/multiple race" category.

In addition, although the majority did not live in households that received food stamps, Express Lane strategies that connect families who receive food stamps to Medicaid and CHIP coverage could help reduce uninsurance among the 15.4 percent of uninsured children who were eligible for Medicaid/CHIP and whose families did receive food stamps.

The participation patterns we found at the national level generally also appeared in the ten states with the largest number of eligible uninsured children. In other words, we generally found lower participation rates for adolescents and higher-income children; for children who had no parents who were citizens or spoke En-

EXHIBIT 4

Children's Participation In Medicaid And The Children's Health Insurance Program (CHIP), By State, 2008



SOURCE Authors' analysis using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey. **NOTES** Estimates reflect an adjustment for the underreporting of Medicaid/CHIP coverage on the survey. The national participation rate in 2008 was 81.8 percent. Statistical significance denotes difference from the national percentage at $p < 0.10$ level.

glish; and for those without phone access (see Appendix Exhibits A.3–A.12).[19] In contrast, the composition of eligible uninsured children appeared to vary across states, particularly with respect to race and ethnicity, citizenship status, and language.

Discussion

These new estimates suggest that as of 2008, nearly five million uninsured children were eligible for but not enrolled in Medicaid/CHIP. To achieve the goal of reaching and enrolling all of these children, as set forth by the HHS secretary, progress is needed in all states. However, it is not clear how much higher participation can be in the states that already have rates greater than 90 percent, given the dynamic nature of family circumstances and eligibility for public coverage.

Absent increases in Medicaid/CHIP participation in the ten states that account for 61 percent of all eligible uninsured children, there would still be close to three million uninsured children nationally who are eligible for Medicaid/CHIP even if the remaining forty states were able to achieve participation rates close to 100 percent. Moreover, because California, Florida, and Texas together account for 1.8 million of the total eligible uninsured children, increasing participation in those three states will be critical to reaching the national goal.

POLICY IMPLICATIONS These estimates indicate that outreach efforts and policy reforms aimed at improving eligibility, enrollment, and retention processes will need to reach children of different ages, incomes, races, ethnic groups, and primary language, given the diversity of the remaining eligible uninsured population. At the same time, however, targeted enrollment, retention, and outreach efforts may be needed for children in particular subgroups who constitute a disproportionate share of the eligible uninsured children nationally and in individual states.

Research suggests that some policies are par-

EXHIBIT 5

Rates Of Children's Participation In Medicaid And The Children's Health Insurance Program (CHIP), By Census Region and Division, 2008

	Medicaid/CHIP participation rate	
Region or division	**Percent**	**90% CI**
United States	81.8	81.6–82.1
Northeast region	87.7*	87.2–88.1
New England division[a]	90.6*	89.7–91.5
Middle Atlantic division[b]	86.8*	86.2–87.4
Midwest region	85.3*	84.8–85.8
East North Central division[c]	86.1*	85.5–86.7
West North Central division[d]	83.2*	82.3–84.2
South region	79.8*	79.4–80.2
South Atlantic division[e]	78.9*	78.3–79.6
East South Central division[f]	85.7*	85.0–86.4
West South Central division[g]	78.3[a]	77.7–78.9
West region	78.8*	78.3–79.3
Mountain division[h]	72.4*	71.3–73.4
Pacific division[j]	81.4	80.8–82.0

SOURCE Authors' analysis using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey. **NOTES** Estimates reflect an adjustment for the underreporting of Medicaid/CHIP coverage on the survey. Statistical significance denotes difference from the national percentage. CI is confidence interval. [a] CT, ME, MA, NH, RI, VT. [b] NJ, NY, PA. [c] IN, IL, MI, OH, WI. [d] IA, KS, MN, MO, NE, ND, SD. [e] DE, DC, FL, GA, MD, NC, SC, VA, WV. [f] AL, KY, MS, TN. [g] AR, LA, OK, TX. [h] AZ, CO, ID, MT, NM, NV, UT, WY. [j] AK, CA, HI, OR, WA. *$p < 0.10$

ticularly promising, such as using income tax data or data from other means-tested programs to automatically qualify children for Medicaid and CHIP, which could reach the vast majority of eligible uninsured children.[30,31]

As indicated above, the estimated national Medicaid/CHIP participation rate is 81.8 percent for children. Our data indicate that ten states have participation rates very close to or above 90 percent. Because these states constitute a diverse group in terms of their size, income distribution, racial and ethnic composition, and region, it seems clear that high participation rates can be achieved across a range of different circumstances.

The data raise questions about the underlying reasons for the observed state-level variation in participation rates. For example, it is not obvious why so many western states, particularly those in the Census Bureau's Mountain division, have participation rates in the lowest quintile, or why such a large share of New England states have rates in the top quintile.

QUESTIONS FOR FURTHER RESEARCH Two related questions need more research. First, we need to understand how much of the variation in participation across states can be explained by differences in the characteristics of states related to such factors as population density, per capita income, political culture, racial or ethnic composition, and access to employer coverage. Second, we need to know how much is related to specific state policies regarding Medicaid/CHIP income eligibility thresholds for both children and their parents; Medicaid and CHIP outreach efforts; and eligibility determination, enrollment, and retention. Analysis that is in process could shed light on the reasons why participation rates vary so much both within and across states.

STUDY LIMITATIONS Our analysis has a number of limitations. First, despite our attempts to produce reliable coverage estimates with the American Community Survey, there still may be measurement errors, which could introduce bias into our estimates of eligible uninsured children and the participation rates at the national, state, within-state, and subgroup levels.

