



Managing Medicaid Take-Up

Medicaid Enrollment Trends: 1995-2000

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Study Highlights

Enrollment of Low-Income Adults and Children Dropped After Welfare Reform Then Began to Increase in 1998

- ❖ After a low point in 1998, Medicaid enrollment of low-income adults and children began to increase in most of the 18 states in the study through 1999 and 2000, with six states experiencing over a 10% increase by 2000 in enrollment relative to 1995 levels. The states with higher enrollment were those that either made greater efforts to simplify their enrollment processes, provide outreach, or had significantly expanded eligibility usually as a result of CHIP. There was significant variation between states' increase or decrease in enrollment compared to 1995 — ranging from a 46% increase in Missouri to a 21% decline in Texas. The rate at which states enrolled the eligible or “take-up” rates, followed a similar pattern to enrollment, with drop-offs occurring in 1998 then recovering slightly, but not completely by 2000.

Children and Individuals Receiving Medicaid and No Cash Assistance Comprised a Much Larger Share of Enrollees in 2000 Than They Did Prior to Welfare Reform

- ❖ The proportion of individuals receiving Medicaid and no cash assistance increased significantly from approximately 44% of the enrolled population of low-income adults and children in 1995 to 71% in 2000. Five states experienced increases in enrollment for Medicaid-only eligible individuals in excess of 100%. Similarly, many states did better at enrolling children compared to adults — so much so that the proportion of children enrolled relative to adults rose from 67% in 1995 to 70% in 2000. Much of the increase came from states that enacted CHIP programs as a Medicaid expansion.

The Ability of States to Enroll Eligible Individuals Varied Among States But Did Not Change Significantly Over Time

- ❖ Even though several states significantly expanded eligibility and increased enrollment, only Maryland and Florida actually increased enrollment for low-income adult and children while also improving their “take-up” rate. Four states that expanded enrollment were actually less successful at enrolling eligible individuals while the majority of states remained consistent over time in their ability to enroll the eligible.

Introduction

Medicaid administrators and front-line workers have dealt with many challenges over the past decade to effectively implement the potentially conflicting directives contained in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), passed in 1996, and efforts to expand enrollment in public health insurance programs such as Medicaid and the Children’s Health Insurance Program (CHIP), which was passed in 1997 and implemented in most states the following year. Billed by President Clinton as “an end to welfare as we know it,” PRWORA encouraged states to devise methods for getting welfare recipients off public assistance programs and into the private work force. Aided by a strong economy, PRWORA’s implementation caused welfare caseloads to fall dramatically.

The implementation of welfare reform also had the largely unanticipated and unintended effect of causing Medicaid caseloads to fall as well among low-income adults and children who were the main target of welfare reform. Medicaid eligibility had historically been closely linked to welfare status, and many of the administrative processes and mechanisms for determining eligibility for Medicaid were managed through state and local welfare agencies. Many former welfare recipients and some welfare workers found the new relation-

ship between Medicaid and welfare complex and confusing, and many states lacked the administrative machinery to deal with large numbers of Medicaid enrollees who were no longer welfare recipients.

In response to these difficulties, the Health Care Financing Administration (HCFA — now known as the Center for Medicaid and Medicare Services, or CMS) undertook major efforts to reverse this decline in Medicaid enrollment and insure that former welfare recipients who continued to be eligible for Medicaid were in fact enrolled. With strong support from President Clinton and Secretary of Health and Human Services Donna Shalala, HCFA officials encouraged states to develop procedures and mechanisms for insuring that former welfare recipients who were eligible for Medicaid remained enrolled and that Medicaid enrollment processes were simplified and streamlined to make them easier for clients and workers to use. These efforts were given further impetus in late 1997 by the passage of CHIP, which allowed states to expand insurance coverage for children beyond the levels supported by Medicaid and provided support for states to undertake outreach and marketing campaigns to attract potentially eligible clients, particularly children, who might not otherwise apply for coverage.

To determine states’ responses to these initiatives, field researchers from The Nelson A.

<i>States Participating in the Study</i>	
<i>Arizona</i>	<i>Colorado</i>
<i>Florida</i>	<i>Georgia</i>
<i>Kansas</i>	<i>Maryland</i>
<i>Michigan</i>	<i>Missouri</i>
<i>New Jersey</i>	<i>New York*</i>
<i>Ohio</i>	<i>Oregon</i>
<i>Tennessee*</i>	<i>Texas</i>
<i>Utah</i>	<i>Washington</i>
<i>West Virginia</i>	<i>Wisconsin</i>

* By the time this report went to print, data were not available from these states.

Rockefeller Institute of Government of the State University of New York examined enrollment mechanisms, processes, and management of Medicaid and CHIP in eighteen states in 2001. The states examined, which are listed on page 2, are not a sample in any statistical sense, but they do present wide variation in Medicaid program features, political culture, economic conditions, and a variety of other factors which might be expected to affect Medicaid management and enrollment.

This report examines trends in Medicaid enrollment among low-income adults and children between 1995, the last year before the passage of welfare reform, and 2000, the last year for which complete enrollment data are available. It also examines Medicaid “take-up,” or states’ success in enrolling those who are eligible for Medicaid. Other reports in this series will examine how states organized, marketed, and implemented their Medicaid enrollment efforts for this population.

Findings on Medicaid Enrollment Trends, 1995-2000

Enrollment Drops After Welfare Reform but Recovers by 2000

Total Medicaid enrollment between 1995 and 2000 for the population of low-income adults and children most affected by welfare reform are presented in Table 1 for the sixteen states for which these data were available.¹ In broad terms, these figures indicate that aggregate Medicaid enrollment across all sixteen states fell moderately after the adoption of welfare reform in 1996, bottomed out in 1998, then grew at an increasing rate through 2000. Aggregate Medicaid enrollment in the study states in 2000 was slightly higher than 1995 enrollment levels. The aggregate increase in enrollment for 14 states from 1996-2000 was just over 1%.

More detailed analysis indicates considerable differences in enrollment trends between states. Ten of the sixteen states had higher Medicaid enrollments when including CHIP programs that were done as a Medicaid expansion in 2000 than in 1995 or 1996. Florida, Missouri, Maryland, Washington, and Michigan experienced enrollment growth in excess of ten percent. By contrast, enrollment fell by more than ten percent in Kansas, Ohio, Oregon, Texas, and West Virginia over this period.

