

Medicaid/CHIP Participation Among Children and Parents

Timely Analysis of Immediate Health Policy Issues

December 2012

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Summary

Despite the economic downturn, most states have maintained and even improved children's eligibility for Medicaid and the Children's Health Insurance Program (CHIP) by expanding eligibility to additional groups of children, improving enrollment and retention systems, and implementing new policy options available under the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA). Income eligibility for children is relatively high: the median threshold is now 250 percent of the Federal Poverty Level (FPL), which is much higher than it is for parents. Using the 2008–2010 American Community Survey (ACS), this analysis suggests that both eligibility and participation increased for children over this time period,

with participation reaching nearly 86 percent nationally in 2010 and increasing among most subgroups and states. As a result, the number of eligible uninsured children declined, reaching 4.4 million in 2010. In contrast, participation rates were lower for parents, both nationally and in every state, though states that had relatively higher/lower participation rates among children were more likely to also have relatively higher/lower participation rates among parents. This analysis suggests that CHIPRA may have contributed to increased take-up of Medicaid/CHIP among children, but that additional efforts will be needed, particularly among parents, to achieve high levels of Medicaid enrollment under the Affordable Care Act (ACA).

Introduction

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 included a number of provisions aimed at increasing participation in both Medicaid and the Children's Health Insurance Program (CHIP) among uninsured children. In recent years, almost all states have maintained or improved their Medicaid/CHIP enrollment processes for children, despite the economic downturn and the attendant pressures on state budgets. Between 2008 and 2010, a third of states expanded Medicaid/CHIP eligibility for children, either by expanding to higher income levels or covering new groups of immigrant children. Currently, the median eligibility threshold for children is 250 percent of the Federal Poverty Level (FPL).¹

CHIPRA funded outreach efforts, offered new tools to boost participation, and encouraged simplifications in enrollment systems. It included grants to state agencies and non-governmental organizations for outreach and

permitted states to adopt express lane eligibility (ELE) policies for children, working through the Supplemental Nutrition Assistance Program (SNAP), school lunch programs, the tax system, and other programs to identify and enroll participants who could be eligible for Medicaid/CHIP; as of April 2012, nine states have implemented the new ELE option for children in Medicaid or CHIP.² Application and renewal processes have been streamlined, and efforts have been made to use technology more efficiently and effectively. For example, fully 44 states have adopted the CHIPRA option to verify citizenship using electronic data matches with Social Security Administration data.³ To encourage these efforts, CHIPRA authorized bonus payments to states that achieve certain enrollment targets for children and that adopt at least five of eight administrative policies,⁴ with larger awards for states with larger enrollment increases. Thus far, 23 states have received bonus payments totaling over \$500 million.⁵ Furthermore, in 2010, Secretary

Sebelius of the U.S. Department of Health and Human Services issued the *Connecting Kids to Coverage Challenge*, encouraging efforts to enroll more eligible children among a variety of organizations.⁶

The Affordable Care Act (ACA) includes a number of provisions that affect the health insurance coverage available to children and their families. Under the ACA, states must meet Maintenance of Effort (MOE) requirements that prohibit them from making policy changes in Medicaid and CHIP that might make securing coverage more difficult.⁷ States also have the option of expanding Medicaid to more parents and other adults.⁸

In contrast to children, eligibility for nondisabled, nonpregnant parents is much more restrictive—currently, just 18 states provide comprehensive Medicaid to parents at or above the FPL, while 33 states have thresholds below this level, with 17 of these only covering parents at 50 percent of FPL or lower.⁹ States have also made fewer policy



changes to simplify enrollment and renewal procedures for parents than for children: for instance, half of states have asset limits for parents, compared with only five states with asset limits for children, and more states request income documentation or interviews at application or renewal for parents than for children.¹⁰

This brief extends other research that has assessed participation among children and adults.¹¹ We present the most up-to-date participation estimates available for children and assess how they vary across states and across subgroups of children. We examine how participation, eligibility, and uninsurance have changed among children between 2008 and 2010 and assess the number of uninsured children who are eligible for Medicaid or CHIP, but not enrolled. In addition, we examine participation rates among children and parents, both nationally and at the state level, and we examine how children's and parents' participation are related across states. The analysis uses data from the 2008, 2009, and 2010 ACS, which includes a public use sample of approximately 700,000 children and over 600,000 parents each year, and which began measuring health insurance coverage in 2008.

The following section provides information on the ACS and the methods underlying the analysis; subsequent sections present results and discuss the policy implications of the findings.

Data and Methods

Data Source. The ACS is an annual survey fielded continuously over a 12-month period by the United States Census Bureau.¹² 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—52.7 percent of the civilian non-institutionalized sample was completed by mail in 2009 (Mach and O'Hara forthcoming), with follow-up by telephone interviews for initial non-responders and by in-person

interviews for a subsample of remaining non-responders.¹³ The reported household response rate in 2009 was 98 percent nationally, ranging from 94.9 percent in the District of Columbia to 99.4 percent in Indiana and Wisconsin (U.S. Census Bureau 2009).¹⁴ We use an augmented version of the public use sample of the ACS prepared by the University of Minnesota Population Center—the Integrated Public Use Microdata Series (IPUMS)—because it has more complete relationship data.¹⁵ The estimates presented here focus on children age 18 and under in the civilian non-institutionalized population (including college students in dorms and a small number of other children living in group quarters, such as outpatient treatment facilities) and parents, who are defined as civilian non-institutionalized adults age 19 to 64 living with a biological, adoptive, or step child under the age of 18.

In 2008, a question was added to the ACS to ask the respondent about coverage of each individual in the household in 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 (by 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 age 65 or 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 [Department of Veterans Affairs] (including those who have ever used or enrolled for VA health care);
- g. Indian Health Service; or
- h. Any other type of health insurance or health coverage plan—specify.

The uninsured are identified on the survey as those not having coverage under categories a through f (including those recoded from the write-in

option, category h) who are also not classified as having coverage based on other information collected on the survey.¹⁶ Since the data are collected continuously over a 12-month period, the coverage estimates represent an average day in the calendar year.

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 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) by Dubay and Cook.¹⁷ The model simulates income-eligibility for comprehensive Medicaid and CHIP coverage 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 of 2008, 2009, and 2010.¹⁸ Eligibility for either Medicaid or CHIP is presented in a single category as “Medicaid/CHIP eligible.” Eligibility for CHIP coverage reflects potential eligibility based on income and does not take into account waiting periods or other anti-crowd out provisions that may apply to children with employer-sponsored coverage. For non-citizen children and parents, the model also takes into account length of United States residency in states where this is a factor in eligibility determination. Overall, our estimates of eligibility line up well with those from a similar model using the CPS ASEC, despite differences between the surveys.¹⁹ Among parents, additional analysis examines the share possibly eligible for Medicaid coverage under the ACA in 2014, including those who are currently eligible for Medicaid and those who are not currently eligible but meet the immigration requirements for coverage and have modified adjusted gross income (or MAGI, the income definition that will be used under the ACA) that is below 138 percent of FPL.²⁰

The 2008 and 2009 estimates contained in this report were derived using a slightly different methodology than was applied in our prior analyses.²¹ The combined effect of these methodological

changes resulted in only small impacts on our national participation and eligible, but uninsured estimates.²²

We define participation rates as the ratio of Medicaid/CHIP-eligible enrolled children/parents to Medicaid/CHIP-eligible enrolled children/parents plus Medicaid/CHIP-eligible uninsured children/parents. We exclude from these counts people with both Medicaid/CHIP and employer/union-based, military, or private nongroup coverage and those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Since the rates for parents are more sensitive to alternative methodologies than those for children, we also assessed how the patterns vary for parents when we include those with Medicaid/CHIP coverage who do not have a known eligibility pathway. Estimates for children are presented nationally and by census region, age, presence of English-speaking parents, family income, race/ethnicity, and citizenship status. Estimates for children and parents are also presented by state, combining the 2009 and 2010 estimates for better precision.

Statistical Analyses and Limitations.

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, and only differences that are statistically significant at the .10 level or less are discussed.

