Policy Flexibility in the Children's Health Insurance Program: Who Is It Good For?

by

N'dea Z. Moore-Petinak

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Health Services Organization and Policy)
in the University of Michigan
2022

Doctoral Committee:

Professor Scott L. Greer, Co-Chair
Associate Professor Holly Jarman, Co-Chair
Professor Jenna Bednar
Research Professor Helen G. Levy
Professor Charles R. Shipan

N'dea Z. Moore-Petinak

moorepen@umich.edu

ORCID iD: 0000-0002-1636-5050

Dedication

For Pete Petinak, Dorothy Holiday and all those who have come before me, for I stand on the shoulders of giants.

Table of Contents

List of Tables

List of Figures

List of Appendices

Abstract

The Children's Health Insurance Program (CHIP) was born of bipartisan congressional compromise to cover the millions of children who were uninsured due to their household income being too high for Medicaid and their parents not being able to afford or access private insurance. Since 1997, it has served as a lifeline to many families whose children would otherwise be without health coverage. States may select a Medicaid, separate, or combination CHIP, as well as several other design elements that affect who is eligible for CHIP, ease of enrollment, and the out-of-pocket cost to families who enroll. The early literature on CHIP is robust, but interest in the subject has waned since the program began twenty-five years ago. Since then, CHIP has survived two reauthorization crises and new enrollment tools have become available to states. Today, CHIP covers nearly ten million children across the country, making it vital to better understand whether the program's success has been equitable.

Previous welfare programs in the United States have served to benefit the "deserving poor" and provide resources to the ingroup. Through the use of Fuzzy Set Qualitative Comparative Analysis (fsQCA), I sought to answer the following question: *How do a state's demographics and partisanship impact program design?* I found that whiter, richer states with fewer immigrants are more likely to select an inclusive CHIP design. These states often have a Democratic legislature and a Republican governor, which points to the power of state legislatures in program design and the willingness of governors to participate in bipartisan solutions for popular policies. I utilized a second fsQCA inquiry to examine how inclusive CHIP design—which should make the enrollment process easier and more children eligible—affects program

enrollment. I found that states use the policy flexibility afforded to them by the federal government and that not all enrollment tools need to be implemented to increase enrollment in CHIP. States that select a Medicaid CHIP, implement Express Lane Eligibility, and remove premiums are more likely to have higher enrollment rates.

For a deeper assessment of state decision making in CHIP, I conducted three case studies in Nebraska, Maryland, and Washington. Through a series of semi-structured interviews, legislative analysis, and qualitative text analysis of administrative reports, I found that states vary widely in their paths to selecting a CHIP design. Some combination CHIP states, like Nebraska, choose stability in CHIP at the price of growth and innovation. Maryland, on the other hand, makes no distinction between CHIP and Medicaid in its approach to state health policy. As one of just two separate CHIPs in the country, Washington is an example of how CHIP can serve as a key component of a broader commitment to funding children's health. And while all three states differ in their approaches, in each state CHIP often serves as a low salience, low conflict issue in the minds of legislators—a "forgotten sibling" of health policy. This characterization has led to both political safety and a lack of attention to potential health disparities in CHIP. While CHIP is less contentious than more recent health policies, its success has not always been equitable.

Chapter 1 Introduction

"Children are being terribly hurt and perhaps scarred for the rest of their lives" said Republican

Senator Orrin G. Hatch on the topic of the millions of children without health insurance in early

1997. Hatch, of course, was one half of the Senate's "legislative odd couple" (Pear, 1997).

Democratic Senator Edward M. Kennedy was the other half, and in a bipartisan compromise

nearly inconceivable today, both led the push to create the State Children's Health Insurance

Program (SCHIP; later shortened to CHIP). The program was an attempt to provide coverage to

some of the nation's ten million uninsured children by financing insurance for children whose

parents made too much to qualify for Medicaid and did not have access to private health

insurance. To finance the program, Congress agreed to increase the federal tax on cigarettes.

States were given incredible policy flexibility, with the ability to create a Medicaid, separate, or

combination CHIP. States also had choice over income eligibility, the enrollment process, and

out-of-pocket cost to families. Kennedy called it, "the most far-reaching step that Congress has

ever taken to help the nation's children, and the most far-reaching advance in health care since

the enactment of Medicare and Medicaid a generation ago" (Schiff, 2010).

