

# Program Churning and Transfers Between Medicaid and CHIP



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## ABSTRACT

**OBJECTIVE:** In the 10 states that are the focus of the Children's Health Insurance Program Reauthorization Act of 2009 evaluation, we analyze in detail the states' recent progress in retaining children in public coverage and public coverage churning.

**METHODS:** We used administrative data spanning a five-and-a-half-year period collected from 10 study states—Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia—to analyze the extent to which children return to the same program a short time after disenrollment and the extent to which transfers between Medicaid and Children's Health Insurance Program (CHIP) lead to public coverage gaps.

**RESULTS:** Our analysis yielded 3 key findings. First, many children moved between Medicaid and CHIP; while most transitioned seamlessly, coverage gaps occurred for as many as 40%, depending on the type of transition. Second, churning continued to be a

concern for public coverage programs, with approximately 21% of Medicaid disenrollees and 10% of separate CHIP disenrollees returning to the same program within 7 months. Third, we found sizable differences in rates of program churning and nonseamless program transfers across the 10 study states.

**CONCLUSIONS:** Notable variation existed across programs and states, which persisted over the period in public program churning. These results suggest the need for continued efforts to simplify renewal processes, particularly in state Medicaid programs, along with the adoption of processes that improve coordination across programs and policies that simplify these transfers.

**KEYWORDS:** children; CHIP; churning; coverage transfers; Medicaid

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## WHAT'S NEW

Some children cycled in and out of Medicaid and the Children's Health Insurance Program, experiencing gaps in public coverage in the interim. These findings suggest that public program churning remains an issue and that continued efforts to simplify the process of remaining enrolled are needed.

TOGETHER, MEDICAID AND the Children's Health Insurance Program (CHIP) insure approximately 34 million children—more than 1 in 3 of all children nationwide, and over 50% of low-income children.<sup>1</sup> Despite the large number of children covered by these programs, there is still room for improvement, as roughly 2 out of every 3 uninsured children in the United States are eligible for one of these programs but not covered.<sup>2</sup> While challenges of take up of public coverage likely play a role, many of the eligible but uninsured had recent experiences with these programs. Indeed, a 2007 study found that nearly half of all eligible but uninsured children have had Medicaid or CHIP coverage within the past year.<sup>3</sup> This finding highlights the persistent challenge states have with public coverage retention—that is, reducing the number of children who leave Medicaid and CHIP, despite being eligible, and become uninsured.

One consequence of poor retention rates for Medicaid and CHIP are the short disruptions in health care coverage

that occur when individuals are disenrolled, only to reenroll after a short period. Such public program churning can occur as a result of fluctuations into and out of eligibility—a common problem among a low-income population. However, churning is also due to families losing coverage because of procedural reasons, most often during periods of renewals, many of whom reenroll in public coverage soon after disenrollment.<sup>4</sup> Other challenges relate to how CHIP and Medicaid are administered and result when different agencies are unable to coordinate referrals between the two programs seamlessly.<sup>5</sup> Children transferring between public programs as a result of changes in family status or income fluctuations are at risk for public coverage discontinuities if problems with coordinating transfers arise between agencies. Historically, program transfers have been paper-based and in some cases required individuals to fill out new applications.<sup>6</sup> Referrals can be delayed or lost during the process, leading to short spells without coverage while families resubmit materials.