The major limitation of our analysis relates to measurement error inherent in simulating eligibility for public coverage based on survey data, particularly for adults, related to misreporting of income, insurance coverage, or other information used to model eligibility, and lack of specific information needed to simulate all

the pathways to eligibility. Modeling eligibility for adults is harder than for children because the eligibility rules for adults are more complex. The ACS, like many other surveys, does not contain information on such factors as pregnancy status, legal disability status,²³ income disregards related to child support, whether custodial parents meet child support cooperation requirements, medical spending used to calculate spend-down for medically needy eligibility, and duration of Medicaid enrollment or income history to determine Transitional Medical Assistance (TMA) and related eligibility. There is also more ambiguity in simulating eligibility for adults as some states offer Medicaid coverage for adults that is less comprehensive in scope than full Medicaid benefits, and survey respondents may report coverage for limited services such as family planning. As a consequence, while there is potential measurement error in our estimates for both children and parents, the estimates for parents are likely to have higher levels of error.

Results

Changes in Eligibility and Participation Among Children.

Between 2008 and 2010, the share of children meeting the eligibility requirements for Medicaid or CHIP based on their family incomes rose by an estimated 5.7 percentage points from 53.0 percent to 58.7 percent (Table 1).²⁴ As a consequence, the number of potentially eligible children increased by over 4.5 million (data not shown). This increase was due to a combination of the downward shift in the income distribution due to the economic downturn and the expansion of Medicaid/CHIP programs in a number

of states. Over this time period, the share of children with incomes below 200 percent of FPL increased from 47 percent to 52 percent and the share with incomes above 400 percent of FPL decreased from 25 percent to 23 percent (data not shown). Meanwhile, a third of the states expanded their Medicaid/CHIP programs for children, either by raising their income eligibility thresholds or by offering coverage to new groups of legal immigrant children.²⁵

At the same time that the number of eligible children was increasing, children’s Medicaid/CHIP participation rose, increasing by 4.2 percentage points nationally between 2008 and 2010. The Medicaid/CHIP participation rate among children was 81.7 percent in 2008, 84.3 percent in 2009, and 85.8 percent in 2010.

Medicaid/CHIP Participation Among Subgroups of Children. In 2010, participation rates varied across subgroups of children (Table 2). For instance, adolescents (ages 13 to 18) participated at lower rates than younger children (under 80% among adolescents, compared with 86.7% for children ages six through 12, and 89.9% for children under six). Participation was also lower for children not living with their parents (77.4%) or with no English-speaking parents in the home (80.5%) than for those with at least one English-speaking parent (88.1%). Eligible children with family incomes above 200 percent of FPL participated at lower rates than those with lower family incomes. There was also variation across racial/ethnic subgroups and citizenship groups, with low rates of 74.0 percent among eligible American Indians/Alaskan Natives and 84.1 percent among Hispanics, compared with a rate of 90.5 percent among eligible black children and a

Table 1: Rates of Eligibility and Participation Among Children Nationwide, 2008–10

	2008	2009	2010
Eligibility Rate for Medicaid/CHIP	53.0%	56.5%**	58.7%** ##
Medicaid/CHIP Participation Rate	81.7%	84.3%**	85.8%** ##

Source: Analysis of 2008, 2009, and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. **(*) indicates estimate is statistically different from prior year estimate at the 0.05 (0.1) level. ##(##) indicates 2010 estimate is statistically different from 2008 estimate at the 0.05 (0.1) level.

Table 2: Medicaid/CHIP Participation Among Children, by Characteristic, 2008 and 2010

	2008	2010	Percentage Point Difference
	Rate	Rate	
Total	81.7%	85.8%	4.2%**
Age			
0 to 5 [^]	85.6%	89.9%	4.3%**
6 to 12	82.4%**	86.7%**	4.3%**
13 to 18	75.5%**	79.5%**	4.1%**
English-Speaking Parent in Home			
At Least One [^]	84.3%	88.1%	3.8%**
None	75.6%**	80.5%**	5.0%**
Child Not Living with Parents	72.3%**	77.4%**	5.1%**
Income (As Percent of Poverty)			
0-132% [^]	82.9%	86.5%	3.6%**
133-199%	78.7%**	85.1%**	6.4%**
200+%	75.5%**	80.7%**	5.3%**
Ethnicity or Race			
Hispanic [^]	78.8%	84.1%	5.3%**
White	81.4%**	85.1%**	3.7%**
Black or African American	86.8%**	90.5%**	3.6%**
Asian/Pacific Islander	79.2%	83.9%	4.7%**
American Indian/Alaskan Native	68.4%**	74.0%**	5.6%**
Other/Multiple	86.4%**	88.5%**	2.1%**
Citizenship Status			
Citizen Child with No Citizen Parents [^]	78.5%	85.0%	6.4%**
Citizen Child with At Least One Citizen Parent	83.3%**	86.9%**	3.6%**
Citizen Child Not Living with Parents	75.5%**	80.7%**	5.3%**
Non-Citizen Child	78.5%	80.0%**	1.5%
Census Region			
Northeast [^]	87.8%	90.5%	2.7%**
Midwest	85.0%**	87.7%**	2.7%**
South	79.7%**	84.9%**	5.2%**
West	78.6%**	83.2%**	4.6%**

Source: Analysis of 2008 and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. [^] Denotes reference category within group. **(*) indicates estimate is statistically different from the reference category at the 0.05 (0.1) level. ++(+)- indicates difference estimate is statistically different from zero at the 0.05 (0.1) level. Estimates may not add up due to rounding. Income is defined as gross income among the health insurance unit (HIU) as a percentage of poverty.

rate of 80.0 percent among non-citizen children compared with rates of 85.0 percent among citizen children with no citizen parents and 86.9 percent among citizen children with at least one citizen parent. Regional differences were also evident, with the with rates ranging from 83.2 percent in the West to 90.5 percent in the Northeast.

With the exception of non-citizen children, who comprise a small share of eligible children, statistically significant increases in Medicaid/CHIP participation were observed between 2008 and 2010 for children in each age, language, income, race/ethnicity, and region group shown in Table 2.²⁶ There was a general narrowing of differences in participation rates across these groups—for example, although Hispanic and American Indian/Alaska Native children had lower participation rates than other children in 2010, they experienced larger increases in participation rates

over the period compared to other children, with increases of 5.3 and 5.6 percentage points between 2008 and 2010, respectively, narrowing differences in participation across racial/ethnic groups. Differences between citizen children with and without citizen parents also narrowed over this period, but participation rates remained slightly lower for citizen children with non-citizen parents. Likewise, participation rates increased by 4.6 and 5.2 percentage points for children living in the West and South, the regions with lower participation rates in 2008, compared to increases of 2.7 percentage points for children in the Northeast and Midwest regions. The participation rate for adolescents (ages 13–18) increased by approximately 4 percentage points (rising from 75.5% in 2008 to 79.5% in 2010), but remained below the participation rates of younger children.

Medicaid/CHIP Participation Rates Among Children by State. In 2010, 14 states (Arkansas, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Louisiana, Maine, Massachusetts, Michigan, New York, Tennessee, Vermont and West Virginia) had Medicaid/CHIP participation rates of 90.0 percent or higher (Table 3).²⁷ In contrast, six states (Colorado, Idaho, Montana, Nevada, Texas and Utah) had participation rates below 80 percent. Nevada, with a participation rate of 67.3 percent, remained substantially below the other states in terms of its Medicaid/CHIP participation rate; the next lowest participation rates were found in Montana and Utah, at 74.3 percent each.²⁸

Between 2008 and 2010, there were statistically significant increases in Medicaid/CHIP participation rates in 36 states. Several states saw increases close to or over 10 percentage points,

