



Managing Medicaid Take-Up

Children and the Take-Up Challenge: Renewal Processes in Medicaid and CHIP

*Frank J. Thompson, Rockefeller College of Public Affairs and Policy,
University at Albany, State University of New York*

Federalism Research Group

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Study Highlights

Renewal processes affect participation rates for children in Medicaid and the State Children's Health Insurance Program (CHIP) and deserve systematic analysis.

- ❖ As states have expanded eligibility for children under Medicaid and CHIP, it has become abundantly clear that a substantial gap exists between policy promise and implementation performance. Many children who qualify for these programs are not enrolled in them. This take-up deficit has prompted a range of stakeholders to launch initiatives to bring down barriers to participation in Medicaid and CHIP. They have called for more vigorous outreach campaigns, for steps to overcome the stigma of "welfare medicine," for simplifying eligibility intake processes, and more. One critical factor has received relatively less attention — the transaction costs families face to keep their children on the rolls. The degree to which states make renewal, or redetermination, processes client-friendly can positively affect participation rates.

States have eased renewal burdens for Medicaid and CHIP beneficiaries by increasing the enrollment spans for children but most have not adopted continuous eligibility.

- ❖ One of the best ways to reduce the burdens of renewal for children is to do less of it. Of the 18 states in the Rockefeller Institute sample, 13 provide one year of eligibility for children enrolled in both their Medicaid and CHIP programs. But most states have not opted for "continuous eligibility" whereby a child can remain enrolled for a year regardless of changes in the financial circumstances of the family. In the case of Medicaid, less than a quarter of the states provide continuous eligibility for twelve months; in the case of CHIP, just over half do.

Most states do not engage in aggressive retention activities to contact and keep children on the rolls, but a majority have simplified renewal processes.

- ❖ A minority of the states in the Rockefeller Institute sample has emphasized following up and assisting enrollees who fail to meet the requirements to renew their eligibility. But most states have opted for other practices that reduce the transaction costs of renewal. These include shortening and otherwise streamlining renewal forms, abolishing asset tests for eligibility, and eliminating the requirement that those seeking renewal appear for a face-to-face interview with eligibility workers. Several states also practice annotative renewal. Under this approach enrollees do not start from scratch to fill out a new form at renewal time. Instead, eligibility workers send beneficiaries the information currently in their files and ask them to note any changes.

Over half of the states have made significant progress toward establishing seamless referral between Medicaid and CHIP in the case of renewal.

- ❖ Children who lose eligibility for either Medicaid or CHIP may qualify to become enrolled in the other program. More seamless referral facilitates continuation of health insurance coverage. Four states in the sample avoid this referral challenge by making CHIP a Medicaid extension. The majority of the remaining 14 states have attempted to deal with this problem by adopting joint renewal forms for Medicaid and CHIP. A handful pursue integration by essentially using common eligibility workers to review renewals for both programs. A few states make extra efforts to track beneficiaries and encourage referrals.

Reviewing a range of renewal factors, about one-third of the states rank relatively high in promoting greater ease of renewal for children enrolled in Medicaid and CHIP.

- ❖ Six of the states have developed a portfolio of renewal practices that substantially reduce the transaction costs of renewal for beneficiaries. Seven states, however, fall at the opposite end of the continuum, having adopted relatively few practices that ease renewal. The remaining five states emerge as hybrids having eliminated some barriers while sustaining others. Half of the six states that ranked in the top tier with respect to user-friendly renewal as of 2002 had achieved this status in part as a response to take-up problems in the late 1990s. Three states (Arizona, Kansas, West Virginia) had experienced stagnant or declining Medicaid enrollments of children from 1995 through 2000. These experiences prompted expressions of concern from advocacy groups, federal officials, and others that served as wake-up calls for administrators and policymakers in these three states. Officials responded by modifying renewal and other enrollment practices. Some states, however, did not respond to declining enrollments of children by taking significant steps to ease renewal.

Three of the four states with the most acute take-up challenges sustain renewal practices that impose relatively greater transaction costs on beneficiaries to preserve their eligibility.

- ❖ The percentage of children from families at or below 200 percent of poverty who lack health insurance serves as a rough proxy for the take-up challenge a state faces. Within the Rockefeller Institute sample states, these percentages range from 34 percent without insurance in the case of Texas to 8 percent in Missouri. Among the four states with the most acute take-up challenges, only Arizona has developed a repertoire of renewal practices that substantially ease renewal. The three others were not, as of 2002, well positioned in their renewal practices to enhance participation rates appreciably.

Introduction

The 1990s witnessed significant new policy initiatives to provide health insurance to low-income Americans, especially children. With the federal government playing a catalytic role, the states moved to extend benefits to more citizens. Legislative amendments to Medicaid in 1989 and 1990 required states participating in that program to insure pregnant women and children under age six in families with income up to 133 percent of poverty. They also required that by 2002 states phase in Medicaid coverage for all uninsured children under 19 residing in families with incomes below the poverty line. In 1997, Congress and President Clinton joined hands to approve the State Children's Health Insurance Program (CHIP), a policy that promised states a more generous federal match than they received under Medicaid to extend coverage to additional low-income children.¹

Consequently, states have greatly enlarged the number of children eligible for publicly funded health insurance. By 2002, 32 states had extended coverage to children in families with incomes ranging from 200 percent to 275 percent of poverty; another six states had opened up eligibility to kids in families at from 300 percent to 350 percent (with New Jersey having the most generous eligibility standards). Only three states had eligibility income thresholds below 150 percent of poverty.