While there are several causes of the wide disparity in enrollment growth, differences in the scale and timing of state administrative actions to publicize the availability of Medicaid and CHIP coverage and efforts to make Medicaid enrollment more accessible are unquestionably important determinants of these variations.² The implementation of welfare reform, which in many states was associated with an increased emphasis on work and reducing caseloads, initially caused administrative problems for many state Medicaid programs. Many clients, and even some eligibility workers, were confused about the Medicaid status of former welfare recipients, and eligibility processes frequently did not check for continued Medicaid eligibility when welfare cases were closed. In many states, large numbers of Medicaid-eligible recipients had Medicaid coverage mistakenly terminated when their welfare cases were closed. While almost all states had the ability to continue Medicaid coverage for former welfare recipients under a variety of guises, states varied widely in the speed with which they educated clients and workers about how to handle these situations and made the necessary changes to computer systems and other administrative processes to re-establish stable contact with a clientele that became less reliant on welfare. Many states also used this opportunity to significantly simplify their Medicaid application processes by eliminat-

1 The numbers in the table represent average monthly enrollment in the calendar year in question for nondisabled children and adults under 65, including those CHIP enrollees who were added as part of a Medicaid expansion, the medically needy, and any other separately recognized group, such as foster children, whose members are not disabled or elderly. Enrollment data for 1995 were not available for Colorado or Utah.

2 Forthcoming publications in this series will address in more detail the various administrative changes — outreach, enrollment simplification, systems changes, and the like — that are only briefly discussed here.

Table 1: Total Average Monthly Medicaid Enrollment 1995-2000

	1995	1996	1997	1998	1999	2000	1995-2000 % Change
*Missouri	417,177	411,126	391,492	420,938	524,247	610,357	46.31%
*Maryland	371,065	376,977	371,804	384,585	413,096	457,899	23.40%
Washington	502,439	533,992	557,890	543,282	537,747	603,225	20.06%
*Florida	1,093,648	1,042,612	948,987	923,885	1,042,800	1,243,289	13.68%
*Michigan	692,665	624,491	587,240	756,921	742,716	783,192	13.07%
^Utah	NA	157,100	146,700	158,200	164,500	167,300	6.49%
Georgia	840,286	871,996	921,741	905,547	897,496	880,020	4.73%
Arizona	368,863	381,312	361,328	301,664	324,483	379,823	2.97%
^Colorado	NA	176,150	168,422	160,234	165,353	180,314	2.36%
*New Jersey	478,015	472,864	450,072	427,085	422,748	484,107	1.27%
*Wisconsin	312,653	289,861	250,430	228,454	240,461	307,177	-1.75%
*West Virginia	188,224	188,741	198,863	177,612	174,774	167,245	-11.15%
Kansas	136,388	127,871	117,086	103,361	110,515	119,866	-12.11%
*Ohio	1,294,496	1,199,832	1,120,088	1,080,691	1,079,189	1,112,211	-14.08%
Oregon	340,675	316,784	293,995	286,321	288,350	282,909	-16.96%
*Texas	1,430,655	1,387,073	1,299,534	1,166,107	1,113,195	1,125,280	-21.35%

* Indicates states with Medicaid data that include CHIP enrollment, which was part of a Medicaid expansion.

^ Calculations are based on 1996 enrollment since data were not available for 1995.

ing requirements for face-to-face meetings and extensive documentation and verification of income and other items required to determine eligibility. States varied widely in the scale and timing of these efforts and the energy with which they pursued contacts with recipients and tried to connect Medicaid and CHIP eligibility processes. Some states “integrated” the eligibility processes for the two programs so that any application was evaluated for eligibility for both programs, while others kept eligibility determination processes for the two programs separate.

While other factors clearly affect Medicaid enrollment, there appears to be a rough correlation between enrollment growth and the timing and scale of state efforts to make enrollment more accessible. Of the six states which lost enrollment between 1995-96 and 2000, three — Texas, Ohio, and Wisconsin — did not adopt enrollment simplification measures until 2000 or later, and Oregon did not adopt any *major* simplification initiatives over this period. West Virginia and Kansas made more ag-

gressive attempts to increase access but not to the same degree as other states.

Enrollment of Children Increases at a Higher Rate than Adults

Given the emphasis on expanding eligibility and enrolling children, not surprisingly, enrollment of children began an upward trend after the enactment of SCHIP. The study findings, which counted children as those individuals under 19, show that states experienced the most growth in enrollment in 2000 when compared to 1995. Even though many states experienced increases in enrollment for children after the enactment of CHIP programs, the rate of growth varied considerably. For instance Georgia, New Jersey, Florida, Maryland, Missouri and Washington all experienced a 10% or more increase in children’s enrollment from 1995 to 2000. Conversely, by 2000 six states had not yet reached enrollment levels for children equal to those prior to welfare reform — although these states tended to be just shy of 2000 levels.

These states included Arizona, Ohio, Oregon, Texas, West Virginia and Wisconsin. Total enrollment for children in 15 states is shown in Table 2.

Clearly, implementation of CHIP programs — whether they were done as a Medicaid expansion, as a separate program or as both — impacted enrollment. Again, the degree to which states were impacted by enactment of the CHIP program varied. Many states implemented their CHIP programs early, such as Missouri, which was the first state in this study to have a CHIP program (which was done as a Medicaid expansion). States’ success also appeared to be dependent upon their emphasis on outreach. For instance, as a result of extensive outreach, Maryland exceeded their enrollment target by 50% during the first year of outreach efforts. Other states also undertook efforts to provide outreach to Medicaid eligible individuals as well. For instance, in 1998, before enactment of its CHIP program, Washington state had authorized \$4 million in enhanced federal funds with local matching funds to support community-based Medicaid out-

reach efforts by contracting with local agencies to enroll Medicaid eligible individuals. Such aggressive outreach campaigns were aided by CHIP’s implementation and were common among states that substantially increased enrollment.

Unlike Maryland and Missouri, other states did not implement their CHIP programs until 1999 or later. This was true of West Virginia, Texas, Kansas, and Washington. Enrollment in West Virginia’s CHIP program was so low that it became a concern for politicians after its first year of operation. The program was subsequently reformed. The states that implemented CHIP early saw huge increases in enrollment due to their outreach and enrollment simplification measures. By 2000, every state had a CHIP program in place. In order to analyze the impact of CHIP on enrollment of children overall, Table 3 compares the proportion of enrollment in 2000 of Medicaid, CHIP programs that were done as Medicaid expansions, and stand-alone CHIP programs.