Coverage instability within public health insurance programs and its consequences has been documented by a number of studies; Guevara et al provide an excellent review of the literature on continuity of public insurance coverage, which we will briefly describe below.<sup>7</sup> Studies have shown that children who are uninsured for even short periods have reduced access to care and report more unmet health care needs than those with continuous coverage.<sup>8–11</sup>

In addition, the enrollment and reenrollment of the same eligible children introduces inefficiencies and unnecessary administrative costs into public programs without increasing program participation rates.<sup>12,13</sup> Finally, eligible children who disenroll from public programs often become uninsured rather than transition to private coverage.<sup>14,15</sup> With new coverage options under the Affordable Care Act (ACA), transfers among options are likely to become more common, thus increasing the importance of policies and procedures to ensure coordination across coverage programs.<sup>16</sup>

In recognition of these problems, as states have enrolled more children in Medicaid and CHIP, their focus has expanded from increasing enrollment to ensuring that eligible children remain enrolled. States have instituted a variety of strategies designed to reduce unnecessary disenrollments. Some of these strategies are similar to those used to increase enrollment, such as simplifying administrative procedures and conducting outreach efforts to educate families about renewal processes. Other strategies, such as offering continuous coverage and grace periods for premium payments, are targeted more at retention.<sup>17</sup> Moreover, in an effort to better coordinate transfers between programs to minimize coverage disruptions, states have adopted several strategies such as joint renewal forms, synchronizing programs' renewals, and automated referrals.<sup>18</sup>

In this study, we used state administrative enrollment data to update the evidence of public coverage churning for children in the 10 states that were the focus of the congressionally mandated evaluation of CHIP: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. The main research questions we addressed in this study were the following: 1) How prevalent is churning within a program, and to what extent has program churning changed over time? 2) How prevalent are program transfers, and to what extent has coordination of these transfers changed over time? 3) How do states differ in their rates of program churning and their ability to successfully coordinate transfers between programs? Taken together, the findings shed light on states' progress retaining children in CHIP and Medicaid and preventing coverage gaps. By contrasting differences and progress across states, we also consider how differences in states' program model, and renewal policies and procedures may be associated with program retention and coverage discontinuities. These are particularly relevant health policy issues because some states are in the midst of enrolling individuals made newly eligible under the expansions allowed by the ACA.

## METHODS

### DATA

Our analysis of program churning and transfers between Medicaid and CHIP used individual-level administrative enrollment data provided by the 10 study states. The data covered the period June 2007 through December 2012. We used these state enrollment files to create 1 longitudinal enrollment record for each child ever enrolled in CHIP or

Medicaid over the study period. The single record detailed, for each month of the study period, whether the child was enrolled in the state's Medicaid program, Medicaid expansion CHIP (M-CHIP), a separate CHIP program (S-CHIP), or a state-funded program. Because M-CHIP is administered by state Medicaid agencies and the difference between the 2 programs is strictly administrative and invisible to families (ie, both programs provide Medicaid benefits), we define both Medicaid and M-CHIP enrollees as Medicaid enrollees throughout.

To help ensure that we did not attribute brief gaps in the administrative history file that are due to administrative errors (and therefore unseen from the perspective of the beneficiary as disenrollments) or the result of misspecifications created by linking across the enrollment and eligibility files, we smoothed each beneficiary's enrollment history on the basis of the following routine: any month of nonenrollment that was immediately preceded and followed by months of enrollment became a month of enrollment; and any single month of enrollment between 2 months of nonenrollment became a month of nonenrollment.

### MEASURES

We constructed a series of measures developed under the Maximizing Enrollment evaluation to help states assess their performance in administering public insurance programs.<sup>19</sup> The measures spanned the course of children's coverage, from program entry to eventual program disenrollment and possible return. We constructed all measures on a monthly basis over the enrollment period, creating a substantial time series from which to investigate trends in public coverage.

Because the research objective was to explore movement into and out of public coverage, the unit of observation was disenrollments from Medicaid (M-CHIP) or S-CHIP. We then focused on the 7 months after disenrollment to determine whether the child returned to public coverage or remained disenrolled. Most children reenrolling in public coverage within 7 months were likely to have been eligible during the intervening period and were unlikely to have picked up private coverage for such a short period, making it an appropriate period for assessment and monitoring public coverage transitions. On the basis of administrative data, we identified up to 4 potential short-term outcomes that followed a program disenrollment from Medicaid or S-CHIP, as follows: 1) long-term disenrollment (child remained without public coverage for 7 or more months); 2) program churning (child returned to the same program after a 2- to 6-month gap in public coverage); 3) program transfer, seamless (child transferred to the other program without a gap in public coverage); and 4) program transfer, nonseamless (child transferred to the other program after a 2- to 6-month gap in public coverage).