Table 3: Children’s Medicaid/CHIP Participation, by State, 2008 and 2010

	2008	2010	Percentage Point Difference
	Rate	Rate	
United States	81.7%	85.8%	4.2%⁺⁺
Alabama	85.4% ^{**}	89.4% ^{**}	4.1% ⁺⁺
Alaska	70.4% ^{**}	82.0%	11.6% ⁺⁺
Arizona	76.3% ^{**}	80.6% ^{**}	4.3% ⁺⁺
Arkansas	87.8% ^{**}	92.4% ^{**}	4.6% ⁺⁺
California	81.4%	84.8% ^{**}	3.4% ⁺⁺
Colorado	69.3% ^{**}	78.7% ^{**}	9.4% ⁺⁺
Connecticut	85.8% ^{**}	93.0% ^{**}	7.2% ⁺⁺
Delaware	81.2%	91.6% ^{**}	10.5% ⁺⁺
District of Columbia	95.6% ^{**}	97.2% ^{**}	1.6%
Florida	69.8% ^{**}	80.7% ^{**}	10.9% ⁺⁺
Georgia	81.0%	84.3% ^{**}	3.3% ⁺⁺
Hawaii	91.5% ^{**}	90.0% ^{**}	-1.4%
Idaho	73.6% ^{**}	79.9% ^{**}	6.4% ⁺⁺
Illinois	88.0% ^{**}	90.4% ^{**}	2.3% ⁺⁺
Indiana	78.5% ^{**}	81.9% ^{**}	3.4% ⁺⁺
Iowa	85.9% ^{**}	89.4% ^{**}	3.6% ⁺
Kansas	81.4%	82.8% ^{**}	1.3%
Kentucky	89.5% ^{**}	89.4% ^{**}	-0.1%
Louisiana	88.3% ^{**}	91.8% ^{**}	3.4% ⁺⁺
Maine	91.0% ^{**}	92.7% ^{**}	1.7%
Maryland	86.3% ^{**}	89.2% ^{**}	2.9% ⁺⁺
Massachusetts	95.0% ^{**}	96.5% ^{**}	1.5% ⁺⁺
Michigan	89.6% ^{**}	92.0% ^{**}	2.4% ⁺⁺
Minnesota	81.3%	82.5% ^{**}	1.2%
Mississippi	81.4%	88.5% ^{**}	7.1% ⁺⁺
Missouri	85.3% ^{**}	86.2%	0.8%
Montana	67.9% ^{**}	74.3% ^{**}	6.4%
Nebraska	80.8%	88.5%	7.8% ⁺⁺
Nevada	56.1% ^{**}	67.3% ^{**}	11.2% ⁺⁺
New Hampshire	85.5%	88.0%	2.5%
New Jersey	82.4%	86.0%	3.7% ⁺⁺
New Mexico	81.6%	85.9%	4.3% ⁺⁺
New York	89.2% ^{**}	90.9% ^{**}	1.7% ⁺⁺
North Carolina	84.6% ^{**}	88.1% ^{**}	3.5% ⁺⁺
North Dakota	75.9%	81.4%	5.5%
Ohio	83.3% ^{**}	88.5% ^{**}	5.3% ⁺⁺
Oklahoma	81.2%	85.1%	3.9% ⁺⁺
Oregon	74.9% ^{**}	83.2% ^{**}	8.4% ⁺⁺
Pennsylvania	86.1% ^{**}	89.2% ^{**}	3.1% ⁺⁺
Rhode Island	85.1%	87.9%	2.8%
South Carolina	79.4% ^{**}	84.3%	4.9% ⁺⁺
South Dakota	83.2%	84.1%	0.9%
Tennessee	86.3% ^{**}	90.7% ^{**}	4.4% ⁺⁺
Texas	74.6% ^{**}	79.7% ^{**}	5.1% ⁺⁺
Utah	65.8% ^{**}	74.3% ^{**}	8.5% ⁺⁺
Vermont	93.5% ^{**}	96.2% ^{**}	2.7%
Virginia	80.0% ^{**}	86.2%	6.2% ⁺⁺
Washington	82.5%	87.4% ^{**}	4.8% ⁺⁺
West Virginia	89.3% ^{**}	91.6% ^{**}	2.3%
Wisconsin	86.2% ^{**}	87.0%	0.8%
Wyoming	76.4%	87.7%	11.3% ⁺⁺

Source: Analysis of 2009/2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. ^{**}(*) indicates estimate is statistically different from national estimate at the 0.05 (0.1) level. ⁺⁺(+) indicates difference estimate is statistically different from zero at the 0.05 (0.1) level. Estimates may not add up due to rounding.

and 14 states had increases of over 5 percentage points. No state had a statistically significant decline in its Medicaid/CHIP participation rate for children between 2008 and 2010 (Table 3). Moreover, many of the states that experienced small or no changes in their participation rate, such as the District of Columbia and Massachusetts, already had participation rates above 90 percent. (Appendix Table 1 provides 95% confidence intervals for the participation estimates in Table 3.)

Changes in Uninsurance Among Children. The increased participation in Medicaid/CHIP was associated with a reduction in uninsurance among children eligible for Medicaid/CHIP (Table 4). The uninsured rate among eligible children declined by 2.3 percentage points between 2008 and 2010, from 11.7 percent to 9.4 percent, while the uninsured rate for the entire child population fell by about half that much, declining from 9.2 percent to 8.0 percent.

The joint effect of the increases in Medicaid/CHIP participation and the declines in uninsurance among eligible

children was to reduce the number of eligible but uninsured children by 10 percent between 2008 and 2010 (Table 4). The number of uninsured children who were eligible for Medicaid/CHIP fell from 4.9 million in 2008 to 4.4 million in 2010, with declines of 300,000 between 2008 and 2009, and 200,000 between 2009 and 2010. Between 2008 and 2010, the number of uninsured children fell by almost 1 million overall, reaching 6.3 million in 2010. In 2010, about 70 percent of all uninsured children nationwide appeared to meet the income and immigration requirements for Medicaid/CHIP; this is an increase from an estimated 67 percent in 2008 and 68 percent in 2009, and is likely due to the expansions in eligibility and the downward shift in incomes over this period (data not shown).

Potential Medicaid Eligibility Among Parents of Uninsured Children. Of the 4.4 million Medicaid/CHIP eligible but uninsured children, approximately 1.8 million have an uninsured parent who could be eligible for Medicaid in 2014 because their income is below

138 percent of FPL and they meet the immigration requirements for Medicaid (data not shown). About half of these eligible but uninsured children have a parent who is currently eligible for Medicaid. Many of the remaining eligible but uninsured children have uninsured parents who could qualify for exchange subsidies under the ACA (data not shown). This indicates that a substantial share of currently eligible but uninsured children have uninsured parents who could also enroll in coverage, either under current rules or starting in 2014.

Distribution of Eligible Uninsured Children Across States. As in prior years, three large states accounted for almost 40 percent of the 4.4 million eligible but uninsured children in the nation in 2010: 15.2 percent live in California, 15.0 percent live in Texas and 7.9 percent live in Florida (Table 5). Altogether, 61 percent of the nation's uninsured children who are eligible for Medicaid or CHIP live in one of 10 large states (Arizona, California, Florida, Georgia, Illinois, Indiana, New York, North Carolina, Ohio and

Table 4: Uninsurance Among All Children and Among Children Who are Eligible for Medicaid/CHIP, 2008–10

	2008	2009	2010
Total Number of Uninsured (1000s)	7,210	6,663**	6,254** ##
Total Number of Eligible but Uninsured (1000s)	4,865	4,559**	4,356** ##
Uninsured Rate Among All Children	9.2%	8.4%**	8.0%** ##
Uninsured Rate Among Medicaid/CHIP-Eligible Children	11.7%	10.2%**	9.4%** ##

Source: Analysis of 2008, 2009, and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. **(*) indicates estimate is statistically different from prior year (as defined in the column header) estimate at the 0.05 (0.1) level. ##(##) indicates 2010 estimate is statistically different from 2008 estimate at the 0.05 (0.1) level.