As states strove to expand access to Medicaid and CHIP, however, it became abundantly clear that a substantial gap existed between policy promise and implementation performance — that take-up, or participation, rates in these two programs left much to be desired.² Thus, Medicaid enrollments tended to be flat or to decline at a time when more people than ever met the income criteria to enroll in these programs. Nor did CHIP enrollments grow as rapidly as many had hoped (including President Clinton). The take-up challenge is no small matter. Out of some 9.5 million children under 19 without health insurance in 2001, an estimated 50 to 80 percent met income and related criteria to be enrolled in either Medicaid or CHIP.³

This take-up deficit has prompted a range of stakeholders to zero in on barriers to enrollment in Medicaid and CHIP. They have called for more vigorous outreach campaigns, for steps to overcome the stigma of “welfare medicine,” for simplifying eligibility intake processes, and more. One critical factor, however, has received relatively less attention — the transaction costs enrollees face to remain on the rolls. In fact, the degree to which renewal, or redetermination, processes are client-friendly can powerfully affect participation rates in Medicaid and CHIP. Various studies estimate that from one-quarter to one-third of the

¹ Other initiatives also opened up avenues to Medicaid eligibility. The federal government's greater willingness to approve comprehensive “1115 waivers” under the Social Security Act permitted states such as Tennessee to launch ambitious new health insurance programs. The passage of welfare reform legislation in 1996 also highlighted a program that had been approved in the late 1980s — Transitional Medicaid Assistance (TMA). This initiative for a time preserves Medicaid eligibility for families who would otherwise lose the benefit as a result of leaving the welfare rolls.

² A take-up rate equals those enrolled in the program (who meet eligibility criteria) divided by the total number of people in an area who could meet the legal requirements to qualify.

³ Genevieve Kenney, Jennifer Haley, and Lisa Dubay, *How Familiar Are Low-Income Parents with Medicaid and SCHIP?* Washington, D.C.: Urban Institute Series B, No. B-34, May 2001. The take-up challenge is not limited to working families who do not qualify for cash assistance. In the past, families with incomes low enough to make them eligible for cash assistance would sign up for those benefits, automatically triggering enrollment in Medicaid. Hence, Medicaid participation rates for the welfare-eligible tended to be higher than for more affluent low-income people. In the wake of welfare reform legislation in 1996, however, participation rates in Temporary Assistance for Needy Families have declined. This development threatens to erode Medicaid take-up rates for the poorest families. See Sheila R. Zedlewski, *Left Behind or Staying Away? Eligible Parents Who Remain Off TANF*. Washington, D.C.: Urban Institute Series B, No. B-51, September 2001.

Medicaid caseloads turn over during a year.⁴ While some of this may reflect a change in the economic circumstances of beneficiaries, this churning also indicates that many who continue to qualify for Medicaid and CHIP fail to complete the requirements needed to sustain their eligibility. This turn-over not only lowers participation rates, it adds to state administrative costs as eligibility workers must deal with more transactions. Moreover, churning can vitiate the delivery of effective preventive care to enrollees. Sensing the frequent disruptions of their relationships, families and providers may lack incentive to develop and implement longer-term protocols for preventive care. In sum, take-up problems stem not just from failures in *outreach* (actions to recruit and sign up qualified individuals for benefits) but also from lapses in *inreach* (efforts to keep those on the rolls who continue to meet income and related eligibility criteria).

The potential importance of renewal processes shaped the focus of ongoing research at the Nelson A. Rockefeller Institute of Government. Field researchers in 18 states (see the chart on page 5) responded to a set of questions concerning the renewal of eligibility for those enrolled in Medicaid and CHIP in 2001 and early 2002.⁵ These queries probed the degree to which redetermination processes in the states appeared to be client friendly.

This brief considers an array of practices related to the transaction costs of renewal. The first section focuses on the enrollment spans that states provide. States that offer longer spans are considered to be more client-friendly. This section documents that the great majority of states provide one year of eligibility for children enrolled in both Medicaid and CHIP, but that a minority has opted for the “gold standard” of renewal — continuous eligibility for 12 months. A second section probes

the degree to which states practice active inreach and have adopted other practices that reduce barriers to renewal. Most states have moved to ease renewal by eliminating asset tests and eradicating the requirement for face-to-face interviews. A minority aggressively works to contact clients who are on the verge of dropping off the rolls. A third section examines the degree to which a seamless referral process exists between Medicaid and CHIP. Such a process can reduce the propensity for children to become uninsured as they lose eligibility for one program but gain it for the other. Two-thirds of the 18 states have made significant headway in fostering smoother referral processes. The fourth section draws on the indicators that have been analyzed in the brief to suggest a tentative ranking of the states in terms of the client friendliness of their renewal processes. It finds that six states have practices that promote considerable ease of renewal and another five moderate ease. The seven remaining states continue renewal practices that impose substantial transaction costs on enrollees.

A final section of the brief looks to the future by asking whether those states facing the most acute take-up problems seem to be well positioned in terms of their renewal practices to meet this challenge. Only one of the four states facing the most pressing problems of uninsured children has adopted renewal practices that augur well for success in enhancing take-up rates.

A caveat deserves emphasis at the outset. This Brief probes many important renewal practices but lays no claim to comprehensiveness. Certain redetermination practices can be discovered only through more intensive case studies. Hence, the findings in this analysis should be viewed as preliminary rather than definitive.

⁴ Marilyn R. Ellwood and Kimball Lewis, *On and Off Medicaid: Enrollment Patterns for California and Florida in 1995*. Washington, D.C.: Urban Institute, Occasional Paper Number 27, July 1999. See also Carol Irvin, Deborah Peikes, Chris Trenholm, and Nazmul Khan, *Discontinuous Coverage in Medicaid and the Implications of 12-month Continuous Coverage for Children*. Cambridge, MA: Mathematica Policy Research, Inc., 2001.

⁵ In addition to the field reports, this brief also draws on charts presented in Donna Cohen Ross and Laura Cox, *Enrolling Children and Families In Health Coverage: The Promise of Doing More*. Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, June 2002.

States Participating in the Study		
<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>

Enrollment Spans: Toward The Annual Review

Enrollment spans loom especially large in any assessment of how client-friendly renewal practices are. Once applicants clear the hurdles to obtain Medicaid and CHIP coverage, how long do states authorize them to remain there without further review? The most generous provision states can adopt under federal law is continuous eligibility for one year. This practice guarantees 12 months of eligibility to children without reference to any income or asset changes that families experience during this time. Thus, the parents of a child with continuous eligibility could win the state lottery and still be entitled to Medicaid or CHIP benefits until the year of enrollment expired. Short of continuous eligibility, states can grant enrollment for a year but require applicants to report any significant changes in their financial condition. Under this financially contingent approach, families whose economic circumstances improve prior to one year could find their children removed from the Medicaid and CHIP rolls regardless of whether they can obtain health insurance from an employer or other sources.