We then aggregated the individual-level enrollment history data to create a state-level panel data set containing 1 record for each month for each state with counts of program-specific disenrollments and disenrollment outcomes. From these, we focused primarily on 2 performance measures. First, in order to assess how the study states are

coordinating transfers between programs, we looked at the “nonseamless transfer rate,” defined as the proportion of all program transfers that occurred with a gap in public coverage. For example, to calculate the S-CHIP to Medicaid nonseamless transfer rate in 2011 for Michigan, we divided the number of S-CHIP disenrollees in 2011 who transferred to Medicaid after a 2- to 6-month gap in public coverage by the total number of S-CHIP disenrollees in 2011 who transferred to Medicaid (those with and without a gap). Second, in an effort to shed light on renewal processes, we examined the program churn rate, the proportion of program disenrollees who returned to the same program after a 2- to 6-month gap in public coverage.

Our analysis of these measures is descriptive, drawing inferences from an examination of unadjusted counts, proportions, and trends over time. We calculated all rates at the state/period level. To calculate a rate for all states included in an analysis, we took the average percentage across the states for the period examined.

**FINDINGS**

A majority of children who left Medicaid or an S-CHIP program remained without coverage, but many children who left soon returned to 1 of the 2 programs. **Table 1** shows the number of children leaving Medicaid and S-CHIP over the 4-year period between calendar years 2008 and 2011 and the resulting coverage outcome in the following 7 months. Children leaving S-CHIP had a substantial likelihood of being enrolled in Medicaid soon after disenrollment: almost half of all S-CHIP disenrollees transferred to Medicaid within 7 months. The fraction of Medicaid disenrollees who moved to S-CHIP was considerably smaller: fewer than 1 in 7 Medicaid disenrollments resulted in a transfer to S-CHIP with 7 months. Because substantially more children were enrolled in Medicaid than S-CHIP, however, more children transferred from Medicaid to S-CHIP than moved in the other direction.

Among children returning to public coverage after a disenrollment, Medicaid disenrollees were more likely to return to the Medicaid than transfer to an S-CHIP program, whereas the opposite pattern was observed for S-CHIP disenrollees.

**TRANSFERS BETWEEN PROGRAMS**

Transfers between programs often led to gaps in coverage, with transfers from Medicaid to S-CHIP programs more likely to result in gaps in public coverage than transfers occurring in the opposite direction (**Fig. 1**). On the basis of the average across the 8 states included in this analysis,\* 43% of transfers from Medicaid to an S-CHIP program led to a gap in coverage, whereas only

\*Our analysis excluded Ohio (which does not have an S-CHIP program) and Alabama because of concerns about the quality of the Medicaid data received from the state. Specifically, the Medicaid data appeared to be truncated, potentially inflating the number of individuals with a gap in coverage coinciding with a transfer from Medicaid to S-CHIP. Given this, we decided not to include the seamless transfer rate for Alabama.