Table 5: 10 States with Largest Number of Children Eligible for Medicaid/CHIP but Uninsured, by State, 2008 and 2010

	2008			2010			Difference
	Count (1,000s)	Share	Cum. Share	Count (1,000s)	Share	Cum. Share	Count (1,000s)
United States	4,865			4,356			-510**
California	723	14.9%	14.9%	660	15.2%	15.2%	-63**
Texas	719	14.8%	29.7%	654	15.0%	30.2%	-66**
Florida	451	9.3%	38.9%	344	7.9%	38.1%	-107**
Georgia	195	4.0%	42.9%	176	4.0%	42.1%	-19*
New York	173	3.6%	46.5%	174	4.0%	46.1%	1
Arizona	161	3.3%	49.8%	141	3.2%	49.3%	-19**
Illinois	136	2.8%	52.6%	127	2.9%	52.3%	-9
Indiana	119	2.4%	55.0%	120	2.8%	55.0%	1
North Carolina	129	2.6%	57.7%	120	2.8%	57.8%	-9
Ohio	141	2.9%	60.6%	117	2.7%	60.5%	-25**

Source: Analysis of 2008 and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. ++(+/-) indicates difference estimate is statistically different from zero at the 0.05 (0.1) level. Estimates may not add up due to rounding.

Texas). Among these 10 states, Arizona, California, Florida, Georgia, Indiana, and Texas had participation rates that were below the national average in 2010; Arizona, Florida, Indiana, and Texas were in the lowest quintile in terms of state-level participation, with participation rates of 80.6, 80.7, 81.9, and 79.7 percent, respectively. (Appendix Table 2 provides estimates for 2009/2010 of the number of eligible but uninsured children in all 50 states.)

Together, these 10 states contributed to over 60 percent of the total decline in the number of children who were eligible for Medicaid/CHIP coverage but not enrolled between 2008 and 2010. Six of the 10 states experienced statistically significant decreases in the total number of eligible but uninsured children. Florida's total decreased by 107,000, and California and Texas each had declines of over 60,000; these three states accounted for over 45 percent of the national decline in number of eligible but uninsured children between 2008 and 2010.

Medicaid Participation Rates Among Parents by State. Nationwide, the average Medicaid participation rate among parents for 2009/2010 was 65.6 percent, 20 percentage points lower than the comparable rate for children over the same period (Table 6).²⁹ Children participate at higher rates than parents in each state, though the differential between parents and children varies from under 8 percentage points in the District of Columbia, Massachusetts and Wisconsin, to over 30 percentage points in Alabama, Arkansas, Georgia, Idaho, Kansas, Louisiana, Maryland, Montana, Nebraska, Oklahoma, Oregon, Wyoming and Texas.

Participation rates for parents and children tend to vary across states in the same direction, meaning high/low participation for children is generally associated with high/low participation among parents—their estimated correlation coefficient is 0.71, indicating a relatively strong positive relationship. Six of the 10 states (Connecticut, Delaware, the District of Columbia,

Maine, Massachusetts and Vermont) in the top quintile with respect to Medicaid/CHIP participation rates for children also are in the top quintile in terms of Medicaid/CHIP participation among adults—these states all have Medicaid eligibility levels for parents above the FPL, higher than the typical state, which could indicate a positive relationship between higher eligibility levels and participation rates.

Meanwhile, five of the 10 states in the bottom quintile of participation rates for children are also in the bottom quintile of participation rates for parents (Florida, Montana, Nevada, Texas and Utah). There are some exceptions to this pattern: for example, some of the southern states that have made substantial improvements in enrolling children have high rates for children but low rates for parents. For example, Arkansas, Alabama, and Louisiana all have participation rates in 2009/2010 above 90 percent for children, but below 60 percent for adults. The opposite relationship occurs in Arizona, which is in the bottom quintile in terms of its Medicaid/CHIP participation rate for children, but in the second-highest quintile for its Medicaid/CHIP participation rates for parents.

Consistent with their lower participation rates, over one in four (26.5 %) Medicaid-eligible parents is uninsured compared to less than one in 10 Medicaid/CHIP-eligible children in 2009/2010 (data not shown). Fully eight states (Florida, Georgia, Idaho, Montana, Nevada, Oklahoma, Texas and Wyoming) have uninsured rates among Medicaid eligible parents of over 40 percent and another 17 states have uninsured rates among eligible parents above 30 percent. As is the case for children, uninsurance among eligible parents is strongly inversely related to their levels of participation in Medicaid at the state level (i.e., the correlation coefficient is -.96 between those two measures for parents across states, meaning high state levels of participation are strongly related to low levels of uninsurance among eligibles).

Conclusions

This analysis shows that Medicaid and CHIP programs made noticeable progress reducing uninsurance among eligible children between 2008 and 2010. Improvements in Medicaid/CHIP participation were broad, occurring in states in all four regions and for children of different ages, racial and ethnic backgrounds, incomes and family immigration status. While it is not possible to attribute the improvements in Medicaid/CHIP participation found here solely to CHIPRA, it is likely that it was a contributing factor, given all the attendant investments and related policy changes aimed at increasing take-up of coverage among uninsured children who are eligible for Medicaid and CHIP.³⁰

While statistically significant improvements in Medicaid/CHIP participation rates were observed for children in 36 states, the declines in the number of eligible but uninsured children in the large states of California, Florida, and Texas accounted for almost half of the total decline nationwide. To achieve further improvements, the key will be to increase participation in Medicaid and CHIP, particularly for children in the states that contain a disproportionately large share of the nation's eligible but uninsured children and that have low participation rates by national standards.³¹

Since many eligible but uninsured children also have uninsured parents, policies that increase coverage among eligible parents could also be effective at reducing the number of uninsured children who are eligible for Medicaid or CHIP but not enrolled. Overall, approximately 1.8 million of the estimated 4.4 million eligible uninsured children had at least one parent with income below 138 percent of FPL who was eligible for Medicaid at the time of the survey or who could be eligible for expanded Medicaid coverage under the ACA. Given that parents must enroll their children in Medicaid/CHIP coverage in order to enroll themselves in Medicaid coverage