Table 2: Average Monthly Medicaid Enrollment for Children 1995-2000

	1995	1996	1997	1998	1999	2000	1995-2000 % Change
Washington	354,749	NA	NA	NA	NA	467,576	31.80%
*Maryland	231,629	229,605	224,717	241,739	266,442	300,830	29.88%
*Missouri	318,105	321,690	317,246	330,839	364,875	394,020	23.86%
#*New Jersey	349,119	346,269	334,267	324,806	336,522	404,775	15.94%
Georgia	596,231	627,562	673,939	691,168	695,523	683,047	14.56%
*Florida	817,789	789,932	726,278	680,898	795,811	936,456	14.51%
^Colorado	NA	133,799	130,315	126,582	132,065	143,501	7.25%
*Michigan	623,296	602,531	605,865	615,182	624,277	650,505	4.37%
Kansas	100,891	96,859	90,802	83,220	92,551	101,421	0.53%
*# West Virginia	122,303	126,257	145,410	129,669	125,261	119,865	-1.99%
Arizona	271,889	269,487	250,235	222,954	234,133	261,994	-3.64%
*Wisconsin	219,719	207,663	186,222	174,234	177,235	207,527	-5.55%
*Ohio	655,450	618,546	570,345	561,343	574,308	591,627	-9.74%
Oregon	182,342	172,825	163,245	159,003	160,247	158,782	-12.92%
*Texas	1,143,106	1,123,215	1,052,874	961,433	936,287	948,087	-17.06%
# Children were counted as individuals 20 and under. * Indicates states where Medicaid data includes CHIP as a Medicaid expansion. ^ Calculations for Colorado are based on enrollment data from 1996 since data were not available for 1995.							

Table 3: Composition of Children’s Enrollment by Program Type in 2000

<i>State</i>	<i>% Medicaid</i>	<i>% CHIP as a Medicaid Expansion</i>	<i>% CHIP Only</i>
Arizona	88.21%		11.79%
Florida	83.24%	14.28%	2.47%
Georgia	87.53%		12.47%
Kansas	85.44%		14.56%
Maryland	83.12%	16.88%	
Michigan	50.97%	46.35%	2.68%
Missouri	86.10%	13.90%	
Ohio	88.79%	11.21%	
Oregon	89.99%		10.01%
Texas	87.98%	2.13%	9.89%
Utah	90.20%		9.80%
Washington	99.64%		0.36%
West Virginia	95.93%	0.67%	3.40%
Wisconsin	89.03%	10.97%	

Note: Missing states did not have program specific data available in time for print.

Some of the states that implemented a separate CHIP program and CHIP as a Medicaid expansion saw significant increases in their enrollment — especially in the portion of the CHIP program that was done as a Medicaid expansion. This was most true in Michigan where 46% of enrollment in 2000 was due to the CHIP-Medicaid-expansion program. However, the opposite was true in West Virginia and Texas where the part of the CHIP program that was done as a Medicaid expansion comprised less than 3% of enrollment in 2000. Again, West Virginia and Texas implemented their CHIP programs and implemented enrollment simplification later than most states and this may account for the lower composition of enrollment via CHIP-expansions. Separate CHIP programs constituted anywhere from less than 1% of enrollment (Washington) to around 15% of enrollment (Kansas.) Again, Washington was later than most states to implement its CHIP program. For states that implemented only a CHIP as a Medicaid expansion program, enrollment in an expansion-type program tended to comprise a little over 10% of enrollment. Ohio, Florida, Wisconsin, Missouri, and Mary-

land’s Medicaid-expansion programs ranged from 11% of enrollment to about 17% of enrollment.

The spillover effect of implementing CHIP programs was noted by states as a way to increase enrollment in Medicaid. To analyze the degree to which CHIP implementation may have impacted children’s enrollment from 1998 until 2000, the degree to which enrollment increased is examined in more detail in Table 4.

Table 4 shows that nearly every state experienced gains in children’s enrollment after 1998 when CHIP programs that were done as Medicaid expansions and separate CHIP programs were counted with regular Medicaid’s enrollment totals. In fact, West Virginia was the only state in the study that did not experience an overall increase in children’s enrollment from 1998-2000. This may be explained by the initial difficulty the state experienced with getting its CHIP program off the ground. Some states such as Kansas, which experienced a sizable increase in children’s enrollment, did not necessarily see increases in overall enrollment when comparing 1995 to 2000 because adult enrollment dropped or because total enrollment dropped more significantly after welfare reform.

Table 4: Percent Change in Children’s Enrollment by Program Type 1998-2000

State	'00-'98 % Change in Children’s Enrollment — All Programs	'98-'00 % Change in Children’s Enrollment — Medicaid (Without Any CHIP)
Arizona	33.22%	17.51%
Florida	35.19%	17.95%
Georgia	12.91%	-1.17%
Kansas	42.64%	21.87%
Maryland	24.44%	5.32%
Michigan	7.94%	-14.12%
Missouri	33.52%	19.10%
New Jersey	42.34%	24.62%
Ohio	5.39%	-0.92%
Oregon	6.28%	-0.14%
Texas	9.44%	-0.80%
West Virginia	-2.09%	-7.56%
Wisconsin	19.11%	6.04%

Many states used the CHIP program to expand eligibility to unprecedented levels and to help identify individuals who were Medicaid eligible. Interestingly, when Medicaid enrollment is examined separately from CHIP, the degree to which “spillover” occurred varies among states. From this cursory analysis, New Jersey appears to have experienced the biggest spillover effect in its regular Medicaid program from CHIP with close to a 25% increase in regular Medicaid enrollment after 1998. Missouri, Florida, Kansas, and Arizona also appear to have experienced a sizable “spillover” effect from Medicaid. The size of the CHIP expansion may have impacted the degree to which the spillover effect occurred. Of the states in the study Missouri, Maryland, Ohio, and Washington all had eligibility levels for CHIP as a Medicaid expansion of 200% of FPL or greater. Some of the states that used a combination program or a separate CHIP program were equally as generous in terms of eligibility levels. In fact, eligibility for New Jersey’s CHIP program was recently raised to 350% of poverty while New York’s eligibility level for its separate CHIP program was raised to 250% FPL. Although it is difficult to tell whether there is a direct correlation between CHIP enrollment growth

and Medicaid enrollment growth, the timing of CHIP eligibility expansions certainly impacted enrollment in Medicaid because outreach and publicity for these programs helped identify individuals that were Medicaid eligible.