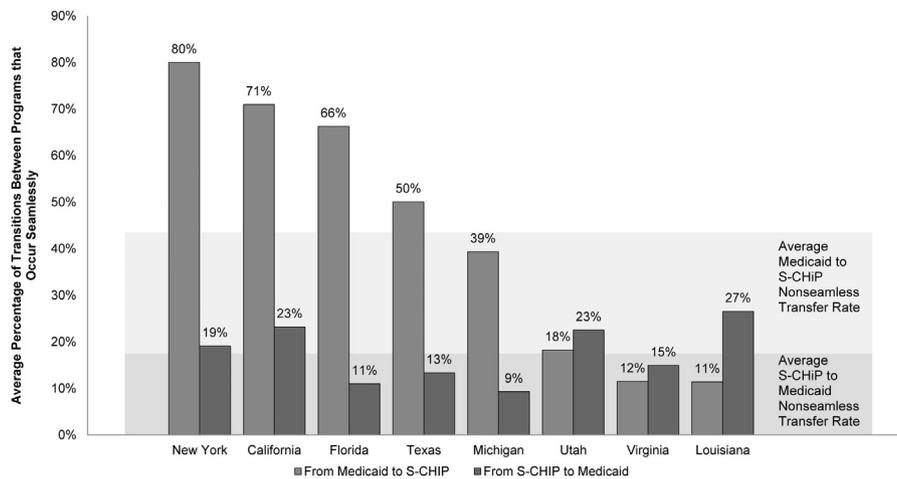
**Table 1.** Disenrollment and Resulting Short-Term Coverage Outcomes, by State and Program, 2008–2011

Characteristic	State Specific										
	All States	Alabama	California	Florida	Louisiana	Michigan	New York	Ohio	Texas	Utah	Virginia
Medicaid and M-CHIP											
Disenrollment	14,753,083	481,835	4,378,460	1,782,648	342,865	840,959	1,537,294	848,987	3,773,564	270,149	496,322
Churn	3,358,070	171,655	919,603	390,197	28,729	203,670	236,891	197,025	1,090,061	48,682	71,557
Transfer	1,932,252	54,575	458,066	239,587	9,624	60,338	192,851	...	776,231	48,405	92,575
Long-term disenrollment	9,462,761	255,605	3,000,791	1,152,864	304,512	576,951	1,107,552	651,962	1,907,272	173,062	332,190
S-CHIP											
Disenrollment	4,009,590	125,461	1,139,274	549,018	9,874	105,019	623,813	...	1,220,865	99,673	136,593
Churn	491,179	12,324	142,000	75,899	232	5,957	116,970	...	125,182	6,538	6,077
Transfer	1,702,180	41,467	416,718	272,971	3,187	63,819	167,950	...	621,763	37,659	76,646
Long-term disenrollment	1,816,231	71,670	580,556	200,148	6,455	35,243	338,893	...	473,920	55,476	53,870

CHIP indicates Children’s Health Insurance Program; M-CHIP, Medicaid expansion CHIP; and S-CHIP, separate CHIP program.

Note: Churn is defined as a disenrollment followed by a return to the same program with a 2- to 6-mo gap in public coverage in between; transfer is defined as a transfer to the other program within 7 mo after disenrollment; and long-term disenrollment is a disenrollment followed by 7 mo without public coverage.

Source: Mathematica analysis of state-provided Medicaid and CHIP enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011.



**Figure 1.** Nonseamless transfer rates, by state and program, 2008–2011. Source: Mathematica analysis of state-provided Medicaid and Children’s Health Insurance Program (CHIP) enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011. The nonseamless transfer rate is the proportion of all program transfers (within 7 mo of disenrollment) that occur with a gap in public coverage.

18% of transfers in the reverse direction coincided with a gap in public coverage. As can be seen in Figure 1, this pattern was not universal across the study states; in Louisiana, Utah, and Virginia, transfers from S-CHIP to Medicaid were more likely to result in a gap in public coverage than those from Medicaid to S-CHIP.

#### CROSS-STATE DIFFERENCES

Figure 1 also shows that there were large, meaningful differences in the Medicaid to S-CHIP nonseamless transfer rate across study states. Whereas 4 in 5 Medicaid to S-CHIP transfers resulted in a short gap in coverage in the state with the highest nonseamless transfer rate (New York), only 1 in 10 Medicaid to S-CHIP transfers resulted in a gap in coverage in the best-performing state (Louisiana). California, Florida, and New York were states with particularly high levels of nonseamless transfers; two-thirds or more of such transfers coincided with a 2- to 6-month gap in public coverage. Transfers between Medicaid and S-CHIP in Louisiana, Virginia, and Utah occurred with fewer coverage disruptions. The nonseamless transition rates in these states ranged from 11% to 18%.