As Table 1 indicates, the 18 states in this study fall into four main clusters with respect to enrollment spans for children under 19. “Gold-standard” states are the most client friendly having adopted continuous eligibility for one year for both Medicaid and CHIP. Only three less populous states, Kansas, Washington, and West Virginia, have pursued this option.

The next category in the chart depicts states ranking relatively high in reducing the burdens of renewal for enrollees via longer enrollment spans.

These states meet two criteria. First, they grant one year of continuous eligibility for either Medicaid or CHIP beneficiaries. Second, they provide a full year of income-monitored eligibility for the other program. Six states, Arizona, Colorado, Michigan, New York, Ohio, and Utah, are in this category. With the exception of New York, states in this cluster confer continuous eligibility on children for their CHIP program rather than Medicaid. CHIP is the more popular candidate for continuous eligibility because states can better control its expenditures. With the exception of Ohio, none of the CHIP programs operated by these six states are entitlements in the sense that Medicaid is. States granting continuous eligibility run some risks that it will increase enrollments and drive up program costs. If this occurs in the case of CHIP, however, states have other levers to pull to stem the drain on their treasuries. Facing a revenue shortfall, for instance, Utah suspended new enrollments to its CHIP program for a period. States do not have this luxury with Medicaid.

States ranking moderately high in client-friendly enrollment spans grant eligibility of one year for both Medicaid and CHIP but require clients to report income changes during that period. At least formally, the continued eligibility of children depends on the economic fortunes of their families not rising above the maximum income threshold for eligibility. Four states fit this category — Maryland, Missouri, New Jersey, and Wisconsin.

A final cluster of five states ranks relatively low in their commitment to client-friendly enrollment spans. Florida, Georgia, Oregon, Tennessee, and Texas grant less than one year of eligibility for Medicaid or CHIP or both. The pattern within this

**Table 1
Enrollment Spans and Continuous Eligibility for
Medicaid and Chip in Selected States, 2002**

<i>State</i>	<i>Medicaid</i>	<i>CHIP</i>
<i>“Gold Standard”</i>		
Kansas	Continuous eligibility for 12 months	Continuous eligibility for 12 months
Washington	Continuous eligibility for 12 months	Continuous eligibility for 12 months
West Virginia	Continuous eligibility for 12 months	Continuous eligibility for 12 months
<i>Relatively High</i>		
Arizona	12 months	Continuous eligibility for 12 months
Colorado	12 months	Continuous eligibility for 12 months
Michigan	12 months	Continuous eligibility for 12 months
New York	Continuous eligibility for 12 months	12 months
Ohio	12 months for regular Medicaid	Continuous eligibility for 12 months for CHIP-funded Medicaid expansion
Utah	12 months	Continuous eligibility for 12 months
<i>Moderate</i>		
Maryland	12 months	12 months
Missouri	12 months	12 months CHIP-funded Medicaid expansion
New Jersey	12 months	12 months
Wisconsin	12 months	12 months CHIP-funded Medicaid expansion
<i>Low</i>		
Florida	Continuous eligibility for 12 months for children under 5; 6 months continuous eligibility plus 6 months financially contingent for all other children	6 months
Georgia	6 months	12 months
Oregon	6 months	6 months
Tennessee	6 months for regular Medicaid	12 months for Medicaid waiver program
Texas	6 months	Continuous eligibility for 12 months

category of states varies considerably. Not surprisingly, enrollment spans among these five states tend to be longer in the case of CHIP, with Georgia and Texas providing 12 months of eligibility to children in this program (Texas offers continuous eligibility for this period). In the case of Medicaid, only Florida provides a 12-month enrollment span and provides continuous eligibility for that period to those under 5. Within this cohort of states, Oregon brings up the rear, offering a 6-month enrollment span without continuous eligibility for both Medicaid and CHIP.

On balance, then, continuous eligibility of one year for children remains a policy pursued by a minority of states in our sample — less than 25 percent of them in the case of Medicaid and just over 50 percent in the case of CHIP. But the limited enthusiasm for continuous eligibility should not cloud the fact that the great majority of states have opted for one-year enrollment spans for children. In the case of Medicaid, over 75 percent have done so; in the case of CHIP nearly 90 percent have pursued this option. These findings appear to reflect the overall pattern present in the 50 states.⁶

In considering the typology embedded in Table 1, three caveats apply. First, some states may well be poised to lengthen enrollment spans. In Texas, for instance, the legislature has enacted a Medicaid simplification bill that, among other things, promises to phase in a full year of continuous eligibility for children on Medicaid no later than June 2003. If this commitment survives the state's fiscal troubles, Texas would join the “gold-standard” states in Table 1.

Second, continuous eligibility does not absolutely guarantee that a child will remain on Medicaid or CHIP eligibility roles for a year. In the case of CHIP, for instance, some children lose eligibility because their parents neglect to pay the premiums the program often requires. Other factors can also prompt children to slip from the rolls. These include such practices as: eligibility worker errors in entering recertification dates, movement

out of state by clients, and protocols that routinely terminate continuous eligibility if a child's parents apply for Temporary Assistance for Needy Families (TANF).

Third, some evidence suggests that one year of continuous eligibility does not enhance participation rates much more than providing income-contingent eligibility for the same period.⁷ This may be because states without continuous eligibility often do little or nothing to monitor changes in the income of enrollees and to enforce eligibility criteria. For their part, families may lack the knowledge and motivation to report shifts in their economic circumstances. Officials in New Jersey, for instance, do not actively seek information on fluctuations in the financial status of Medicaid and CHIP enrollees. Nor do they make special efforts to motivate clients to report any income changes.

Despite the possibility that the transaction costs of renewal for clients who have one year of continuous eligibility may not in fact differ much from enrollees on financially contingent eligibility for the same period, a strong case exists that continuous eligibility fosters more client-friendly renewal processes. In this regard, not all states are carbon copies of New Jersey in their approach to monitoring enrollee income. Some states do not depend on clients to report changes in their financial status. Instead, they scan other databases. Officials in Wisconsin, for example, rely on their CARES eligibility system to check Social Security and state unemployment insurance wage records of enrollees. If this computerized program flags an enrollee whose income appears to exceed eligibility levels, a worker usually contacts the participant to request pertinent information.

The granting of continuous eligibility, as distinct from income-linked enrollment, also does more to preserve administrative integrity. Continuous eligibility obviates the need for officials and clients to ignore or “look the other way” on possible rule infractions to sustain health insurance cov-

⁶ Ibid.