And yet, CHIP today receives surprisingly little recognition for a program that covers 9.6 million

children (CMS, n.d.-d). Much of the research exploring the impact of the program lies in the late

1990s and early 2000s, with a small increase surrounding a reauthorization crisis during the Bush

administration. CHIP can hardly be considered a failure, but the lack of political and

methodological attention leaves the program to be characterized as the stereotypical middle child of health policy—sandwiched between Medicare, Medicaid, and the Affordable Care Act. Despite the relative lack of focus on CHIP, two questions remain largely unanswered. First: *What influences state decision making in CHIP?* Second: *What is the impact of those design choices*? Over the past twenty-five years, CHIP has been reauthorized under three different administrations and multiple Congresses, bringing with them new design features and flexibility to the states. This has made the need to understand the motivations for and effects of CHIP design even greater. I attempt to answer those two questions through a series of three inquiries and various methods.

Welfare programs like Social Security can trace their origins to exclusions directly aimed at reducing benefits to Black Americans. Similarly, reforms like the 1996 Personal Responsibility and Work Opportunity Reconciliation Act were created to exclude immigrants, who have long been othered in America. In "Demographics and Partisanship in the Children's Health Insurance Program," I examine how two state factors—demographics and partisanship—may affect program design in CHIP. Through this inquiry, I attempt to answer whether CHIP is living up to its promise of equitably reducing the number of children without access to health insurance, or whether partisan actors structure program design to benefit the perceived ingroup. I use Fuzzy Set Qualitative Comparative Analysis (fsQCA), a method appropriate for use in small samples, to measure the combined effect of race, citizenship, poverty, and partisanship on how inclusive a state's CHIP design is. I find that whiter, richer states with fewer immigrants, such as Vermont, design their CHIPs to be more inclusive. In other words, states often use the flexibility afforded to them by the federal government to give access to some children, but not all. I also find that

states with a Democratic legislature and Republican governor are more likely to select an inclusive design, suggesting that state legislatures have considerable power in shaping CHIP and that children's health may serve as a low conflict issue for the two parties to work together on.

In "Program Design and Enrollment in the Children's Health Insurance Program," I examine the effect of those design choices on enrollment. In addition to the choice of whether to create a Medicaid, separate, or combination CHIP, states can also implement design tools that have the potential to increase eligibility (e.g., making qualified non-citizens eligible) or streamline enrollment (e.g., Express Lane Eligibility). Some of these design tools have been available to states since CHIP's inception, and others were created in the past decade, making their impact less studied. States also have the option to implement design elements known to potentially impact enrollment (e.g., premiums) to reduce their administrative costs. I find that not all design options available to states need to be implemented to increase CHIP enrollment, though eliminating premiums and waiting periods, as well as implementing Express Lane Eligibility, do increase enrollment. The main structure of a state's CHIP does matter, and Medicaid states tend to have higher enrollment than combination or separate states. However, states need not allow non-citizen children to enroll or implement other design options to increase enrollment, which suggests that the policy flexibility in CHIP results in states finding many paths to meeting the needs of their children.

In my "CHIP Policy Flexibility in Nebraska, Maryland, and Washington," I use a series of qualitative methods to better understand state decision making in CHIP. While traditional data can tell us which kinds of states design more inclusive CHIPs and how program design impacts

enrollment, it often cannot fully explain why administrators or legislators make the decisions they do. I use the findings from my fsQCA inquiries to select three representative case studies: Nebraska, Maryland, and Washington. In each state, I conduct semi-structured interviews with a range of administrators, legislators, and staff at related nonprofits to study how states make decisions about their CHIPs. I triangulate these findings through thematic analysis of legislation and qualitative text analysis of administrative reports in each state. I find that CHIP occupies a unique but familiar place in a state's health policy landscape. Children's health is a popular and bipartisan area of policy, until it comes to funding it. While parties may not have the same polarized reactions to the merits of children's coverage as they do with adult Medicaid coverage, the ideological split over funding is the same. I also find that state values in health policy can play a considerable role in shaping a state's CHIP. In the mid 2000s, Washington made a pivotal choice to make sure nearly all children had access to coverage, a choice that can be seen in its CHIP design to this day. Nebraska, conversely, has taken a stable approach to CHIP design; funding is steady and consistent, but growth and innovation are slow. In Maryland, there is virtually no distinction between Medicaid and CHIP, making the program politically safe. In each state, two things were exceedingly clear. CHIP receives far less attention than other policies, and that reduced attention often results in little emphasis on decreasing—and in many cases even a lack of knowledge of—health disparities.