Compared to the Medicaid to S-CHIP nonseamless transfer rate, variation across states in the proportion of transfers from S-CHIP to Medicaid that resulted in a gap in coverage was considerably smaller. In all states but Louisiana, fewer than 1 in 4 of these transfers occurred with a gap in public coverage. Michigan had the lowest rate of nonseamless transfers, with only 9% of transfers coinciding with a gap in coverage. Louisiana, which operates a small S-CHIP program, was the state with the highest nonseamless rate: 27% of transfers from S-CHIP to Medicaid followed a gap in coverage.

#### TRENDS

The proportion of program transfers that occurred with a gap in coverage consistently declined over the 4-year study period, suggesting that states had improved program coordi-

nation over time (Table 2). For children moving from Medicaid to S-CHIP, the rate of nonseamless transfers fell from 48% in 2008 to 41% in 2011, a 16% decrease. We observed a similar pattern for transfers in the opposition direction; the S-CHIP to Medicaid nonseamless transfer declined from 23% in 2008 to 16% in 2011, a 43% decrease.

#### WITHIN-PROGRAM CHURNING

Overall, the proportion of disenrollees churning back onto coverage within 7 months was more common among Medicaid disenrollees than among children leaving S-CHIP programs (Fig. 2). On average over the 4-year period, approximately 21% of Medicaid disenrollees returned to the program within 7 months, whereas just 9% of S-CHIP disenrollees returned to the program after a short time without public coverage. This finding was consistent across the 10 study states, where, in all but New York, the Medicaid churn rate exceeded that of S-CHIP disenrollees.

#### CROSS-STATE DIFFERENCES

The cross-state variation in program churn rates was considerable, particularly in the Medicaid program. Depending on the state, anywhere from 8% to 36% of Medicaid disenrollees returned to the program within 7 months over the 4-year study period, with the corresponding S-CHIP rates ranging between 2% and 19% (Fig. 2). Alabama and Texas had markedly higher churn rates in their Medicaid programs than the other study states: approximately 1 in 3 disenrollees returned to Medicaid coverage within 6 months. In contrast, Louisiana had the lowest churn rate: only 8% of Medicaid disenrollees returned to the program after a period without public coverage.

Although the range in the S-CHIP churn rate across states was not as pronounced as it was for the Medicaid program, we found meaningful differences across the 9 states with S-CHIP programs. Louisiana and Virginia experienced little

**Table 2.** Changes Over Time in the Nonseamless Transfer Rate, By State and Program, 2008–2011

Characteristic	All States	State Specific							
		California	Florida	Louisiana	Michigan	New York	Texas	Utah	Virginia
Medicaid									
2008	48%	72%	80%	21%	41%	80%	55%	19%	13%
2009	45%	68%	73%	10%	46%	78%	55%	20%	11%
2010	43%	70%	58%	9%	48%	81%	51%	18%	10%
2011	41%	74%	65%	8%	31%	80%	43%	16%	11%
S-CHIP									
2008	23%	27%	15%	49%	11%	24%	15%	29%	17%
2009	18%	22%	11%	28%	8%	20%	14%	24%	13%
2010	16%	21%	10%	25%	7%	16%	13%	22%	14%
2011	16%	23%	10%	24%	10%	17%	12%	17%	17%

CHIP indicates Children's Health Insurance Program; S-CHIP, separate CHIP program.

Note: The nonseamless transfer rate is the proportion of all program transfers (within 7 mo of disenrollment) that occur with a gap in public coverage.

Source: Mathematica analysis of state-provided Medicaid and CHIP enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011.

churn in their S-CHIP programs, with rates of 4% and 6%, respectively, whereas in New York, approximately 20% of disenrollees returned to its S-CHIP program after a short time without public coverage.