⁷ Andrew W. Dick et al., “Consequences of States’ Policies for SCHIP Disenrollment,” *Health Care Financing Review* 23 (Spring 2002): 65-88.

erage for children. Clients do not need to “cheat” to keep children on the rolls by neglecting to report income changes. Nor do officials have to engage in the selective enforcement of law and regulation to foster greater take up. Such selective enforcement is, of course, a pervasive feature of American governance. The failure of some states to enforce the letter and spirit of income-linked enrollment hardly qualifies as a major implementation breach. But, other things being equal, it usually makes sense to reduce the number of instances where achieving program effectiveness (e.g., keeping children insured) requires officials and clients to skirt the law and administrative regulation. At least in this sense, states that opt for continuous eligibility of one year deserve a higher ranking (the “gold standard”) than those that rely on income-contingent enrollment spans for the same period.

Renewal Processes: Movement To Reduce Hurdles

Although enrollment spans loom large in gauging how client-friendly renewal processes are, they tell only part of the story. An array of other factors also affects the transaction costs incurred by low-income people to stay on the Medicaid and CHIP rolls. These factors tend to fall into two general categories — those associated with inreach and those embedded in the paperwork and officially required transactions that clients must endure to stay enrolled.

Variation in Active Inreach. A client-friendly renewal process features active inreach. Such inreach occurs when eligibility workers and systems clearly convey to families the need to take action to sustain health insurance for their children. It entails aggressive monitoring and intervention by eligibility workers to keep beneficiaries enrolled. This inreach repertoire may include phone calls to parents who have not responded to notices and active assistance to them in filling out pertinent renewal forms.

The 18 states in the Rockefeller Institute sample have adopted certain basic procedures to make sure that enrollees understand the need for renewal but only a handful have emphasized active inreach. At the most elemental level, all states sustain sys-

tems for notifying families of the need for recertification. On occasion, this process does not go as smoothly as state officials would like. In West Virginia, for instance, officials expressed concern that initially a complicated, confusing notification letter exacerbated take-up problems. They subsequently took steps to remedy this situation. On balance, states appear to send reasonably clear signals to clients about renewal.

While states sustain basic notification systems, they vary greatly in the degree to which they engage in more active inreach. A minority of the states in the sample shows some sign of monitoring clients carefully and following up on incomplete renewal forms. For example, the state of Arizona expects eligibility workers to make the contacts needed to persuade clients to complete the information requirements of renewal. If clients fail to respond to notices, workers usually follow up with phone calls to them. Michigan also responds aggressively to incomplete renewal forms. Maximus, the enrollment contractor in that state for CHIP, makes at least two reminder phone calls to enrollees with unfinished forms. Eligibility workers in Maryland and Oregon also engage in some inreach if clients fail to complete renewal requirements.

Overall, however, most of the states in the sample appear to practice a more passive approach. Beyond notification, they do relatively little to follow up with clients. In Colorado, for example, Medicaid eligibility-intake workers have substantial caseloads and often run many days behind schedule in processing applications. These workers have little time to reach out to applicants who have failed to provide needed information. In Georgia, the attentiveness to incomplete renewal efforts varies considerably from one caseworker to the next. In one office, workers send applicants a reminder letter noting the need for additional information. But in another, a worker observed that if he had to call all of the clients with incomplete applications, he could not keep up with his caseload.

The Burdens of Completing the Renewal Process. A renewal process also becomes more client friendly if it features less formidable paperwork and interview requirements. By and large the 18 states in our sample have simplified renewal.

Forms have become shorter, require enrollees to present less documentation, and are available in several languages. Among the panoply of factors that affect the transaction costs of renewal, three in particular receive attention here: the degree to which states rely on income rather than asset tests for eligibility determination, the extent to which they employ an annotative approach to renewal, and the degree to which they require a face-to-face interview with eligibility workers to remain enrolled.

States have taken a major step to ease renewal by focusing on the income of enrollees rather than their assets. Evidence of income can typically be readily obtained. In contrast, requiring clients to list and document their assets requires more effort. The imposition of asset criteria heightens the risk of incomplete applications. The great majority of states in the Rockefeller Institute sample have moved to reduce asset considerations at renewal time for children. In the case of Medicaid, only three states in the sample, Colorado, Texas, and Utah, insist upon such asset information. In the case of CHIP, only Oregon applies this standard.

States can also reduce the transaction costs for enrollees through annotative renewal. Using this approach, programs send beneficiaries the eligibility-related information currently in their files. Families then review this information, note any changes, and return the forms to eligibility workers. They do not need to start from scratch to fill out a new form. Annotative renewal has made some headway among the states with a significant minority of them opting for this approach for Medicaid, CHIP, or both. In the case of Medicaid, for instance, such states as Arizona, Florida, Missouri, and Texas practice annotative renewal. Other states, such as Michigan, require those seeking renewal for Medicaid to complete a new application form but use the annotative approach for CHIP. Most states, however, continue to insist that enrollees complete new forms at renewal time.

The transaction costs of renewal also decline if beneficiaries can handle the process over the phone, through the mail, or electronically without the need for a face-to-face interview with eligibility workers. Here too states have moved to become more client friendly. Only two of the 18 states in

the sample require a face-to-face meeting for renewal. New York does so for Medicaid but not for CHIP. Tennessee requires this encounter for continued enrollment in its TennCare program.

Overall the states in our sample present a mixed picture in terms of reducing renewal barriers. Many have moved to ease renewal by simplifying forms, eliminating asset tests, and doing away with face-to-face interviews. They have also managed to get basic notification systems up and running. A minority has moved to adopt annotative renewal. But only a few manifest much evidence of active inreach when enrollees fail to respond to renewal notices or submit incomplete paperwork.

The Relationship Between Medicaid And CHIP

So far, this brief has focused on the challenge of renewal when children continue to qualify for the particular program in which they are enrolled — either Medicaid or CHIP. But issues of renewal cut across these programs as well. As the age composition and economic circumstances of a family change over time, children may lose eligibility for one program but gain it for the other. Some children on Medicaid will need to move to the CHIP program; others enrolled in CHIP will need to shift to Medicaid. Hence, the “renewal” of health insurance for children depends on a smooth, or seamless, referral process between the two programs.