Chapter 2 Demographics and Partisanship in the Children's Health Insurance Program

2.1 Introduction

While the Clinton administration was unsuccessful in its attempts to pass sweeping health care reform, in 1997 it passed a piece of legislation that became a highlight of its legacy: The State Children's Health Insurance Program (SCHIP) (Balanced Budget Act of 1997, 1997). Eventually shortened to the Children's Health Insurance Program (CHIP), it provides health insurance to low-income children through three state-run options: Medicaid, separate, or combination. All three options are funded through block grants to the states and require reauthorization and funding extensions by Congress on an intermittent basis. In addition to choosing how to insure children, states have flexibility in who is eligible (e.g., income thresholds and citizenship requirements), how enrollment and reenrollment occurs, some of the benefits available to eligible children, and cost-sharing features. Along with Medicaid and employer-based insurance, CHIP is an integral part of the complex map of health insurance coverage for children in the United States.

Since the 1997 passage of CHIP, literature surrounding the program has focused on different aspects of program design (Nikolova & Stearns, 2014), the success of individual states (Slifkin et al., 2002), and how well it has met its goal of reducing the number of uninsured children (Lo Sasso & Buchmueller, 2004). Little to no investigations have been done to determine why states make the decisions that they do—even though states have considerable flexibility in program design. My questions are focused on why states select some designs over others. *How do a*

state's demographics impact program design choice? How does state partisanship impact program design choice? Through the use of Fuzzy Set Qualitative Comparative Analysis (fsQCA), I find that whiter, richer states with fewer immigrants, a Democrat controlled legislature, and a Republican governor are more likely to select a Medicaid program design and offer inclusive enrollment features. Next, I detail my underlying theory about how I define inclusive design and why some types of states may choose it for their CHIP programs.

2.2 What is Inclusive Design?

States have many options available to them when designing or amending their CHIP programs. The major decision before them is choosing the structure of their CHIP program. States can choose from three options: Medicaid, separate, or combination. States that select a Medicaid design fully incorporate their CHIP into the state's existing Medicaid infrastructure. This design option is very similar to Medicaid expansion (i.e., expanding Medicaid to higher income brackets). States that select a separate design have a completely separate CHIP, and unlike states that select a Medicaid design, may charge higher premiums and require cost sharing of enrollees (CMS, n.d.-a). States that select a combination design enroll some children in the state's Medicaid program and the rest in a separate CHIP. While states that select a Medicaid design are prohibited from charging enrollment fees and other forms of cost sharing, states that select a separate or combination design are not. This varies by age and income across states. States have complete control over which design they select; they will still receive a higher Federal Medical Assistance Percentage (FMAP)—the federal portion of Medicaid/CHIP funds that is based on per capita income; (Mitchell, 2020)—for CHIP enrollees than traditional Medicaid (Kaiser Family Foundation, 2021a).

Unlike with Medicaid, states are allowed to set the upper income limit for eligible children at whichever level they choose. This results in upper limits ranging from 175% of the Federal Poverty Line (FPL) in North Dakota to 405% FPL in New York. However, despite this variation, 97% of children enrolled in CHIP are at or below 250% FPL (MACPAC, n.d.-a). I will not be including the upper income limits that states select in my analysis, because if a state has a smaller income eligibility window, it can have fewer children enrolled by default. While this does tell us which states are more restrictive in total eligibility, states with higher income limits may have several outcomes that are hard to parcel out. They may have lower uptake because of the higher level of cost sharing at higher income levels, lower uptake because children at higher income levels are more likely to have access to employer sponsored coverage, or higher/comparable uptake because the higher income limits accurately account for the national variation in median family income. Regardless, this complicated relationship is outside of the scope of this analysis, and thus I will be excluding it.

When deciding which children can benefit from CHIP, states also get to decide: if they will offer a buy-in option for those who would otherwise be income-ineligible for CHIP, if they will allow non-citizen children to enroll, and whether they will allow pregnant women to enroll (CMS, n.d.-c). While I do include the buy-in option and the option to extend coverage to non-citizens in my analysis, I exclude the coverage option for pregnant women for two reasons. First, the focus of this work is on children's health and how states treat children's access to affordable health insurance. Children are politically voiceless themselves and thus a distinct beneficiary group. While pregnant mothers are an important group to consider in health equity, they fall outside of the scope of this core relationship. Second, on a more practical level, it is nearly impossible to

account for pregnant women in the eligibility data because they show up as part of the broader adult population.