As noted earlier, many of the states where enrollment growth was low were seen as “latecomers” to the process of providing outreach and enrollment simplification for children. For instance, Ohio, Texas, and Wisconsin had not enacted significant changes to simplify enrollment until after most other states in the study. Similarly, West Virginia’s CHIP program was slow to get off the ground. CHIP outreach programs typically attracted interest and applications from children eligible for Medicaid. For instance, Washington attributed 60% of Medicaid enrollment to CHIP’s enactment. Colorado reported that one in every five individuals contacted for CHIP was Medicaid eligible. Even the methods for providing outreach varied considerably. For instance, New Jersey advertised the CHIP program at New Jersey Nets games while Maryland advertised the program on buses and commuter trains. Many states were similar in that they used schools or other community groups to advertise the program. The investment in

outreach and extent to which enrollment processes were simplified appeared to roughly correlate to the level of increase or decrease in child enrollment.

Adult enrollment followed a similar pattern to children’s enrollment, whereby it dropped after welfare reform and began to increase in 1999 after a low point in 1998. However, adult enrollment was not as robust as children’s enrollment most likely due to the emphasis placed on enrolling children. Again, patterns among states varied considerably. As can be seen in Table 5, Missouri, Colorado, Maryland, Florida, and Wisconsin were the only states in which adult enrollment was actually greater in 2000 than it was in 1995. Ironically, for Florida and Maryland, much of the increase in adult enrollment may have been the result of “spillover” from the huge outreach efforts to enroll children. In Wisconsin and Maryland, the increases in enrollment were likely due to sizable eligibility expansions that were implemented during the time period studied.

Comparing adult enrollment to children’s enrollment shows that the number of children enrolled

in the states studied in 2000 exceeded the number of children enrolled in 1995 while the opposite was true for adults. Only five states had higher levels of adult enrollment in 2000 when compared to 1995. Only two states, Missouri and Wisconsin experienced an increase in the proportion of adults that were enrolled when compared to the proportion of children that were enrolled. In aggregate, the proportion of children covered versus the proportion of adults changed from 67% in 1995 to 70% in 2000 while adults dropped from 33% to 30%, respectively. (Colorado was excluded from this proportional total because data were missing for 1995.)

The aggregate increase in the number of children enrolled in Medicaid relative to adults is captured in Figure 1. This figure shows that enrollment for both adults and children reached its lowest levels in 1998 before increasing. The increase in enrollment for children is slightly steeper than it is for adults after 1998.

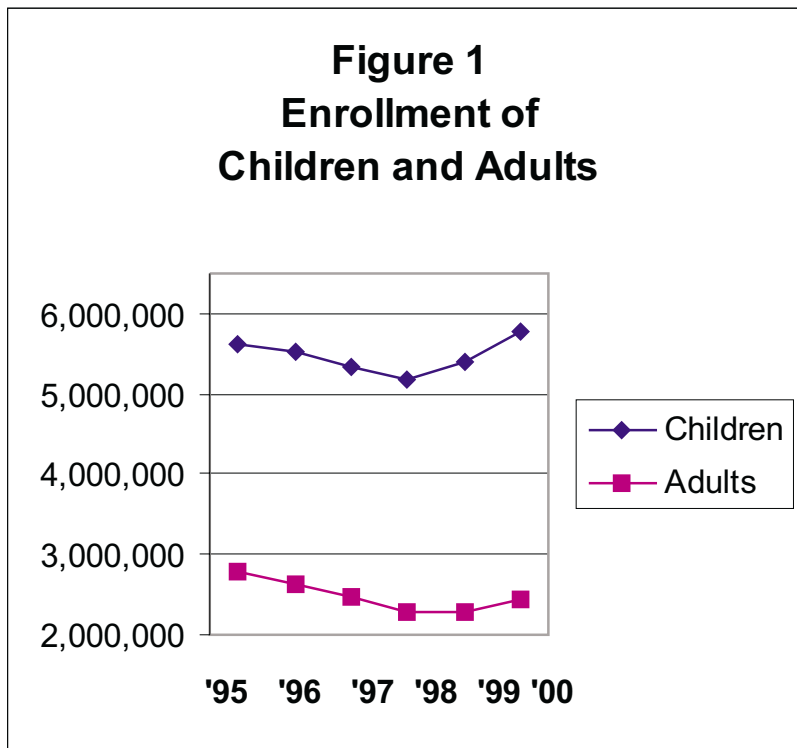
Totals include Medicaid and CHIP programs that were done as a Medicaid expansion. Figure 1

Table 5: Average Monthly Medicaid Enrollment for Adults, 1995-2000

	1995	1996	1997	1998	1999	2000	% Change
Missouri	99,072	89,437	75,297	78,199	113,617	152,704	54.13%
^Colorado	NA	42,351	38,107	33,652	33,288	36,813	13.07%
Maryland	139,437	147,372	147,086	142,845	146,654	157,059	12.64%
Florida	275,859	252,679	222,709	213,786	246,990	306,833	11.23%
Wisconsin	92,934	82,199	64,208	54,220	63,226	99,652	7.23%
Michigan	509,346	494,035	495,586	479,872	468,078	488,777	-4.04%
Washington	147,690	NA	NA	NA	NA	135,649	-8.15%
Arizona	96,974	111,825	111,093	78,710	75,365	82,798	-14.62%
Ohio	639,046	581,286	549,743	519,348	504,881	520,585	-18.54%
Georgia	244,055	244,434	247,802	214,379	201,973	196,973	-19.29%
Oregon	158,333	143,959	130,750	127,318	128,102	124,127	-21.60%
*West Virginia	65,921	62,484	53,453	47,943	49,513	47,380	-28.13%
Texas	287,549	263,858	246,660	204,674	176,908	177,193	-38.38%
*New Jersey	128,896	126,595	115,805	102,279	86,226	79,332	-38.45%
Kansas	35,497	31,013	26,184	20,141	17,964	18,445	-48.04%

* West Virginia and New Jersey’s data count adults as age 20 or older. Data delineating age categorizations was not available from Utah.

^ Calculations for Colorado are based on 1996 enrollment levels since data was not available for 1995.



excludes Colorado and Washington since data were missing for intervening years

The discrepancies between adult and child enrollment are not surprising given the emphasis on covering children after enactment of the Children’s Health Insurance Program. However, adult enrollment may increase if more states recognize that Medicaid can be used as a support for working uninsured adults. Under the Bush Administration’s Health Insurance Flexibility and Accountability (HIFA) Waiver, some states may attempt to increase adult enrollment. This is true in Arizona, which was the first state to expand eligibility for adults via a HIFA waiver. In addition, as states recognize the importance of increasing child enrollment by enrolling parents, more states may expand eligibility levels for adults while cutting back on optional services.