The CHIP legislation gave states the option of avoiding referral problems by covering additional children under a Medicaid extension. Nationally, however, less than a third of the states pursued this approach. The remainder forged a separate CHIP program or pursued a hybrid using some CHIP funds to extend Medicaid benefits while setting up a separate program for other categories of low-income children. Of the 18 states in the Rockefeller Institute sample, four (Missouri, Ohio, Tennessee, and Wisconsin) opted for Medicaid extensions with CHIP funds. The remaining 14 face the challenge of building links between two “stovepipes” — of assuring a seamless referral process between CHIP and Medicaid eligibility determination.

How committed have states been to integrating Medicaid and CHIP renewal processes? Available evidence does not permit a definitive assessment. But an examination of three indicators casts some light on this question. These indicators are: (a) the use of joint renewal forms for the two programs; (b) the use of common eligibility workers to staff both Medicaid and CHIP; and (c) other evidence in the field reports pointing to a relatively seamless referral process.

Joint Renewal Forms. The use of joint renewal forms for CHIP and Medicaid can reduce the transaction costs of referral between the two programs. That way, families or eligibility workers do not have to fill out another form if the enrollee loses eligibility for one program but wishes to be considered for the other. This mode of integration has made considerable headway in our sample of states. Eight of the 14 states with separate CHIP programs (Georgia, Kansas, Maryland, New Jersey, New York, Oregon, Washington, West Virginia) use a joint renewal form.

Common Eligibility Workers. The interests of integration could also be served by having the same eligibility workers process both Medicaid and CHIP renewals. One office could therefore determine which program should provide insurance to the children. There would be less need to transmit application and renewal forms from one cluster of workers to another either electronically or through the mails. So too, collocation of CHIP and Medicaid eligibility workers might foster a more seamless relationship.

Evidence from the field reports indicates that most states do not feature this mode of integration. Distinct, geographically separated eligibility workers make renewal decisions for CHIP and Medicaid, respectively. In Georgia, for example, the Department of Community Health has responsibility for both the Medicaid and Peach Care (CHIP) programs. But this agency contracts with the state Department of Human Resources to implement Medicaid eligibility determination through its local family and children service units. It employs a private contractor, Dental Health Administrative and Consulting Services Inc., to administer eligibility for the Peach Care program. When the need for referral arises, Medicaid eligi-

bility staffs in the local offices of the Department of Human Resources ask beneficiaries to mail pertinent Peach Care forms to the enrollment contractor. In turn, this contractor refers applicants eligible for Medicaid back to the local offices of the Department of Human Resources.

Although most states do not permit the same eligibility workers to process Medicaid and CHIP eligibility determinations, a handful of exceptions exist. Oregon, for example, administers CHIP and Medicaid as components of the Oregon Health Plan. A central processing unit located in Salem, Oregon, handles some 90 percent of all eligibility determinations for this plan. Eligibility workers in local offices of the State Department of Human Services also process Medicaid and CHIP renewals. Kansas has moved toward a version of the Oregon model. In that state, a private contractor, Maximus, has handled CHIP renewals although state employees in the Department of Social and Rehabilitation Services make the final determinations. These state workers are frequently stationed in Maximus offices. Other eligibility staff in the Kansas Department of Social and Rehabilitation Services handle Medicaid renewals without help from Maximus. As of late 2001, however, the state moved to have Maximus do both Medicaid and CHIP eligibility determinations under the supervision and final approval of state workers located in Maximus offices. West Virginia has also moved toward using common eligibility workers for both CHIP and Medicaid. The Bureau for Medical Services in that state relies on the Bureau for Children and Family Services to handle eligibility determinations; so does the agency responsible for CHIP, the Department of Administration. Hence, the same eligibility workers to a substantial degree review renewals for both programs. Again, however, practices like those of Kansas, Oregon, and West Virginia in consolidating eligibility decisions remain the exception rather than the rule.

Other Steps Toward Seamless Referral. In addition to joint forms and common eligibility workers, other factors define the level of integration achieved between Medicaid and CHIP. The field reports indicate that some states go to considerable lengths to assure that children moving from one program to the other do not fall between the cracks.

Michigan, for instance, does not have a joint renewal form for its Medicaid and CHIP programs (called MICHild). Nor does it have eligibility workers that routinely handle both Medicaid and MICHild eligibility determinations. The same unit that administers cash assistance, the Family Independence Agency, processes renewals for Medicaid. A separate administrative unit, the Managed Care Support Division of the Michigan Department of Community Health, houses MICHild. This division relies on a private contractor, Maximus, to function as an enrollment broker for CHIP. Although these features of the administrative apparatus in Michigan call to mind the stovepipe model, state officials have worked hard to facilitate referrals between the two programs. In August 2000, the Family Independence Agency moved some of its staff to Maximus offices to assure immediate attention to applications and renewals that fail to qualify for CHIP but meet the standards for Medicaid enrollment. When eligibility workers in the Family Independence Agency find that children are ineligible for Medicaid but qualify for CHIP, they send pertinent information to Maximus via the mail so that the enrollment contractor does not start from zero in its MICHild assessment.

Other states in the sample have also worked to build bridges between Medicaid and CHIP. In the state of Washington, for example, a central office in Olympia processes CHIP applications and renewals. Local state agencies called community service organizations deal with Medicaid renewals. Workers in the state's 65 community service organizations enter data into a computerized information system to determine Medicaid eligibility for certain children. If these children fail to qualify but appear to be eligible for CHIP, the local staff electronically transmits the renewals to CHIP administrators in Olympia for an eligibility determination.

In many states, however, families seeking health insurance for children must be attentive and skillful in dealing with the administrative procedures required to cross the bridge between Medicaid and CHIP eligibility. In Texas, for instance, different agencies housed under that state's Health and Human Services Commission have responsibility for Medicaid and CHIP, respectively.

Medicaid relies on workers in the Department of Human Services; the CHIP program depends heavily on an enrollment contractor, Birch & White. If a Medicaid eligibility worker determines that none of the children in a family qualify for that program but believes that they meet CHIP enrollment criteria, he or she gives the family a CHIP application form with instructions on where to submit it. Only if workers determine that some children in the family meet Medicaid standards and others those of CHIP will they electronically submit a complete CHIP application form to the contractor. If a family becomes ineligible for CHIP but potentially qualifies for Medicaid, the enrollment contractor electronically refers pertinent information to the Department of Human Services and sends a letter to the applicant concerning whom to contact in their administrative region. The letter encourages the rejected CHIP applicant to set up a Medicaid eligibility appointment. This process appears to have fueled frustration and confusion for many parents. One analysis cited by Texas officials indicated that only 25 percent of the families referred from CHIP to Medicaid actually become enrolled in the latter.