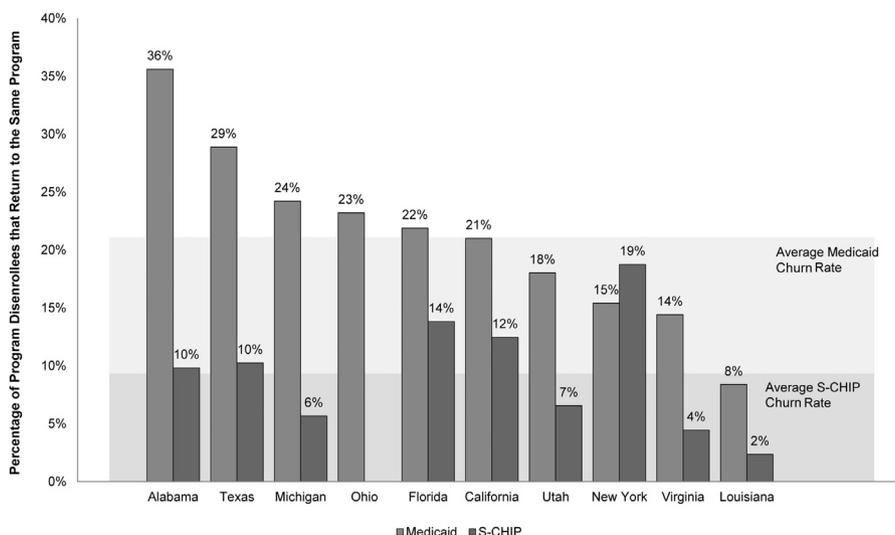
#### TRENDS

The rate of both Medicaid and S-CHIP disenrollees returning to coverage within 7 months was fairly constant across the 4 calendar years for which we have data (Table 3). However, although we saw no evidence of declines in churn rates on average across the study states, there were some notable state-specific changes. Although Alabama and Texas had the highest rates of churn in their Medicaid programs among the study states, rates of churn fell over the study period, with declines in the churn rate from 37% to 30% and 30% to 25%, respectively. Trends in the S-CHIP churn rate by state indicated that most states experienced no change or small declines over the period. The exceptions were Florida, where the S-CHIP churn rate fell from 19% to 12% over 2008 to 2011, a 38%

decline; and Utah, where the rate fell from 8% to 5% over the 4-year period (a 34% decline).

## DISCUSSION

Using administrative Medicaid and CHIP enrollment data from 10 states, we investigated what happened to children after their disenrollment from public coverage programs. We found that many of these disenrollments were due to children moving between Medicaid and S-CHIP programs, with 12% of Medicaid disenrollments resulting in a transfer to S-CHIP and 43% of S-CHIP disenrollments moving to Medicaid coverages across states. These transfers often led to gaps in public coverage, suggesting that coordination between these programs remains a concern. We found that transfers from Medicaid to S-CHIP programs were substantially more likely to result in a gap of coverage than transfers occurring in the opposite direction (43% vs 18%). Although this latter finding might seem somewhat surprising, it is consistent with at



**Figure 2.** Churn rate, by state and program, 2008–2011. Source: Mathematica analysis of state-provided Medicaid and Children's Health Insurance Program (CHIP) enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011. The churn rate is the proportion of all program disenrollees that return to the same program after a 2- to 6-mo gap in coverage.