Enrollment of Medicaid Only Individuals Increases While Cash Recipients Decline

Not surprisingly, welfare reform caused many individuals who were also Medicaid eligible to lose this benefit as well. In fact, enrollment of individuals who were receiving both cash assistance and

Medicaid fell dramatically in every state in the study. Again, the degree to which enrollment of Medicaid individuals receiving cash assistance declined differed among states. Enrollment of individuals receiving cash and Medicaid and the percent change in enrollment from 1995-2000 is shown in Table 6.

Part of the sharp decline in cash recipients was due to the success of welfare reform. However, several states experienced “glitches” with their eligibility processes or had incorrectly designed computer systems that may have inadvertently caused individuals who were still eligible for Medicaid to lose this benefit when they lost cash assistance. This was true in Kansas where nearly 9,500 individuals had to be contacted to be re-certified for Medicaid enrollment after being incorrectly dropped. As a result, several states restructured their computer systems to automatically determine Medicaid eligibility. Unfortunately, reforms to eligibility took time to implement and so the drop in cash recipients who were also receiving Medicaid did not bottom out until 1998.

What is more interesting, however, is the degree to which Medicaid-only enrollment (meaning

Table 6: Average Monthly Enrollment for Individuals Receiving Cash Assistance and Medicaid 1995-2000

	1995	1996	1997	1998	1999	2000	% Change
Missouri	214,947	193,061	163,207	164,557	159,454	186,478	-13.24%
Washington	324,596	315,562	299,668	273,444	245,480	272,714	-15.98%
West Virginia	101,578	92,785	58,652	NA	77,746	67,871	-33.18%
Oregon	122,283	106,322	86,069	79,248	77,120	78,619	-35.71%
Ohio	535,435	490,737	384,375	319,657	284,047	296,597	-44.61%
Texas	789,365	718,046	640,842	509,647	423,331	406,673	-48.48%
Arizona	183,377	166,284	140,292	100,425	91,327	93,148	-49.20%
Maryland	240,533	224,366	206,860	171,240	134,934	116,761	-51.46%
New Jersey	302,218	275,045	232,699	181,444	145,011	130,011	-56.98%
Kansas	78,252	66,232	48,404	32,182	28,294	30,965	-60.43%
Michigan	524,487	448,816	391,642	281,453	216,565	185,677	-64.60%
^Colorado	NA	92,915	78,089	53,762	35,464	28,236	-69.61%
Wisconsin	202,447	156,087	107,166	70,909	57,355	56,238	-72.22%
Florida	582,206	529,364	399,259	249,710	180,229	139,717	-76.00%
Utah	NA	NA	52,190	49,207	44,497	NA	

^ Calculations are based on the percent change from 1996-2000 since data were not available for 1995.

those not receiving cash assistance) increased. As shown in Table 7, every state except Oregon experienced enrollment levels for non cash assistance Medicaid enrollment in 2000 that were greater than those in 1996. This growth was dramatic, with five states, including Florida, Maryland, Michigan, New Jersey and Wisconsin experiencing over a 100% increase in Medicaid-only (no cash) enrollment between 1995 and 2000.

When examining why certain states increased Medicaid-only enrollment significantly while other states did not, differences in program administration can be noted. For instance, Oregon implemented welfare reform at the state level prior to federal reform. This was not necessarily true of other states in the study, most of which de-linked eligibility for Medicaid and cash assistance when they implemented PRWORA.

Comparing Medicaid enrollment for individuals receiving cash assistance to those receiving only Medicaid shows the according decrease and increase in enrollment. As shown in Figure 2, sometime in 1997, enrollment of Medicaid-only individuals surpassed enrollment of individuals who were receiving Medicaid and cash assistance.

Looking at the total proportion of individuals who were receiving Medicaid-only versus cash assistance from 1995 to 2000 shows that Medicaid-only enrollment grew from 44% of total enrollment to 71% of total enrollment in 2000 while cash-assistance enrollees dropped from 56% of the total in 1995 to 29% in 2000.

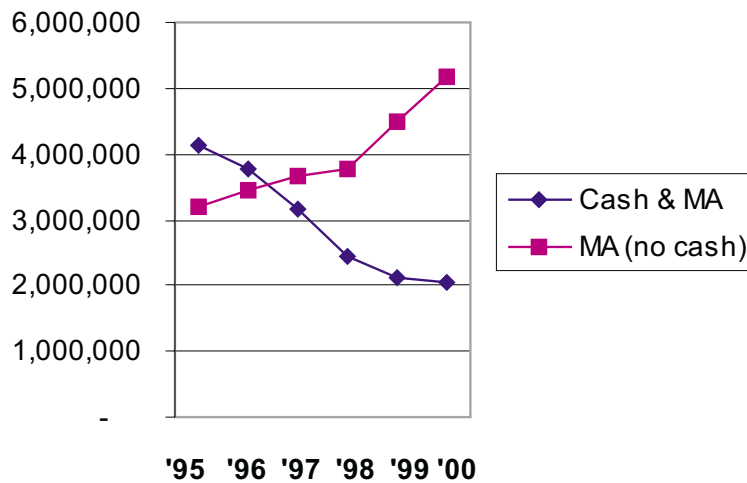
One of the biggest factors most likely contributing to the growth in Medicaid-only enrollment was the new emphasis on Medicaid as “vital support” for working uninsured individuals. In fact, many states expanded Medicaid eligibility for adults above pre-welfare levels. Other states implemented Medicaid “buy-in” programs that allowed individuals who began to work to pay a premium to maintain their Medicaid coverage. Missouri’s CHIP program, which was done as a Medicaid expansion, includes a “no-cost” CHIP expansion, a CHIP “co-pay” group and “CHIP premium” group – each of which requires a different level of financial commitment from the enrollee. The new approach to Medicaid as a support for working families as opposed to a welfare program continued after the time period studied. The degree to which states require cost-sharing varies consid-

Table 7: Average Monthly Medicaid-only (no cash) Enrollment, 1995-2000

	1995	1996	1997	1998	1999	2000	% Change
Maryland	130,533	152,611	164,942	213,345	278,163	341,137	161.34%
Wisconsin	110,206	133,774	143,264	157,545	183,106	250,939	127.70%
Florida	511,443	513,248	549,727	674,174	862,572	1,103,572	115.78%
Michigan	296,112	329,523	380,598	475,469	526,152	597,515	101.79%
New Jersey	175,797	197,819	217,373	245,641	277,737	354,096	101.42%
Washington	177,843	218,430	258,222	269,838	292,267	330,511	85.84%
^Colorado	NA	83,235	90,333	106,472	129,994	152,078	82.70%
Missouri	202,230	218,065	229,336	244,481	319,037	360,246	78.14%
Arizona	169,672	205,271	217,772	225,744	240,683	273,283	61.07%
Kansas	58,137	61,640	68,682	71,179	82,221	88,901	52.92%
West Virginia	176,052	191,076	239,734	NA	194,306	201,375	14.38%
Texas	641,290	669,027	658,692	656,460	689,864	718,607	12.06%
Ohio	342,699	350,343	345,021	339,383	341,408	345,411	0.79%
Oregon	218,392	210,461	207,925	207,073	211,230	204,290	-6.46%
Utah	NA	NA	80,984	84,251	89,076	NA	

^ Calculations for Colorado are based on the percent change from 1996-2000 since data were not available for 1995.