Although our national estimates match closely those derived from other surveys, targeted methodological research on the American Community Survey coverage estimates would provide much more certainty about our adjustments and a better understanding of the response patterns, particularly with respect to the underreporting of Medicaid/CHIP coverage. Such research could involve a number of steps, including matches of the survey to Medicaid and CHIP enrollment records, more cognitive testing to understand how low-income families and respondents with low educational attainment or whose primary language is not English interpret the coverage categories included on the survey.

Also needed are thorough follow-up surveys

EXHIBIT 6

Rates Of Children's Participation In Medicaid And The Children's Health Insurance Program (CHIP) And The Distribution Of Eligible Uninsured Children, By Child And Household Characteristics, 2008

Characteristic	Medicaid/CHIP participation rate (%)	Distribution of eligible uninsured children	
		Percent	90% CI
Total	81.8	100.0	
AGE (YEARS)			
0–5	85.5*	30.1	29.6–30.6
6–12	82.6*	33.5	33.0–33.9
13–18[a]	75.9	36.4	35.8–37.0
ETHNICITY OR RACE			
Hispanic	78.8*	39.1	38.4–39.8
White[a]	81.8	36.9	36.2–37.7
Black/African American	86.8*	15.8	15.2–16.3
Asian/Pacific Islander	79.4*	3.2	3.0–3.3
American Indian/Alaskan Native	68.0*	2.2	2.1–2.4
Other/multiple races	86.7*	2.8	2.6–3.0
CITIZENSHIP STATUS			
Citizen child with no citizen parents	78.5*	17.3	16.7–17.8
Citizen child with citizen parents[a]	83.6	65.9	65.2–66.5
Noncitizen child	69.1*	4.6	4.3–4.8
Child not living with parents	76.6*	12.3	11.9–12.7
ENGLISH-SPEAKING PARENT IN HOME			
At least one[a]	83.1	73.5	72.9–74.0
None	77.2*	14.2	13.8–14.7
Child not living with parents	76.6*	12.3	11.9–12.7
FAMILY INCOME (AS PERCENT OF POVERTY)			
0–132%[a]	84.2	63.4	62.7–64.2
133%–199%	76.0*	25.8	25.1–26.6
200% or more	73.5*	10.7	10.3–11.2
HOUSEHOLD RECEIVES FOOD STAMPS			
No	72.9*	84.6	84.0–85.1
Yes[a]	93.5	15.4	14.9–16.0
ACCESS TO PHONE IN HOME			
No[a]	72.9	5.3	4.9–5.7
Yes	82.2*	94.7	94.3–95.1

SOURCE Authors' analysis using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model, based on data from the 2008 American Community Survey. **NOTES** Estimates reflect an adjustment for the underreporting of Medicaid/CHIP coverage on the survey. Statistical significance denotes difference from the reference group in each category. Cumulative percentages might not total 100 because of rounding. See Appendix Exhibit A.2 for the confidence intervals of the estimates provided (the Appendix can be accessed by clicking the Appendix link in the box to the right of the article online). Family income is defined in terms of the child's health insurance unit. [a]Reference group. *$p < 0.10$

with a sample of families who reported on the survey that their children had either no coverage, employer-sponsored insurance, or nongroup coverage but who appear to be enrolled in Medicaid or CHIP based on other information provided on the survey. It may be particularly important to examine these factors in states where there is a larger apparent gap between the survey's totals of children in Medicaid/CHIP and the enrollment totals from administrative data.

Second, our eligibility simulation also has measurement error, particularly with respect to noncitizen children, which could introduce bias as well. Third, estimates for smaller states (such as North Dakota, Vermont, and Wyoming) and the District of Columbia are less precise because of the relatively smaller samples available for them in the public use files. It will be important to assess how robust these estimates are, using the full sample, additional analyses, and another year of data.

RECENT LEGISLATIVE CHANGES Our analysis pertains to 2008, before CHIPRA was enacted. Since then, a number of important changes have occurred that could affect the estimates. In particular, a number of states have expanded eligibility for public coverage or introduced policies aimed at increasing enrollment and re-

tention in Medicaid and CHIP. These actions should increase enrollment levels nationally but have differential effects across states.

ECONOMIC EFFECTS Moreover, the economy has worsened, a fact that is likely to have increased the number of children who are eligible for Medicaid and CHIP. More information will be available on how coverage patterns are changing once the new Current Population Survey and American Community Survey are released in the fall of 2010.

CONCLUSION Whether states can develop and maintain momentum around increasing Medicaid/CHIP participation among children in the coming years will be critical to determining the extent of progress. In the short term, a key issue relates to current state budget problems. Without strong economic growth, states may be reluctant to seek aggressively to increase enrollment among eligible children in the near term, or even to maintain recent coverage improvements. The recently enacted extension of enhanced federal Medicaid matching rates through the first half of 2011 may encourage states to implement new policies or maintain existing policies aimed at increasing Medicaid/CHIP participation among children.

Although questions remain about the future of CHIP and state capacity issues, the combination of policies to be implemented under the Affordable Care Act should increase participation in Medicaid and CHIP among children who are eligible but not enrolled. These policies include the increased funding for streamlined enrollment, renewal, and outreach; the Medicaid expansion to parents; and the individual mandate for both adults and children to obtain coverage. The American Community Survey will provide an invaluable tool for monitoring progress at both the state and local levels as national health reform is implemented.[32] ■

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NOTES

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