**Table 3.** Changes Over Time in Churn Rate, by State and Program, 2008–2011

Characteristic	All States	State Specific										
		Alabama	California	Florida	Louisiana	Michigan	New York	Ohio	Texas	Utah	Virginia	
Medicaid												
2008	21%	37%	21%	23%	9%	22%	14%	25%	30%	17%	15%	
2009	22%	39%	21%	23%	10%	27%	14%	25%	31%	19%	15%	
2010	21%	36%	21%	20%	7%	25%	16%	20%	30%	20%	14%	
2011	20%	30%	21%	22%	7%	23%	16%	23%	25%	16%	14%	
S-CHIP												
2008	10%	9%	14%	19%	3%	6%	19%	...	11%	8%	5%	
2009	10%	11%	12%	14%	2%	5%	20%	...	11%	7%	4%	
2010	9%	9%	11%	11%	3%	5%	19%	...	10%	7%	4%	
2011	9%	10%	13%	12%	2%	6%	18%	...	10%	5%	5%	

CHIP indicates Children's Health Insurance Program; S-CHIP, separate CHIP program.

Note: The churn rate is the proportion of all program disenrollees who return to the same program after a 2- to 6-mo gap in coverage.

Source: Mathematica analysis of state-provided Medicaid and CHIP enrollment data for children who disenrolled from Medicaid or CHIP during calendar years 2008 to 2011.

least one other study that used administrative data from the Medicaid Statistical Information System to examine movement between programs.<sup>20</sup> It is unclear whether this difference was due to program coordination problems that occur with moving from Medicaid to an S-CHIP program, or whether it was due to differences between the 2 programs, such as the presence of premiums for most S-CHIP programs but not for Medicaid, or retroactive coverage in Medicaid programs. The challenges in coordinating these transfers may be particularly acute for states where S-CHIP and Medicaid eligibility are administered by separate agencies; among the study states, only 2—Louisiana and Utah—administered the S-CHIP program and the Medicaid program out of the same agency. Perhaps not coincidentally, these states had relatively few Medicaid-to-S-CHIP transfers that occurred with a gap in coverage.

The administrative data showed that although churning remained an issue in both Medicaid and S-CHIP programs, it was more common in Medicaid than in S-CHIP; approximately 21% of Medicaid disenrollees and 10% of S-CHIP disenrollees returned to the same program within 7 months. One reason for this difference might be differences in renewal processes. Although states have worked hard to align the eligibility and renewal procedures across the 2 programs, inconsistencies remain. S-CHIP procedures tend to be more generous than corresponding policies in states' Medicaid programs.<sup>5</sup> For example, Texas uses a 6-month eligibility period for children in Medicaid and a 12-month eligibility period in S-CHIP. Similarly, Utah grants 12-month continuous eligibility for children in S-CHIP, while families with children enrolled in Medicaid must reverify eligibility each month. Although these more stringent requirements enable states to ensure program integrity in their Medicaid programs, they also place a heavy burden on families who are trying to keep their children enrolled.

We found that states' progress in reducing these coverage discontinuities was decidedly mixed. Trends in the nonseamless transfer rate showed widespread improvement; public coverage discontinuities associated with

transfers between Medicaid and S-CHIP declined by 7 percentage points over the 4-year period. This suggests that recent steps by states to improve coordination have reduced coverage discontinuities resulting from these transfers. However, overall program churn rates were fairly constant across the 4 calendar years for which we have data, with no notable increase or decrease over time. This latter finding is disappointing, given the considerable recent attention paid to simplifying renewal processes in the study states.

Through these analyses, we had hoped to identify how increases (or decreases) in outcome measures could be linked with specific policy or procedural changes in the states, such as the adoption of Express Lane Eligibility or administrative renewal policies. Although we did note some state-specific gains in reducing coverage gaps, these gains tended to be persistent over the 4-year period rather than coinciding with the adoption of any one renewal simplification. This suggests there is no silver bullet to keeping eligible children enrolled—at least among the policies adopted over this period.