Figure 2: Aggregate Medicaid Enrollment 1995-2000, (Cash assistance vs. no-cash)



erably. As states continue to place emphasis on the Medicaid program as a support for individuals who return to work, the variability in states' program structures will likely continue.

Take-Up Rates Decline

Enrollment trends, while important measures of state progress, are only partial measures of the effectiveness of state programs in improving coverage of low-income adults and children. Perhaps more important is state success at “take up,” or actually enrolling the population which is eligible for Medicaid and CHIP. A variety of studies have shown that a large share of those low-income families and children without health insurance are eligible for either Medicaid or CHIP. Regardless of changes in enrollment, therefore, improvements in “take-up rates” — the percentage of those eligible for Medicaid who are actually enrolled — are perhaps better measures of state success at improving access to health insurance and reducing the number of the uninsured.

To examine these trends, take-up rates for individual states for the period 1995-2000 were created by dividing the average monthly enrollment for low-income adults and children (the data in Table 1) by estimates of the number of low-income adults and children eligible for Medicaid in each state developed with data from the Current Population Survey (CPS)³. For a more detailed description of the procedures used to develop these estimates,

see Craig W. Abbey “Estimating Medicaid Eligibility in Sixteen States: A Technical Report” (Rockefeller Institute of Government, forthcoming). While the CPS is widely used to estimate health insurance coverage and income, it has several well-known difficulties which can make its results difficult to interpret. Like all surveys, it has confidence intervals associated with each estimate of income, which can be quite large in smaller and medium-sized states.⁴ CPS estimates may also understate the number of Medicaid eligibles over the course of a year, since they only count as eligible those whose income is below the state income standard for the entire year. Those families or individuals whose incomes made them eligible for any part of the year are not counted as eligible. To minimize the consequences of these difficulties, take up rates are reported as “High” or “Low” compared to the distribution of take-up rates in 1995, the last full year before the adoption of welfare reform.⁵

The overall distribution of take-up rates from 1995-2000 is reported in Table 8. These results show the same broad pattern as the enrollment data. As measured here, take-up declined sharply between 1997 and 1998, then began to increase through 2000. By contrast with the enrollment trends, however, the proportion of states with “Low” take-up increased significantly, from about half in 1995 and 1996 to about two-thirds in 2000.⁶

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- 3 Briefly, data from the Current Population Survey (CPS) and state Medicaid income eligibility rules were used to produce an estimate of the eligible population in each state. The CPS provides data on age, family income, poverty thresholds (based on family structure), and weights. State Medicaid rules were used to determine if a family was income eligible for Medicaid. These rules were expressed as a percentage of the poverty threshold as compared to an individual's family income. If the individual's family income fell below the state's income eligibility level, the individual was counted as eligible. To improve the accuracy of the estimates, three years of CPS data were combined.
 - 4 The 90 percent confidence interval for the number of Medicaid eligibles in Colorado in 1996, for example, ranges from 225, 449 to 335, 823; a difference of over 50 percent.
 - 5 The median take-up rate for 1995 — approximately 75 percent — was used to divide states between “High” and “Low” categories for each year. A state with an estimated take-up rate of 60 percent in 1998, for example, would be classified as “Low” for that year. It should be remembered that the estimates of the number of Medicaid eligibles derived from the CPS understate the number of Medicaid eligibles over the course of a year, so the take-up rates calculated here overstate the actual take up rate.
 - 6 Enrollment and take-up data were not available for Colorado and Utah for 1995.

Table 8: States with High or Low Take-Up Rates Using 1995 as the Standard

	1995	1996	1997	1998	1999	2000
High	7	7	7	3	4	5
Low	7	9	9	13	12	11

Note: Take-up rates were not available in 1995 for Colorado or Utah.

The major reason for this decline in take-up is likely the significant expansions of Medicaid eligibility that occurred as a result of the passage of CHIP in 1997 and the implementation of several large waivers that expanded Medicaid eligibility for adults. Nine of the states in this study implemented at least part of their CHIP program as a Medicaid expansion, which expanded, in some cases significantly, the number of children eligible for Medicaid. In addition, four states were granted waivers that allowed them to expand the number of adults who were Medicaid eligible. These eligibility expansions, which were frequently sizeable, added more eligibles than states were able to enroll in the short run, thus causing take-up rates to decline.

A more detailed picture is provided in Table 9, which lists how states compared to each other with their relative take-up rates over this period. Four distinct groups of states can be identified. Three states — Georgia, Utah, and West Virginia — had high take-up rates over the entire period, both before and after welfare reform. All three had formal or informal efforts in place prior to welfare reform to encourage Medicaid enrollment, and there was less fall-off in enrollment after the adoption of welfare reform than in other states. Georgia, for example, had implemented outreach activities in 1993, which may have elevated its take-up rate and limited the decline in Medicaid enrollments after the implementation of welfare reform. Medicaid eligibility workers have been stationed outside welfare offices in hospitals and clinics for almost fifteen years. The state also automatically enrolls former welfare recipients into Transitional Medical Assistance without requiring an additional application. Utah also has a longstanding tradition of encouraging Medicaid enrollment. The state initiated a sizeable Medicaid outreach program in 1996 when welfare reform was implemented. While not for-

mally related to welfare reform, this program may have reduced the impact of welfare reform on Medicaid enrollment. Utah had also been operating its welfare program under a waiver approved in 1992 that had many of the same program features as the welfare reform legislation. Over half the state’s welfare caseload was covered by this waiver by 1996, which may have limited the number of clients affected by welfare reform and mitigated its potential effects on Medicaid enrollment.