Table 6: Children and Parents' Participation, by State, 2009/2010

	Children			Parents			Percentage Point Difference
	Rank	Rate	95% CI	Rank	Rate	95% CI	
United States		85.1%	84.9% - 85.3%		65.6%	65.2% - 66.0%	-19.5%**
District of Columbia	1	97.3%**	95.8% - 98.7%	2	90.5%**	85.8% - 95.3%	-6.7%**
Massachusetts	2	96.1%**	95.5% - 96.7%	1	91.4%**	90.1% - 92.7%	-4.7%**
Vermont	3	94.4%**	92.0% - 96.8%	3	81.7%**	76.5% - 86.9%	-12.7%**
Arkansas	4	92.5%**	91.6% - 93.5%	39	56.5%**	51.9% - 61.1%	-36.0%**
Maine	5	91.9%**	90.0% - 93.8%	4	81.1%**	78.0% - 84.2%	-10.8%**
Michigan	6	91.8%**	91.0% - 92.6%	13	72.1%**	70.2% - 74.1%	-19.6%**
Connecticut	7	91.5%**	90.2% - 92.8%	9	76.1%**	73.7% - 78.5%	-15.4%**
Delaware	8	91.3%**	88.7% - 94.0%	8	78.7%**	72.8% - 84.5%	-12.7%**
West Virginia	9	90.9%**	89.2% - 92.6%	20	66.1%	60.9% - 71.2%	-24.9%**
New York	10	90.7%**	90.2% - 91.2%	12	74.7%**	73.6% - 75.9%	-16.0%**
Hawaii	11	90.7%**	88.7% - 92.6%	6	79.9%**	74.6% - 85.2%	-10.7%**
Illinois	12	90.6%**	89.9% - 91.4%	15	69.9%**	68.6% - 71.1%	-20.8%**
Louisiana	13	90.5%**	89.7% - 91.4%	32	58.7%**	55.5% - 62.0%	-31.8%**
Tennessee	14	90.3%**	89.4% - 91.1%	16	69.2%**	67.3% - 71.1%	-21.1%**
Kentucky	15	89.5%**	88.5% - 90.6%	30	59.7%**	57.0% - 62.4%	-29.8%**
Rhode Island	16	89.3%**	86.9% - 91.7%	7	78.8%**	75.0% - 82.5%	-10.6%**
Alabama	17	89.3%**	88.1% - 90.5%	38	57.0%**	53.6% - 60.5%	-32.3%**
Nebraska	18	89.2%**	87.1% - 91.3%	31	59.0%**	52.4% - 65.5%	-30.2%**
Maryland	19	89.0%**	88.0% - 90.0%	37	57.2%**	54.9% - 59.4%	-31.8%**
Pennsylvania	20	88.7%**	87.7% - 89.6%	11	74.8%**	72.9% - 76.7%	-13.9%**
Iowa	21	88.1%**	86.4% - 89.8%	17	67.9%	64.0% - 71.8%	-20.2%**
North Carolina	22	87.6%**	86.8% - 88.4%	23	64.8%	62.3% - 67.2%	-22.8%**
Wisconsin	23	87.6%**	86.3% - 88.9%	5	80.4%**	78.4% - 82.4%	-7.2%**
Ohio	24	87.3%**	86.4% - 88.2%	10	75.7%**	74.2% - 77.1%	-11.7%**
New Hampshire	25	87.3%	84.1% - 90.4%	29	61.3%	54.2% - 68.3%	-26.0%**
Mississippi	26	86.5%**	85.2% - 87.9%	36	57.4%**	54.1% - 60.6%	-29.1%**
Washington	27	86.4%**	85.5% - 87.3%	25	63.2%	60.1% - 66.3%	-23.2%**
New Mexico	28	85.5%	83.7% - 87.3%	33	58.5%**	53.9% - 63.1%	-27.0%**
Wyoming	29	85.4%	81.7% - 89.1%	49	42.9%**	32.3% - 53.5%	-42.5%**
Missouri	30	85.1%	83.9% - 86.3%	18	66.8%	64.0% - 69.6%	-18.3%**
New Jersey	31	85.0%	84.1% - 85.9%	21	65.7%	63.4% - 68.0%	-19.3%**
Virginia	32	84.8%	83.6% - 86.0%	27	62.4%**	59.3% - 65.4%	-22.4%**
California	33	84.4%**	83.9% - 84.8%	26	63.1%**	62.2% - 64.0%	-21.3%**
Oklahoma	34	84.2%	82.8% - 85.6%	48	43.9%**	40.8% - 47.0%	-40.3%**
South Dakota	35	84.2%	80.1% - 88.4%	35	58.2%*	50.1% - 66.3%	-26.0%**
South Carolina	36	83.8%**	82.5% - 85.1%	40	55.9%**	53.5% - 58.3%	-27.9%**
Georgia	37	83.2%**	82.2% - 84.1%	45	47.3%**	45.0% - 49.5%	-35.9%**
Kansas	38	82.4%**	80.5% - 84.4%	44	51.7%**	45.7% - 57.7%	-30.7%**
Oregon	39	82.3%**	80.8% - 83.9%	24	64.4%	59.9% - 68.8%	-18.0%**
Idaho	40	81.6%**	79.3% - 83.9%	46	44.1%**	37.1% - 51.1%	-37.5%**
Minnesota	41	81.2%**	79.3% - 83.1%	14	70.7%**	68.2% - 73.2%	-10.5%**
Arizona	42	81.2%**	80.2% - 82.2%	19	66.4%	64.0% - 68.8%	-14.8%**
Indiana	43	80.9%**	79.7% - 82.2%	22	64.9%	62.3% - 67.5%	-16.0%**
Alaska	44	80.2%**	76.7% - 83.6%	28	61.7%	53.5% - 70.0%	-18.4%**
Colorado	45	79.4%**	78.0% - 80.8%	41	55.1%**	51.4% - 58.7%	-24.4%**
Florida	46	78.6%**	77.8% - 79.3%	43	52.0%**	50.4% - 53.7%	-26.5%**
North Dakota	47	78.3%**	72.9% - 83.7%	34	58.5%	49.0% - 68.0%	-19.8%**
Texas	48	77.8%**	77.3% - 78.3%	47	43.9%**	42.5% - 45.3%	-33.9%**
Montana	49	75.0%**	71.4% - 78.6%	51	40.9%**	33.6% - 48.2%	-34.1%**
Utah	50	74.8%**	72.2% - 77.4%	42	53.7%**	49.0% - 58.4%	-21.1%**
Nevada	51	64.7%**	62.3% - 67.1%	50	41.6%**	38.1% - 45.0%	-23.2%**

Source: Analysis of pooled 2009/2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. **(*) indicates estimate is statistically different from national estimate at the 0.05 (0.1) level. +(+)(+) indicates children's estimate and parents' estimate are statistically different at the 0.05 (0.1) level. Estimates may not add up due to rounding. Pearson correlation coefficient between state participation rates for children and adults is 0.7066.

under the ACA,³² outreach efforts that target low-income parents should reduce uninsurance among children. In addition, many of the remaining eligible but uninsured children have parents who will become eligible for subsidized exchange coverage under the ACA. This indicates an important potential route to increasing coverage among both children and parents, as parents seeking coverage for themselves could have a child who is also identified as eligible and could be enrolled, or vice versa. This could have important potential benefits for both groups; in particular, increased coverage among parents could have other positive effects on their families that could benefit their children's health and well-being.³³

This analysis has shown that Medicaid/CHIP participation rates for parents, while positively correlated with the rates found for children at the state level, are lower on average relative to the rates for children. Nationwide, over one in four parents who were eligible for Medicaid coverage were uninsured in the 2009/2010 period, and in eight states, the uninsured rate among Medicaid-eligible parents is over 40 percent. The participation differential between children and parents presents an opportunity for states to successfully reduce uninsurance rates among parents, given that nearly three-quarters of uninsured parents

who could be eligible for Medicaid in 2014 have a child who is already enrolled in Medicaid/CHIP.³⁴ This suggests that outreach efforts targeted at parents whose children are covered by Medicaid and CHIP could be an efficient mechanism for reducing uninsurance among low-income parents, with even greater potential payoff in 2014 for states that expand Medicaid coverage under the ACA. In addition, states may be able to achieve high rates of Medicaid participation among parents by adopting the strategies that have worked for children to the enrollment and retention procedures that are used for parents.³⁵

Other evidence suggests that uninsurance rates among children have continued to fall since 2010. Recent analysis using the 2009–11 ACS indicates that uninsurance among all children age 17 and under continued to decline between 2010 and 2011.³⁶ Furthermore, analysis of administrative data confirms that Medicaid/CHIP enrollment for children grew between mid-2010 and mid-2011, albeit at a slower rate than during the prior two years.³⁷

When fully implemented, the ACA is projected to reduce uninsurance among children and parents by 40 and 50 percent, respectively.³⁸ In both cases, the gains rely heavily on increased enrollment in Medicaid and CHIP coverage, particularly among

poor and near-poor families. Although eligibility for most children will not expand under the ACA, increased public attention toward health insurance coverage, new penalties for lacking coverage, additional improvements to enrollment systems, and other factors are likely to increase enrollment among already-eligible children. For parents, this so-called “welcome mat effect” will likely lead to increased enrollment among those already eligible even in states not implementing the Medicaid expansion or who already cover parents up to 138 percent of FPL.³⁹ This analysis suggests the importance of examining the role that state-level enrollment and retention policies are playing in shaping participation rates among children and parents, particularly in the states that have low participation rates for one or both groups.

As described above, our estimates, particularly as they pertain to parents, have a number of inherent limitations which raise concerns about the possibility of measurement error. However, we have confidence in our key findings—that participation rates have been rising among children, that participation rates among parents are lower than those among children, and that participation rates vary systematically across states for both children and parents—since they hold up under alternative methodological approaches.