Although there might not be any one single policy that can help a state close these gaps, this is not to say that these efforts have been unsuccessful, when taken together. It may be that states need a multipronged approach to streamline renewal processes and eliminate reporting requirements in order to see notable improvements. For example, Louisiana, the state that is near the bottom in terms of both nonseamless transfers and program churn rate, has enacted many innovative renewal processes that moved away from requiring families to fill out renewal forms, as illustrated in Table 4. The adoption of multiple simplifications—administrative (passive) renewals, ex parte renewals, rolling renewals, online renewals, and Express Lane Eligibility—broadens the population eligible for at least one streamlined renewal process and gives caseworkers a range of tools to efficiently manage their caseloads. Virginia, which also fares well on these performance measures, has adopted numerous renewal simplifications, particularly in its Medicaid program.

Our study has several limitations. Although we have detailed information on the timing of public insurance

**Table 4.** CHIP Renewal Requirements and Procedures, 2012

State	Program	Renewal Requirements				Renewal Processes					
		Active Renewal	Preprinted Form	Self-Declaration of Income	State Administratively Verifies Income	Passive Renewal	Ex Parte Renewal	Rolling Renewal	Mail-in Renewal	Online Renewal	Express Lane Eligibility
Alabama	S-CHIP	X	X	X	X				X	X	
	Medicaid	X	X		X				X	X	X
California	S-CHIP	X	X						X	X	
	Medicaid/M-CHIP	X							X		
Florida	S-CHIP	X	X	X	X				X	X	
	Medicaid/M-CHIP	X	X*						X	X	
Louisiana	S-CHIP			X	X	X	X	X	X	X	
	Medicaid/M-CHIP			X	X	X	X	X	X	X	X
Michigan	S-CHIP	X		X					X	X	
	Medicaid/M-CHIP	X		X					X†	X†	
New York	S-CHIP	X		X	X				X		
	Medicaid	X	X		X				X		
Ohio	Medicaid/M-CHIP	X						X	X	X	
	S-CHIP	X	X	X	X				X	X	
Texas	Medicaid	X	X	X	X				X	X	
	S-CHIP	X	X			X			X	X	X
Utah	Medicaid	X			X				X	X	
	S-CHIP	X	X	X	X					X	
Virginia	Medicaid/M-CHIP	X	X		X	X	X	X	X		
	S-CHIP	X		X	X					X	

CHIP indicates Children's Health Insurance Program; M-CHIP, Medicaid expansion CHIP; and S-CHIP, separate CHIP program.

\*In Florida Medicaid/M-CHIP, preprinted/prepopulated forms are used unless a family's income has changed.

†In Michigan Medicaid/M-CHIP, beneficiaries can also renew their benefits in person at their local Department of Human Services offices.

Source: Hill et al. (2013).<sup>5</sup>

coverage, a major limitation in relying solely on administrative data when conducting research on insurance transitions is the lack of information on private coverage. It is possible that the gaps we observed are due to children enrolling in private coverage for a short time—a transition that is likely to be viewed very differently than a discontinuity that includes a time without coverage. Our choice of the length of time in which to define disenrollment outcomes was designed to minimize this; however, we cannot exclude the notion that some of these outcomes are due to take up of private coverage in the interim period. Related to this, we know little about the reasons why children disenrolled from coverage or failed to reenroll. We assumed here that a decrease in the churn rate was likely to be driven by a decline in the number of children disenrolling while still eligible; however, a decrease in the churn rate might not be a positive outcome for children's coverage if the reason for the decline is that it is more difficult to reenroll after a gap in coverage. Last, although the relative levels of churn and transfer that we observed across states and over time are largely robust to different definitions of these measures, their absolute levels naturally differ depending on the durations used to define them, so we recommend caution in interpreting them.

Our results suggest that Medicaid and S-CHIP churning and transitions between the two programs remain issues for many states. Continued efforts to simplify the renewal processes, particularly in state Medicaid programs, along with

the adoption of processes that improve coordination across programs, are needed. It remains to be seen whether the many changes embedded in the Affordable Care Act will reduce the gaps in public program coverage experienced by many children when their eligibility has to be reverified or when they experience changes in eligibility for different types of coverage.

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