Florida and Maryland demonstrate a second pattern. Both had low take-up rates before and immediately after the implementation of welfare reform, but invested sizeable resources in outreach and enrollment simplification after the passage of the CHIP program in 1997. Both implemented substantial portions of their CHIP programs as Medicaid expansions rather than as separate programs, and both experienced improvements in both enrollment and take-up rates, particularly among children.

A third group of states — Missouri, Ohio, Oregon, Washington, and New Jersey — experienced a decline in their relative take-up rates after the implementation of welfare reform and the passage of CHIP. All of these states except Washington received waivers to significantly expand Medicaid eligibility for adults over this period, so that each would have to increase enrollment substantially to maintain their take-up rate at its pre-waiver level. Both Missouri and New Jersey adopted aggressive outreach programs that produced sizeable increases in enrollment, while enrollment in Ohio and Oregon actually declined slightly. In all four cases, enrollment growth failed to keep pace with expanded eligibility, causing take-up rates to fall. Washington did not apply for a waiver to expand eligibility during the time period studied, and made little concerted effort to increase enrollment until 2000, when the threat of

Table 9: State Take-Up Levels, 1995-2000

<i>State</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Arizona	low	low	low	low	low	low
Colorado	NA	low	low	low	low	low
Florida	low	low	low	low	low	high
Georgia	high	high	high	high	high	high
Kansas	low	low	low	low	low	low
Maryland	low	low	low	low	high	high
Michigan	low	low	low	low	low	low
Missouri	high	high	high	low	low	low
New Jersey	high	high	high	low	low	low
New York	NA	NA	NA	NA	NA	NA
Ohio	high	high	high	low	low	low
Oregon	high	high	high	low	low	low
Tennessee	NA	NA	NA	NA	NA	NA
Texas	low	low	low	low	low	low
Utah	NA	high	high	high	high	high
Washington	high	low	low	low	low	low
West Virginia	high	high	high	high	high	high
Wisconsin	low	low	low	low	low	low

Note: NA indicates data were not available.

legal action from advocacy groups focused attention on enrollment issues.

The remaining six states had low take-up rates for the entire period under consideration. Low take-up in these states appears to be more a matter of low enrollment rather than large increases in the number of Medicaid eligibles.⁷ Total Medicaid enrollment as measured here declined in three states — Kansas, Texas, and Wisconsin — between 1995 and 2000, and enrollment in the other three states increased at a slower rate than in other states. Even enrollment among children, which grew substantially elsewhere, either declined or grew at a slower rate than elsewhere. Enrollment among children declined in Arizona, Texas, and Wisconsin; and

grew by less than ten percent in Colorado, Michigan, and Kansas.

While these differences in take-up rates across states reflect a number of factors, both differences in the number of Medicaid eligibles and in rates of enrollment growth are important determinants of differences in take-up. In addition to whatever differences in the number of Medicaid eligibles are due to differences in local economic conditions, some states significantly expanded the number of Medicaid eligibles by implementing CHIP as a Medicaid expansion rather than as a separate program and increasing the number of Medicaid eligible adults. In some states, these expansions were quite sizeable — in Missouri, for

7 Arizona voters passed a referendum (Proposition 204) significantly expanding family eligibility for Medicaid, but this referendum was passed in November 2000 and its implementation did not begin until 2001, after the field work for this study was concluded.

example, the number of Medicaid-eligible adults roughly tripled — so that even large increases in enrollment could not keep pace with the increased number of eligibles, causing take-up rates to decline.

State take-up rates were also influenced by differences in the scale and timing of state efforts to expand Medicaid enrollment through outreach, simplification of enrollment processes, and other administrative measures intended to make Medicaid more accessible to clients. While almost all states undertook these activities at some level after the passage of CHIP, which provided federal financial support for these efforts, states varied widely in the level of resources and energy they invested in these enrollment enhancement endeavors and when these investments were made. Some states, such as Georgia and Utah, had outreach efforts in place before the implementation of welfare reform, and others, such as Missouri, New Jersey, Florida, and Maryland, invested considerable resources in these programs shortly after the implementation of welfare reform and the passage of CHIP. Other states adopted these changes much later — Wisconsin and Washington in 2000, for example, and Texas in 2001. Other states made more limited changes, had smaller and less aggressive outreach programs, or did not change their application processes appreciably. Other things being equal, there appears to be a rough correlation between the timing and scale of state process improvements and take-up rates — states which did more, earlier, had higher take-up rates than those that did less, later.

Interestingly, comments from the states that were consistently low in their take-up rates often indicated that take-up was not a priority politically or administratively. This was true in Kansas and Texas. Reports from states whose take-up rate was close to average, indicated that take-up may have been an issue at the state level but priorities diverged at the local level. These “divergences” and the varied emphasis on take-up over time most

likely contributed to the differences in states rate of take-up over time.

What Happened After 2000?

While detailed data on Medicaid enrollment are not available after 2000, it seems likely, for several reasons, that more recent data would show that Medicaid enrollment for low-income adults and children continued to increase in subsequent years. First, several states in this sample were bringing enrollment simplification and outreach processes on line at the end of the period examined in this study, which has likely produced increased enrollment in these states after 2000. Similarly some states may have improved the administrative relationship between Medicaid and CHIP, so that eligible children initially applying for CHIP may be more likely to eventually be enrolled in Medicaid. Medicaid caseloads may also have been increased by the national economic slowdown, which may have reduced employment and earnings and made more families eligible for Medicaid.

Recent trends in both state budgets and Medicaid spending suggest a more complicated picture. States fiscal positions in the mid-to late 1990's were very strong, supported by strong economic growth and a rapidly growing stock market. Medicaid spending grew over this period at rates of 5 percent or less; well below historical averages and far below the 25 percent compounded annual rates of the early 1990's. This combination of strong revenues and low expenditure growth may have led states to be more willing to support outreach programs, enrollment simplification, and other measures whose avowed purpose was to increase Medicaid enrollment and spending.