Appendix Table 1: Children’s Medicaid/CHIP Participation, by State, 2008–2010

	2008		2009			2010			
	Rate	95% CI	Rate	95% CI	Test '08-'09	Rate	95% CI	Test '09-'10	Test '08-'10
United States	81.7%**	81.4% - 81.9%	84.3%**	84.1% - 84.6%	++	85.8%**	85.6% - 86.1%	++	++
Alabama	85.4%**	83.4% - 87.3%	89.1%**	87.6% - 90.6%	++	89.4%**	87.8% - 91.1%		++
Alaska	70.4%**	63.5% - 77.4%	78.3%**	72.7% - 84.0%	+	82.0%	76.7% - 87.3%		++
Arizona	76.3%**	74.3% - 78.2%	81.8%**	80.2% - 83.4%	++	80.6%**	79.3% - 81.9%		++
Arkansas	87.8%**	85.5% - 90.2%	92.6%**	91.2% - 94.1%	++	92.4%**	91.0% - 93.8%		++
California	81.4%	80.6% - 82.2%	83.9%	83.2% - 84.5%	++	84.8%**	84.3% - 85.4%	++	++
Colorado	69.3%**	65.8% - 72.7%	80.3%**	77.9% - 82.6%	++	78.7%**	76.5% - 80.9%		++
Connecticut	85.8%**	83.0% - 88.7%	89.8%**	87.7% - 91.9%	++	93.0%**	91.4% - 94.6%	++	++
Delaware	81.2%	74.2% - 88.1%	90.9%**	87.2% - 94.7%	++	91.6%**	87.5% - 95.8%		++
District of Columbia	95.6%**	93.0% - 98.2%	97.3%**	95.3% - 99.4%		97.2%**	95.5% - 99.0%		
Florida	69.8%**	68.5% - 71.1%	76.3%**	75.2% - 77.5%	++	80.7%**	79.7% - 81.7%	++	++
Georgia	81.0%	79.7% - 82.4%	82.0%**	80.9% - 83.1%		84.3%**	83.0% - 85.6%	++	++
Hawaii	91.5%**	88.4% - 94.5%	91.4%**	88.7% - 94.1%		90.0%**	86.8% - 93.3%		
Idaho	73.6%**	69.3% - 77.9%	83.5%	80.3% - 86.6%	++	79.9%**	76.6% - 83.3%		++
Illinois	88.0%**	86.8% - 89.2%	90.9%**	90.1% - 91.7%	++	90.4%**	89.2% - 91.5%		++
Indiana	78.5%**	76.3% - 80.7%	79.8%**	77.9% - 81.7%		81.9%**	80.4% - 83.5%	+	++
Iowa	85.9%**	82.6% - 89.1%	86.7%**	84.3% - 89.0%		89.4%**	87.3% - 91.6%	+	+
Kansas	81.4%	78.0% - 84.9%	82.0%	79.2% - 84.8%		82.8%**	80.0% - 85.6%		
Kentucky	89.5%**	87.8% - 91.2%	89.7%**	88.2% - 91.3%		89.4%**	87.8% - 90.9%		
Louisiana	88.3%**	86.6% - 90.0%	89.3%**	87.9% - 90.6%		91.8%**	90.7% - 92.9%	++	++
Maine	91.0%**	87.9% - 94.1%	91.1%**	88.2% - 93.9%		92.7%**	90.3% - 95.0%		
Maryland	86.3%**	84.4% - 88.2%	88.8%**	87.4% - 90.2%	++	89.2%**	87.8% - 90.5%		++
Massachusetts	95.0%**	93.8% - 96.2%	95.7%**	94.8% - 96.7%		96.5%**	95.8% - 97.2%		++
Michigan	89.6%**	88.4% - 90.9%	91.5%**	90.5% - 92.5%	++	92.0%**	90.8% - 93.2%		++
Minnesota	81.3%	78.5% - 84.1%	79.9%**	77.3% - 82.5%		82.5%**	79.8% - 85.2%		
Mississippi	81.4%	78.8% - 84.0%	84.4%	82.6% - 86.2%	+	88.5%**	86.7% - 90.2%	++	++
Missouri	85.3%**	83.7% - 87.0%	84.0%	82.1% - 85.9%		86.2%	84.5% - 87.8%	+	
Montana	67.9%**	62.2% - 73.6%	75.8%**	70.5% - 81.1%	++	74.3%**	68.6% - 80.0%		
Nebraska	80.8%	76.7% - 84.8%	89.9%**	87.0% - 92.8%	++	88.5%	85.3% - 91.8%		++
Nevada	56.1%**	51.6% - 60.5%	61.9%**	58.5% - 65.3%	++	67.3%**	64.0% - 70.5%	++	++
New Hampshire	85.5%	80.8% - 90.2%	86.5%	82.9% - 90.1%		88.0%	83.7% - 92.3%		
New Jersey	82.4%	80.8% - 84.0%	83.9%	82.4% - 85.4%		86.0%	84.7% - 87.4%	++	++
New Mexico	81.6%	79.0% - 84.2%	85.2%	82.9% - 87.4%	++	85.9%	83.6% - 88.2%		++
New York	89.2%**	88.3% - 90.0%	90.6%**	89.8% - 91.3%	++	90.9%**	90.1% - 91.6%		++
North Carolina	84.6%**	83.3% - 85.9%	87.0%**	85.8% - 88.3%	++	88.1%**	87.1% - 89.2%		++
North Dakota	75.9%	67.4% - 84.5%	74.6%**	65.9% - 83.4%		81.4%	74.7% - 88.1%		
Ohio	83.3%**	81.8% - 84.7%	86.0%**	84.6% - 87.5%	++	88.5%**	87.3% - 89.8%	++	++
Oklahoma	81.2%	79.2% - 83.2%	83.2%	81.0% - 85.5%		85.1%	83.3% - 87.0%		++
Oregon	74.9%**	71.5% - 78.3%	81.2%**	78.9% - 83.6%	++	83.2%**	81.1% - 85.3%		++
Pennsylvania	86.1%**	84.5% - 87.6%	88.1%**	86.6% - 89.6%	+	89.2%**	88.1% - 90.2%		++
Rhode Island	85.1%	80.0% - 90.2%	90.7%**	87.9% - 93.5%	+	87.9%	83.6% - 92.2%		
South Carolina	79.4%**	77.3% - 81.6%	83.3%	81.4% - 85.1%	++	84.3%	82.5% - 86.2%		++
South Dakota	83.2%	76.5% - 89.9%	84.3%	78.9% - 89.8%		84.1%	77.6% - 90.6%		
Tennessee	86.3%**	84.7% - 87.8%	89.9%**	88.7% - 91.0%	++	90.7%**	89.5% - 91.9%		++
Texas	74.6%**	73.7% - 75.4%	75.9%**	75.0% - 76.8%	++	79.7%**	78.9% - 80.4%	++	++
Utah	65.8%**	61.9% - 69.7%	75.5%**	72.0% - 79.0%	++	74.3%**	70.9% - 77.6%		++
Vermont	93.5%**	90.0% - 96.9%	92.4%**	87.9% - 96.8%		96.2%**	93.8% - 98.6%		
Virginia	80.0%**	78.3% - 81.6%	83.3%	81.6% - 85.0%	++	86.2%	84.6% - 87.8%	++	++
Washington	82.5%	80.4% - 84.6%	85.3%	83.9% - 86.8%	++	87.4%**	86.1% - 88.6%	++	++
West Virginia	89.3%**	86.8% - 91.8%	90.2%**	87.9% - 92.6%		91.6%**	89.4% - 93.8%		
Wisconsin	86.2%**	83.7% - 88.7%	88.2%**	86.4% - 90.0%		87.0%	85.3% - 88.8%		
Wyoming	76.4%	67.9% - 84.9%	82.7%	74.9% - 90.4%		87.7%	83.6% - 91.8%		++

Source: Analysis of 2008, 2009, and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. **(*) indicates estimate is statistically different from national estimate at the 0.05 (0.1) level. ++(+) indicates change across years is statistically different at the 0.05 (0.1) level. CI is confidence interval.