Overview Of Integration. In sum, the 18 states in our sample vary considerably in the degree to which they have achieved a seamless relationship between Medicaid and CHIP eligibility processes. Four states, Missouri, Ohio, Tennessee, and Wisconsin, have essentially avoided the pitfalls of referral by policy design. They rejected the stovepipe model at the outset by using CHIP funds to pursue extensions of Medicaid coverage for children.

The remaining 14 states in the Rockefeller Institute sample established a separate CHIP program. Among them, three — Kansas, Oregon, and West Virginia — have achieved relatively high integration in the referral of renewals between Medicaid and CHIP. All three of these states feature two important structural features contributing to integration. First they use joint application and renewal forms. Second they essentially rely on the same staffs to do eligibility determinations for both Medicaid and CHIP. In addition, the field reports reveal considerable commitment among officials in these states to sustaining referral processes be-

tween Medicaid and CHIP that foster higher take-up rates.

A second cluster of states with separate CHIP programs — Maryland, Michigan, New Jersey, New York, and Washington — achieve moderate integration in dealing with Medicaid and CHIP referral processes. All states in this category, except Michigan, have adopted joint renewal forms. Each of these states has taken additional measures to build a bridge between CHIP and Medicaid enrollment processes.

A final group of six states — Arizona, Colorado, Florida, Georgia, Texas and Utah — ranks relatively low in the achievement of a seamless referral process. Within this group only Georgia has adopted a joint renewal form. To be sure, all of these states evince some signs of working to overcome the barriers to collaboration endemic to the stovepipe model. But the field reports and related evidence generally suggest less effort or success by these states in establishing smooth referral processes.

Client-Friendly Renewal: Ranking The States

This discussion has indicated common trends among the states but it has also pointed to considerable variation among them. Table 2 estimates ease of renewal in the 18 states based on an assessment of six equally weighted indicators: the presence of one-year continuous eligibility, evidence of active efforts (inreach) to retain Medicaid and CHIP enrollees, state elimination of the asset test as an eligibility criterion, the presence of annotative renewal, abolition of face-to-face interviews for renewal, and the degree to which referral processes between Medicaid and CHIP are seamless.⁸ Employing these criteria, the chart suggests that six states have achieved relatively greater ease of renewal and five moderate ease. The remaining seven sustain practices that tend to drive up the transaction costs beneficiaries must pay to stay on the rolls.

One third of the states in the Rockefeller Institute sample (Arizona, Kansas, Michigan, Missouri, Washington, and West Virginia) have adopted practices that suggest greater ease of renewal. All of the states in this cluster manifest respect for the dictum that the best way to facilitate renewal is to do less of it. Three states in the cluster have established one-year continuous eligibility for both Medicaid and CHIP. Two other states have adopted this approach for CHIP. All of the six states call for 12 month enrollment spans for both Medicaid and CHIP beneficiaries, whether continuous or not. The six states in this cluster have abandoned asset eligibility tests and interviews. At least two have opted for annotative renewal practices and show some signs of active inreach. With the possible exception of Arizona, all states in this group have made progress toward developing a seamless relationship between Medicaid and CHIP. Missouri has avoided this problem entirely by using CHIP monies to fund a Medicaid extension.

At the other end of the spectrum, seven states (Colorado, Florida, Georgia, Oregon, Tennessee, Texas, Utah) demonstrate relatively lower ease of renewal. No state in this cluster has opted for one-year continuous eligibility for both Medicaid and CHIP (Colorado, Florida, and Texas have done so for subgroups of enrollees). Five of the states have adopted enrollment spans of only six months for major cohorts of beneficiaries. Four still demand asset tests for some enrollees and one requires an interview to stay enrolled. With the exceptions of Oregon and Tennessee these states also appear to have made limited headway toward establishing seamless referral processes between Medicaid and CHIP.

Five states (Maryland, New Jersey, New York, Ohio, and Wisconsin) tend to cluster between the top and bottom groups in terms of estimated ease of renewal. These states present mixed profiles reducing the transaction costs for renewal in some spheres while maintaining barriers in others. New York, for instance, has established one-year continuous eligibility for Medicaid and

⁸ This estimate of seamless referral derives from the categorization of states at the end of the preceding section.

Table 2: Estimates of Ease of Renewal in 18 States Based on Selected Indicators	
<i>Relatively Greater Ease Of Renewal</i>	
Arizona	Partial progress toward one-year continuous eligibility; some evidence of active inreach; no asset tests; annotative renewal for Medicaid; no interviews; CHIP-Medicaid referral processes not well integrated.
Kansas	One-year continuous eligibility for Medicaid and CHIP; no asset tests; no interview required; significant progress toward seamless Medicaid-CHIP referral.
Michigan	Partial progress toward one-year continuous eligibility; some evidence of active inreach; no asset test; annotative renewal for CHIP; no mandated interview; some progress toward seamless Medicaid-CHIP referral.
Missouri	No continuous eligibility but 12-month eligibility periods; no asset tests; annotative renewal; no face-to-face interview; no problem of referral since CHIP is a Medicaid extension.
Washington	One-year continuous eligibility for Medicaid and CHIP; no asset test; no interview; some progress toward seamless Medicaid-CHIP referral.
West Virginia	One-year continuous eligibility for Medicaid and CHIP; no asset test; no face-to-face interview; significant progress toward seamless Medicaid-CHIP referral
<i>Moderate Ease Of Renewal</i>	
Maryland	No continuous eligibility but 12-month eligibility period; some evidence of active inreach; no asset test; no interview; modest progress toward seamless Medicaid-CHIP referral.
New Jersey	No continuous eligibility but 12-month eligibility period; no asset test; no interview; modest progress toward seamless Medicaid-CHIP referral.
New York	One-year continuous eligibility for Medicaid; no asset test; renewal interview required for Medicaid; modest progress toward seamless Medicaid-CHIP referral.
Ohio	No continuous eligibility for regular Medicaid beneficiaries but 12-month eligibility period; no asset test; no interview; no problem of referral since CHIP is a Medicaid extension.
Wisconsin	No continuous eligibility but 12-month eligibility period; no asset test; no interview; no problem of referral since CHIP is a Medicaid extension.
<i>Relatively Lower Ease Of Renewal</i>	
Colorado	Partial progress toward one-year continuous eligibility; asset test required for Medicaid; no interview; limited progress toward seamless Medicaid-CHIP referral.
Florida	One-year continuous eligibility for Medicaid for children under 5 but CHIP enrollment period is for only 6 months; no asset test; annotative renewal for Medicaid; limited progress toward seamless Medicaid-CHIP referral.
Georgia	No continuous eligibility and only 6-month eligibility period for Medicaid; no asset test; no interview; limited progress toward seamless Medicaid-CHIP referral.
Oregon	Eligibility periods only six months; some evidence of inreach to enrollees; asset test for CHIP; no interview; significant progress toward seamless Medicaid-CHIP referral.
Tennessee	Six-month eligibility for regular Medicaid; no asset test; interview required; no referral problem since CHIP is a Medicaid extension.