Both revenue and spending pictures have worsened appreciably in the last few years. As a result of the economic slowdown, the sharp decline in the stock market, and the economic fallout of September 11, state revenues have fallen dramatically in late 2001 and early 2002.⁸ Revenue declines have been the most severe in the large

8 For a detailed analysis of recent state revenue developments, see Nicholas Jenny, “Third Quarter has Worst State Tax Revenue Decline Yet,” *State Fiscal News* (Vol. 2, No. 6, May 2002) and “April State Personal Income Tax Revenues Decline Severely” (Rockefeller Institute of Government, May 2002)

states which rely heavily on the income tax, which have experienced very large declines in revenue from capital gains, dividends, stock options, and other nonwage income, but growth in sales tax revenue has also declined significantly from levels in the late 1990s. Initial indications suggest that the economic recovery, which many have claimed is currently under way, may produce relatively little impact on state revenues, which have been particularly affected by the decline in the stock market.⁹

In addition to these recent revenue developments, Medicaid spending growth has accelerated appreciably over the last few years. After several years of low growth by historical standards, Medicaid spending growth started back up in the late 1990s.¹⁰ Medicaid spending in the sample of states examined here, for example, grew by 6.6 percent in 1998-99; 8.7 percent in 1999-2000; and 11.8 percent in 2000-01.¹¹ Most state and federal forecasts envision continued growth around these levels for the next several years.

The causes of this accelerated growth are complex, but both increased spending for elderly and disabled Medicaid beneficiaries, particularly for prescription drugs, and state “gaming” of upper payment limits (UPL) to hospitals and nursing homes have been identified as major causes by several observers.¹² The expansion of enrollment of low-income adults and children described here ap-

pears to have played at best a small role in pushing up growth in Medicaid spending. Women of child-bearing age and children are relatively healthy and incur relatively small health care bills compared to the elderly and disabled, who are much heavier users of all kinds of Medicaid-covered services. Estimates by the Congressional Budget Office, for example, indicate that the average annual Medicaid cost of a disabled or elderly beneficiary is more than seven times that of a child.¹³

While enrollment expansions of low-income adults and children are clearly not a significant cause of Medicaid spending growth, states recent budgetary problems inevitably raise questions about the political sustainability of recent efforts to increase the accessibility of Medicaid. Faced with declining revenues and increasing Medicaid costs, states may find it expedient to reduce or eliminate outreach and other activities intended to increase enrollment. The result may be reinstatement of lengthier and more elaborate application processes to discourage applicants and reduce the likelihood that ineligible applicants are enrolled. As reported on June 12, 2002, in the *Los Angeles Times*, although California faced a budget shortfall of \$23.6 billion it still chose to expand eligibility for public health insurance while at the same time, the legislature passed measures that would make it more difficult for adults to enroll in Medicaid. Other states may or may not follow California’s lead. In

9 Donald Boyd and Nicholas Jenny, “States Will be Raising their Economic Forecasts But May Lower Their Revenue Forecasts,” *State Fiscal News* (Vol. 2, No. 3, March 2002)

10 For recent surveys of Medicaid growth, see Leighton Ku and Jocelyn Guyer “Medicaid Spending: Rising Again, but Not to Crisis Levels” (Center for Budget and Policy Priorities, April 2001); Vernon Smith and Eileen Ellis “Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001, and 2002” (Kaiser Commission on Medicaid and the Uninsured, October 2001); and National Association of State Budget Officers “NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal 2003” (March 15, 2002).

11 Medicaid spending increase estimates are based upon calculations from CMS data in 18 states; Medicaid FY1998-FY2000 “Net Reported Medicaid and SCHIP Expenditures” available at <http://www.hhs.cms.gov>.

12 Ku and Guyer, “Medicaid Spending Rising Again,” pp. 3-4. UPL schemes, which involve payments above normally acceptable levels to certain kinds of hospitals and nursing homes where the state keeps the “overpayment,” actually make money for the states. Both Clinton and Bush Administrations have taken actions to limit or eliminate these schemes. For details, see Andy Schneider and David Rousseau, “Upper Payment Limits: Illusion and Reality in Medicaid Finance” (Kaiser Commission on Medicaid and the Uninsured, February 2002) and Karen Matherlee “The Federal State Struggle Over Medicaid Matching Funds: An Update” (National Health Policy Forum Background Paper, May 2002)

13 As reported in Ku and Guyer, pp. 5-6.

many states the CHIP program has been viewed as a budget burden while in others states, it is seen as a method for increasing revenue due to the greater amount of federal matching money available for expanding such programs.

To examine the extent to which recent enrollment initiatives survive state budget difficulties, the Rockefeller Institute of Government will be conducting a study of legislative and administrative actions that affect Medicaid during the summer of 2002. This study will examine the extent to which Medicaid is affected by state budget actions and will assess state administrative actions affecting Medicaid enrollment processes to determine the extent to which efforts to expand public insurance coverage via Medicaid and CHIP to a larger proportion of the population have become institutionalized.

Conclusions

Regardless of what the future holds, this report demonstrates that programmatic and administrative changes resulted in increased enrollment and take-up after 1998. By 2000 several states in the study had improved enrollment — especially for children and Medicaid-only eligible individuals. However, enrolling the eligible remains a challenge as demonstrated by the drop-off in states' take-up rates. These findings are not surprising given the economic conditions of the late 1990s, the implementation of CHIP, eligibility expansions and the

increased emphasis on simplifying the enrollment process.

This analysis also shows that partial fiscal and programmatic devolution of social programs provided states with tremendous opportunities as well as tremendous responsibilities for the public's well being. The management of Medicaid after welfare reform and after eligibility expansions enabled under the Children's Health Insurance Program are just two policy shifts that can be further studied to determine how states have dealt with the opportunities provided as a result of devolution. Managing human service programs to accommodate these policy shifts was a challenge for states — perhaps resulting in the apparent rollercoaster of enrollment and take-up rates.

As shown by the varied findings in this report, states often need flexibility and time to determine for themselves what administrative methods and program designs will work best in their own state. By tracking state success with Medicaid take-up in confluence with underlying federal directives, public policy makers can better understand the likely impact of their actions on state and local governments. However, it appears that adequate funding, federal guidance, and flexibility — such as that purported by the current federal administration, can impact state success at covering the uninsured and Medicaid eligible individuals.

The Nelson A. Rockefeller Institute of Government

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

The American Federalism Group

The Institute's American Federalism Group was established in 1996 in response to the growing importance of state governments in the American federal system and the devolution of social programs. Despite the ever-growing role of the states, there is a dearth of high-quality, practical, independent research about state and local programs.

The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

This Report

Courtney E. Burke, Senior Research Scientist with the Institute's American Federalism Group wrote this report with assistance from Jim Fossett. Craig W. Abbey calculated each state's number of potentially Medicaid eligible individuals, which helped to determine take-up rates. Frank Thompson, Dean of Rockefeller College of Public Affairs and Policy, provided valuable suggestions on the contents. Institute field researchers from the states in the study obtained enrollment data and qualitative information. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michelle Charbonneau.

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