Appendix Table 2: Uninsurance Among Children Who are Eligible for Medicaid/CHIP Coverage, by State, 2009/2010

	2009/2010			
	Count (1,000s)	95% CI	Share	Cumulative Share
United States	4,457	4,391 - 4,523		
Texas	699	681 - 718	15.7%	15.7%
California	666	645 - 687	14.9%	30.6%
Florida	374	359 - 388	8.4%	39.0%
Georgia	185	174 - 196	4.2%	43.2%
New York	173	163 - 183	3.9%	47.0%
Arizona	137	129 - 145	3.1%	50.1%
Ohio	125	115 - 136	2.8%	52.9%
Illinois	122	112 - 131	2.7%	55.7%
North Carolina	120	111 - 128	2.7%	58.4%
Indiana	119	112 - 127	2.7%	61.0%
Pennsylvania	118	108 - 127	2.6%	63.7%
New Jersey	94	88 - 100	2.1%	65.8%
Washington	86	80 - 92	1.9%	67.7%
Missouri	85	78 - 92	1.9%	69.6%
Colorado	84	77 - 90	1.9%	71.5%
Nevada	82	75 - 89	1.8%	73.3%
South Carolina	77	71 - 83	1.7%	75.1%
Virginia	75	69 - 82	1.7%	76.8%
Michigan	72	65 - 80	1.6%	78.4%
Minnesota	69	61 - 77	1.5%	79.9%
Oklahoma	66	60 - 72	1.5%	81.4%
Tennessee	62	57 - 68	1.4%	82.8%
Oregon	59	53 - 64	1.3%	84.1%
Utah	57	51 - 63	1.3%	85.4%
Mississippi	56	50 - 62	1.3%	86.7%
Wisconsin	56	49 - 62	1.3%	87.9%
Alabama	55	48 - 61	1.2%	89.1%
Louisiana	54	48 - 59	1.2%	90.4%
Maryland	48	44 - 53	1.1%	91.4%
Kentucky	46	41 - 50	1.0%	92.5%
Kansas	41	36 - 46	0.9%	93.4%
New Mexico	41	36 - 46	0.9%	94.3%
Iowa	29	25 - 33	0.7%	95.0%
Idaho	27	24 - 31	0.6%	95.6%
Arkansas	27	23 - 30	0.6%	96.2%
Montana	21	18 - 24	0.5%	96.6%
Connecticut	21	18 - 24	0.5%	97.1%
Massachusetts	16	13 - 18	0.4%	97.5%
Nebraska	16	13 - 19	0.4%	97.8%
West Virginia	15	12 - 18	0.3%	98.2%
Alaska	12	10 - 15	0.3%	98.4%
South Dakota	11	8 - 14	0.2%	98.7%
New Hampshire	10	8 - 13	0.2%	98.9%
Maine	9	7 - 11	0.2%	99.1%
Hawaii	8	7 - 10	0.2%	99.3%
Rhode Island	8	6 - 10	0.2%	99.5%
North Dakota	7	5 - 8	0.2%	99.6%
Delaware	6	4 - 8	0.1%	99.8%
Wyoming	6	4 - 7	0.1%	99.9%
Vermont	3	2 - 5	0.1%	100.0%
District of Columbia	2	1 - 2	0.0%	100.0%

Source: Analysis of pooled 2009/2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series.

Notes: See text for how eligibility, participation, and uninsurance are defined. Confidence intervals given at the 95%-level. CI is confidence interval.

Endnotes

- 1 See: Heberlein M, et al. 2012. "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011–2012." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/upload/8272.pdf>.
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- 3 Heberlein M, et al. "Performing Under Pressure."
- 4 The eight policies are continuous eligibility, liberalization of asset requirements, elimination of in-person interviews, same application and renewal forms, automatic renewal, presumptive eligibility, express lane eligibility, and premium assistance subsidies.
- 5 For ease of presentation, we treat the District of Columbia as a state. U.S. Department of Health and Human Services. "Connecting Kids to Coverage: Steady Growth, New Innovation." 2011 CHIPRA Annual Report, 2012. <http://www.insurekidsnow.gov/chipraannualreport.pdf>.
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- 11 Kenney G, Lynch V, Cook A and Phong S. "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs*, 29(10): 1920–29, 2010; Kenney G, Lynch V, Haley J, Huntress M, Resnick D, and Coyer C. "Gains for Children: Increased Participation in Medicaid and CHIP in 2009." Washington, DC: The Urban Institute, 2011; Kenney G, Lynch V, Haley J, and Huntress M. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry* 49(3): 231–253, 2012.
- 12 U.S. Census Bureau. "American Community Survey." <http://www.census.gov/acs/www/>.
- 13 Griffin D and Hughes T. "Mixed mode data collection in the American Community Survey." American Association of Public Opinion Research Conference Proceedings: May 13–16, 2010; Chicago, IL.
- 14 U.S. Census Bureau. "American Community Survey: How to Use the Data: Quality Measures." <http://www.census.gov/acs/www/UseData/sse/>.
- 15 Ruggles S, Alexander TJ, Genadek K, Goeken R, Schroeder M, and Sobek M, 2010. "Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]." Minneapolis: University of Minnesota.
- 16 While the ACS coverage estimates released by the Census Bureau are generally considered reliable and line up fairly well with those from other surveys, we developed a set of logical coverage edits that are applied if other information collected in the ACS implies that coverage for a sample case likely has been misclassified (Lynch V, Kenney G, Haley J, and Resnick D, 2011. "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits." Submitted to the U.S. Census Bureau.; Lynch V, and Kenney G, 2011. "Improving the American Community Survey for Studying Health Insurance Reform." Proceedings of the 10th Conference on Health Survey Research Methods, April 2011, Atlanta, GA. Hyattsville, MD.: Department of Health and Human Services.). We draw from approaches that have been applied to other surveys (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.) and build on ACS edit rules used by the Census Bureau (Lynch V, Boudreaux M, and Davern M, 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.). The edits bring the ACS estimates more closely aligned with distributions from other national surveys that are commonly used to measure health insurance coverage. For more details, see Kenney G, Lynch V, Haley J, Huntress M, Resnick D, and Coyer C. "Gains for Children: Increased Participation in Medicaid and CHIP in 2009." Washington, DC: Urban Institute and Robert Wood Johnson Foundation, 2011. <http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf70806>. See also: Turner J, Boudreaux M, and Lynch V. "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, 2009; Lynch V, Boudreaux M, and Davern M. "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, 2010; Kenney et al. 2012; Lynch et al. 2011; Kenney et al. 2011.
- 17 Dubay L and Cook A. "How Will the Uninsured be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009.
- 18 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. Family-level characteristics used in determining eligibility, such as income, are based on the family grouping that states use during the eligibility determination process. Our descriptive statistics for family-level characteristics are based on the person's health insurance unit (HIU), which is similar to the nuclear family and defined as the members of the family who are generally eligible for the same private health insurance plan. For children, the model compares family income and other characteristics to the Medicaid and CHIP thresholds in their state of residence. For parents, the model identifies eligibility for comprehensive Medicaid or Medicaid-equivalent benefits using state rules for major pathways for adults (Section 1931 programs, Section 1115 waivers, Supplemental Security Income [SSI] recipients, aged/blind disabled persons, medically needy adults, relative caretakers, and aged-out foster children) but does not include eligibility for more limited benefits such as federally- or state-funded programs that have benefit limits, higher cost sharing, or other limitations (Ross D, Horn A, Rudowitz R, and Marks C. "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, 2008; Heberlein, et al. 2011; Cohen Ross D, Jarlenski M, Artiga S, Marks C. "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, 2009; Kaiser Commission on Medicaid and the Uninsured. "New Options for States to Provide Federally Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women." Washington, DC, 2009; Kaiser Commission on Medicaid and the Uninsured; National Immigration Law Center. "Table: Medical Assistance Programs for Immigrants in Various States." 2010. <http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf>.

For non-citizen children and parents, the model also takes into account length of residency in the United States in states where this is a factor in eligibility determination. 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 used in the CPS. 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. "Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow." Washington, DC: Pew Hispanic Center, 2008). 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 (California, New York, New Jersey, Florida, Illinois, and Texas). Passel J and Cohen D. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center, 2008.

- 19 Kenney G, Lynch V, Cook A and Phong S. "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" Health Affairs, 2010. 29(10): 1920-1929.
- 20 The Medicaid eligibility threshold established under the ACA is 133 percent of FPL, to which a 5 percent disregard is applied; therefore, de facto, the Medicaid eligibility threshold under the ACA is 138 percent of FPL. Potential eligibility for expanded Medicaid under the ACA should be considered an upper bound, as it is not clear that all states will implement the Medicaid expansion in 2014. See: The Advisory Board Company. "Where each State Stands on ACA's Medicaid Expansion: A Roundup of What Each State's Leadership Has Said About Their Medicaid Plans." Last updated November 19, 2012. <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>.
- 21 In particular, because the 2009 Census Bureau ACS release contained logical edits for health insurance coverage whereas the original 2008 ACS release did not, we needed to develop new procedures for 2008 so that the editing would be as similar as possible 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 in turn 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 model in CPS and used more specific categories for imputation. 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.