**Table 2:
Estimates of Ease of Renewal in 18 States Based on Selected Indicators (Continued)**

Texas	One-year continuous eligibility for CHIP but 6-month Medicaid eligibility; asset test for Medicaid; no interview; limited progress toward seamless Medicaid-CHIP referral.
Utah	One-year continuous eligibility for CHIP; asset test for Medicaid; no interview; limited progress toward seamless Medicaid-CHIP referral.

does not impose an asset test. But it still requires an interview for those seeking to renew their eligibility for Medicaid and has made modest progress toward building bridges between Medicaid and CHIP. Most of the other states in this cluster have failed to adopt continuous eligibility for one year although they do provide enrollment spans of 12 months. Nor do the remaining four states require an interview for renewal or impose an asset eligibility test. Two of the states, Ohio and Wisconsin, have dodged the CHIP-Medicaid integration problem by opting to use CHIP monies for Medicaid extensions.

In reviewing Table 2, several caveats apply. Above all, these rankings reflect one point in time and may change rapidly. For instance, a subset of states with practices reflecting relatively greater ease of renewal appear to have recently adopted this approach partly as a response to prior take-up problems. Half of the six states with more user-friendly renewal (Arizona, Kansas, West Virginia) had experienced stagnant or declining Medicaid enrollment of children from 1995 through 2000.⁹ These experiences prompted expressions of concern from advocacy groups, federal officials, and others that served as wake-up calls for administrators and policy makers in these three states. Officials responded by modifying renewal and other enrollment practices. A similar pattern may more belatedly apply in Texas. This state experienced a sharp decline in the number of children enrolled in Medicaid in the period from 1995 through 2000; moreover, it continued to rank in the bottom tier of states with respect to ease of renewal at the end of 2001. Texas policymakers have, however, approved a Medicaid simplifica-

tion law that will substantially ease renewal costs for enrollees if it is fully implemented in 2003. It deserves note that not all states responded to enrollment problems by moving toward more client-friendly practices. Oregon, for example, experienced a 13 percent decline in Medicaid enrollments for children from 1995 to 2000, yet remained in the bottom tier of states in terms of ease of renewal in early 2002.

Two other caveats also apply to the ranking of states in Table 2. First, these rankings in part rest on subjective impressions. While the chart reflects careful and systematic consideration of several key factors, no calipers exist to assure absolute precision in the rankings. Second, states that have done the most to ease renewal cannot be assumed to have solved the take-up challenge related to this aspect of the enrollment process. In all of these states, it appears that many children who continue to qualify for Medicaid and CHIP fall off the rolls, at least for short periods, at renewal time.

Ease of Renewal and the Take-Up Challenge

Do those states currently facing the greatest take-up challenge have renewal practices in place that will help them deal with this problem in the future? If the answer to this question is “yes,” it would be an encouraging sign for those who seek to bolster the participation rates of children in Medicaid and CHIP.

Addressing this question presents formidable problems largely because of the complexities involved in measuring take-up rates for children in

⁹ Courtney E. Burke and Craig W. Abbey, *Managing Medicaid Take-Up: Medicaid Enrollment Trends, 1995-2000*. Albany, New York: Nelson A. Rockefeller Institute of Government, 2002.

different states. In essence, a participation rate at any given point in time equals the number of children appropriately enrolled for a benefit divided by the total number in the more general population who could meet the legal requirements to qualify (e.g., in terms of income and health insurance status). The data needed to compute precise take-up rates by state are unavailable. However, the United States Census Bureau does offer data that serve as a rough proxy to estimate the take-up challenge that different states face. In order to meet requirements embedded in CHIP legislation, the Census Bureau must annually provide state-specific estimates of the number and percentage of children at or below 200 percent of poverty without health insurance. These estimates factor into the CHIP allocation formula for states.

While it is likely that the percentage of uninsured children in the states is strongly and negatively correlated with purer measures of participation rates, these Census Bureau data are not perfect indicators of the take-up challenge. Given sample size and other methodological issues, state-specific estimates are subject to some measurement error.¹⁰ Moreover, the majority of states in the Rockefeller Institute sample provide eligibility for children in families with income above 200 percent of poverty. These Census Bureau numbers cast no light on the health insurance status of these “better off” low-income children. In addition, some children in families with income at or below 200 percent of poverty are ineligible for either Medicaid or CHIP. Granting these limitations, however, there is much to commend these census estimates as an important indicator of the take-up challenge states confront. It is likely that the great majority of the uninsured children in this cohort meet the criteria to receive Medicaid or CHIP benefits if states can find a way to enroll them.

Table 3 assesses the states in the Rockefeller Institute sample by the percentage of children at or below 200 percent of poverty without health insur-

ance and ease of renewal (as indicated in Table 2). In the United States as a whole, 21 percent of these children lack health insurance. States vary considerably in this regard. In this sample of 18 states, the percentage of uninsured children in this cohort ranges from 34 percent in Texas to 8 percent in Missouri. In general terms the states can be portrayed as clustering into three general categories, those facing acute take-up challenges (four states where over 26 percent of children in the designated income group lack insurance), those facing significant challenges (from 16 percent to 26 percent uninsured), and those facing moderate challenges (15 percent and below).