- 22 In both instances, our estimate was that there were approximately 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.
- 23 States' determinations of disability-related eligibility use additional criteria than the indicators of functional limitations available on the ACS. Thus, some of the adults that appear in our model to be eligible through the disability pathway might not qualify when the more detailed information on their characteristics is taken into account.
- 24 As stated above, some of the children who are classified as eligible for CHIP coverage may not qualify because of waiting periods that are applied for children who have employer-sponsored coverage.
- 25 We applied the eligibility rules in place in the middle of each year. The following changes in Medicaid/CHIP eligibility thresholds from mid-2008 to mid-2009 were applied: in Indiana, eligibility increased 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 (see Kenney, G, et al. "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," 2011). The following changes in Medicaid/CHIP upper eligibility thresholds from mid-2009 to mid-2010 were applied: Alabama expanded from 200 percent to 300 percent of FPL in October 2009; Arizona instituted an enrollment freeze in its CHIP program in December 2009; Colorado expanded from 205 percent to 250 percent of FPL in May 2010; Kansas expanded from 200 percent to 250 percent of the 2008 FPL (approximately 241% of FPL) in January 2010; Montana expanded from 175 percent to 250 percent in October 2009; Nebraska expanded from 185 percent to 200 percent in September 2009; and Oregon expanded from 185 percent to 200 percent of FPL in October 2009 and from 200 percent to 300 percent of FPL in February 2010. In addition, Delaware, Iowa, Montana, New Mexico, North Carolina, Oregon, Rhode Island, Texas, and Wisconsin added coverage for legal immigrant children between 2009 and 2010 (Cohen Ross D, Jarlenski M, Artiga S, Marks C. "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, 2009; Heberlein M, Brooks T, Artiga S, and Stephens J. "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; 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).

- 26 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. See Kenney et al. 2011, endnote 11, for a discussion of the impact on estimates if IHS were reclassified as insurance coverage.
- 27 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.
- 28 In 2009 and 2010, uninsurance rates among children who are eligible for Medicaid or CHIP vary from 2.0 percent in DC to 22.7 percent in Nevada (data not shown). The correlation coefficient between state rates of uninsurance and state rates of participation is -.96, suggesting that uninsurance rates among eligibles are strongly associated with Medicaid/CHIP participation.
- 29 As discussed above, the complexity of measuring eligibility for parents results in participation rates being much more sensitive to the inclusion or exclusion of individuals with Medicaid/CHIP coverage with no modeled eligibility pathway; when we include those with Medicaid/CHIP coverage who do not have a known eligibility pathway, their participation rate rises to 75.1 percent. However, whether those individuals are included or excluded, participation rates for children are higher than those for parents nationally and in every state. For children, the alternative specification has less impact: the alternative participation rate for them is 86.5 percent, just 1.4 percentage points higher than the standard rate.

The standard definition is defined as: (eligible and has Medicaid)/(eligible and either has Medicaid or is uninsured). The alternative definition is defined as: (has Medicaid/(has Medicaid or is both eligible and uninsured). Under the alternative definition, participation rises from 65.6 percent to 75.1 percent nationally, a 9.6 percentage point change that is statistically significant at the 5 percent level. Every state experiences some sort of increase in participation rates under the alternative definition and is statistically significant at the 5 percent level in 43 of the 51 states, ranging from 1.3 percentage points in DC to 25.7 percentage points in Idaho. These differences tend to be much smaller in states that have high participation rates under the standard definition. None of the 10 states with the highest participation rates under the standard definition have a difference greater than the national average: the highest is a 5.9 percentage point increase in Ohio. Meanwhile, for the

10 states with the lowest participation rates under the standard definition, the percentage points increases are much greater, with the smallest being a 14.4 percentage point change in Oklahoma, which is still greater than the national average. When switching from the standard to the alternative definition for Medicaid/CHIP participation rates for parents, seven of the top 10 states remain in the top 10 under the alternative definition (Delaware, DC, Hawaii, Maine, Massachusetts, Vermont and Wisconsin), while seven of the bottom 10 states remain in the bottom 10 under the alternative definition (Georgia, Montana, Nevada, Oklahoma, Texas and Wyoming). When switching from the standard to the alternative definition for Medicaid/CHIP participation rates for the difference between children and parents, five of the top 10 states remain in the top 10 under the alternative definition (DC, Hawaii, Massachusetts, Ohio and Wisconsin), while six of the bottom 10 states remain in the bottom 10 under the alternative definition (Arkansas, Georgia, Maryland, Montana, Oklahoma and Wyoming).

³⁰ Department of Health and Human Services. "Connecting Kids to Coverage: Continuing the Progress." CHIPA Annual Report, 2010.

³¹ Also, coverage in Arizona for parents between 100 and 200 percent of FPL was eliminated in

October 2009 (Cohen Ross D, Jarlenski M, Artiga S, and Marks C. "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, 2009).

³² Patient Protection and Affordable Care Act (P.L. 111-148), Section 2001(a)(4)(A)(3).

³³ Golden O and Fortuny K. "Improving the Lives of Young Children: Meeting Parents' Health and Mental Health Needs through Medicaid and CHIP So Children Can Thrive." Washington, DC: Urban Institute, 2011. <http://www.urban.org/UploadedPDF/412315-Meeting-Parents-Health.pdf>; Loprest PJ, Zedlewski SR and Schaner SG. "Mental Health, Work and Mental Health Service Use among Low-Income Mothers." Washington, DC: Urban Institute, 2007. http://www.urban.org/UploadedPDF/411522_low_income_mothers.pdf.

³⁴ See Heberlein, Huntress, et al, 2012.

³⁵ Heberlein M, Brooks T, Artiga S, and Stephens J. "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, 2011.

³⁶ Alker J, Mancini T, and Heberlein M. "Uninsured Children 2009-2011: Charting the Nation's Progress." Georgetown University Health Policy Institute: Center for Children and Families, October 2012.

³⁷ Kaiser Commission on Medicaid and the Uninsured. 2012. "Medicaid Enrollment: June 2011 Data Snapshot." Kaiser Family Foundation Publication No. 8050-05. Available at: <http://www.kff.org/medicaid/upload/8050-05.pdf>; Kaiser Commission on Medicaid and the Uninsured. 2012. "CHIP Enrollment: June 2011 Data Snapshot." Kaiser Family Foundation Publication No. 7642-07. Available at: <http://www.kff.org/medicaid/upload/7642-07.pdf>.

³⁸ Kenney G, Buettgens M, Guyer J, and Heberlein M. "Improving Coverage for Children under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP." *Health Affairs*, 2011. 30(12): 2371-2381.

³⁹ Blewett L. "Medicaid Expansion: Out of the Woodwork or onto the Welcome Mat?" State Health Access Data Assistance Center Blog, October 12, 2012. Available at: <http://www.shadac.org/blog/medicaid-expansion-out-woodwork-or-welcome-mat>.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Genevieve M. Kenney is a senior fellow, Victoria Lynch and Jennifer Haley are research associates, and Michael Huntress and Nathaniel Anderson are research assistants in the Urban Institute's Health Policy Center. This research and the Urban Institute Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Eligibility Simulation Model were developed under a grant from the Robert Wood Johnson Foundation. The authors appreciate the helpful suggestions and comments of John Holahan, Joan Alker, Tricia Brooks, Martha Heberlein and Catherine Hess. We also thank Samantha Artiga and Martha Heberlein for their helpful advice on Medicaid/CHIP eligibility rules, Cheryl Camillo and Esther Regan for sharing their knowledge about how states determine eligibility, Jeff Passel for providing advice on modeling documentation status, Dean Resnick for modeling documentation status and other technical advice, and Christine Coyer for her work on compiling Medicaid and CHIP eligibility rules.

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