For many reasons, one cannot safely infer that the ease of renewal in the states as recorded in Table 3 accounts for, or has substantially determined, the percentage of uninsured children in these jurisdictions. As indicated earlier some states scoring high on ease or renewal only recently achieved this ranking. Table 3 does, however, cast some light on whether states with the most serious take-up challenges are well positioned in their renewal processes as of 2002 to improve participation rates. In this regard, the table presents cause for concern. Among the four states facing the most acute challenges, only Arizona appears to be reasonably well positioned in terms of its renewal processes. In contrast, Colorado, Florida and Texas rank relatively low on ease-of-renewal indicators.

The two other clusters in Table 3 suggest a more mixed-picture in terms of how well positioned states are to achieve higher take-up rates. Among the eight states in the middle tier (those facing a significant challenge), only Kansas and Washington have processes ranking relatively high on ease of renewal. Three (Georgia, Oregon, Utah) rank relatively low in reducing the transaction costs enrollees must pay to stay on the rolls. Among the six states with relatively lower percentages of uninsured children, half (Michigan, Missouri, West Virginia) have adopted renewal practices that augur well for their ability to sustain

¹⁰ For an overview of some of these issues, see Frank J. Thompson, “Federalism and Health Care Policy: Toward Redefinition?” in Robert B. Hackey and David A. Rochefort (Eds.), *The New Politics of State Health Policy*. Lawrence, KS: University of Kansas Press, pp. 60-66.

Managing Medicaid Take-Up

Table 3: States By Magnitude Of Take-Up Challenge And Ease Of Renewal (1999-2001)*

<i>State</i>	<i>Percentage of Children at Or Below 200 Percent of Poverty Without Health Insurance</i>	<i>Ease Of Renewal</i>
United States As Whole	21%	
<i>States Facing Acute Challenge</i>		
Texas	34%	Lower
Arizona	28%	Greater
Colorado	28%	Lower
Florida	27%	Lower
<i>States Facing Significant Challenge</i>		
Kansas	21%	Greater
New Jersey	21%	Moderate
Oregon	21%	Lower
Maryland	20%	Moderate
Washington	19%	Greater
Georgia	18%	Lower
Utah	17%	Lower
Ohio	16%	Moderate
<i>States Facing Moderate Challenge</i>		
New York	15%	Moderate
West Virginia	15%	Greater
Wisconsin	13%	Moderate
Michigan	12%	Greater
Tennessee	9%	Lower
Missouri	8%	Greater

Source: Data on low-income children without insurance come from the U.S. Bureau of the Census, Current Population Survey, 2002 (<http://www.census.gov/hehs/hlthins/lowinckid.html>).

* The figures represent three-year averages for the states. This approach helps mitigate misleading fluctuations that can arise from small sample sizes in some states.

and enhance participation rates in the future. Among the six states in this “moderate-challenge” cluster, Tennessee stands out. Along with Missouri, it had one of the lowest rates of uninsured children of any state in our sample. Yet it does not appear particularly well positioned in terms of its renewal processes to sustain that status. To be sure, other factors unique to the state’s TennCare program may well compensate for these barriers and foster higher participation rates. Recently enacted cuts in TennCare may, however, erode some of the elements that have facilitated take up in that state.

Conclusion

The efforts of national and state governments to extend health insurance to low-income children comprise a major policy development of the last decade. If states enroll children under 19 who meet Medicaid and CHIP eligibility criteria, this cohort could inch toward the status enjoyed by those 65 and over in the United States — nearly complete insurance coverage. But issues of take up have done much to thwart this prospect so far. Among an array of factors depressing participation rates in Medicaid and CHIP, renewal processes deserve attention. Once on the rolls, many children lose their health insurance even though they continue to qualify under a state’s eligibility criteria.

To what degree have states moved to make renewal processes more client friendly? The 18 states in the Rockefeller Institute sample provide grounds for optimism. The great majority of them provide one-year enrollment spans for both Medicaid and CHIP. Most of them have also eliminated the requirements that clients go through an interview at renewal time and pass asset tests. About half of the states have also made considerable progress in moving toward a more seamless referral process between Medicaid and CHIP. Several states may well be poised to make their renewal processes more client-friendly.

But other renewal practices in the states continue to undercut participation rates. Although states have moved toward one-year enrollment spans, most of them have shunned the “gold standard” of renewal — one year of continuous eligibility. Few states in the sample practice active inreach. In roughly half the states, the presence of Medicaid and CHIP stovepipes makes crossing the bridge between the two programs to preserve health insurance coverage burdensome. Taken as a whole, only a third of the states have adopted an array of renewal practices that suggest a high degree of client friendliness. With one exception, these user-friendly states tend to be the less populous ones. Two of the most populous states in the sample, whose enhanced performance could do the most to improve national take-up rates, rank relatively low in the ease of their renewal processes. On top of all of this, the acute fiscal difficulties that virtually all of the states currently face does not over the near term bode well for further steps to strike down renewal barriers.

In considering the relationship between renewal practices and take-up rates, two concluding observations seem pertinent. First, research needs to continue on the degree to which specific renewal practices affect participation rates. This Management Brief has reviewed several factors that affect ease of renewal. But available evidence and analyses do not cast definitive light on the relative importance of specific renewal practices in fostering greater take up. Second, in the face of uncertainty about which renewal factors matter most, it still seems likely that a certain dictum will stand the test of subsequent analysis, namely, that *the best way to reduce renewal problems is to do less of it*. In this regard, a movement by all states to grant continuous eligibility for one year to children enrolled in Medicaid and CHIP appears particularly promising as a vehicle for reducing the number of uninsured children.

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 1997 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

Frank J. Thompson, Dean of the Rockefeller College at the University at Albany, SUNY, wrote this report. Courtney E. Burke, James Fossett, John Gnuschke, Jocelyn Johnston, and Christopher Plein provided valuable feedback to strengthen the report's content. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michele Charbonneau.

For More Information

For more information about the Rockefeller Institute of Government, call (518) 443-5522 or visit the Institute's web site at www.rockinst.org

Federalism Research Group
The Nelson A. Rockefeller
Institute of Government
State University of New York
411 State Street
Albany, New York 12203-1003

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