The final option design decision left to states is how children enroll. While there is some literature on the need for multiple methods of enrollment (e.g., language translation, internet, and analog versions of the application, etc.) (Ross & Hill, 2003), there is no comprehensive examination of the different enrollment features available to states. Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, and waiting periods represent the major enrollment features available to states. Presumptive Eligibility and Continuous Eligibility have been available to states since CHIP's inception in the late 1990s. Presumptive Eligibility allows states to authorize qualified entities (e.g., health care providers, community organizations, schools, etc.) to screen children for CHIP and enroll them immediately if they are deemed eligible (CMS, 2021c). Continuous Eligibility allows states to provide CHIP eligible children with continuous coverage for 12 months, regardless of changes in family income (CMS, 2021d). Express Lane Eligibility, which was created as part of The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), allows states to expedite the eligibility and renewal process for CHIP by relying on information from other Express Lane programs (e.g., SNAP) (CMS, 2021b). States are also allowed to implement a waiting period of up to 90 days prior to enrollment to reduce crowd out (CMS, n.d.-f), a phenomenon that "occurs when public funds substitute private dollars that otherwise would have been spent on health care" (Georgetown University Health Policy Institute, 2009).

Rather than examining each of these individual factors on their own, I am interested in the combination of a state's decisions. Specifically, I aim to study how "inclusive" state CHIP designs are. A perfectly inclusive CHIP design is one that has a Medicaid structure (due to reduced cost to families and integration into a state's existing health infrastructure) and is designed to facilitate more children enrolling in CHIP. On the eligibility side, this would include offering a buy-in option and extending coverage to non-citizens. On the enrollment side, this would mean implementing Presumptive Eligibility, Continuous Eligibility, and Express Lane Eligibility, as well as eliminating waiting periods before children enroll.
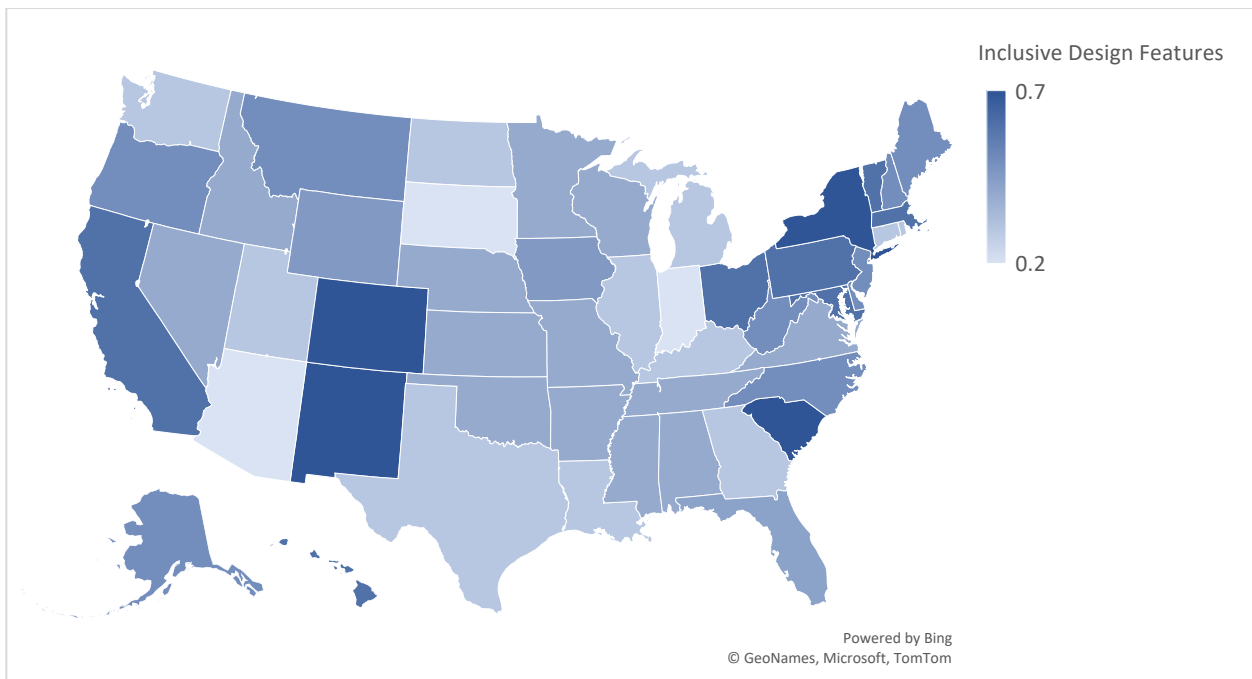
Figure 1: State Variation in Inclusive Design

2.3 Factors Influencing Inclusive Design

2.3.1 Demographics

Over the course of its two hundred- and forty-five-year history, America has built a modern welfare state. In the past one hundred and fifty in particular, it has created welfare institutions of considerable size and longevity. And yet, as with many other parts of American history, the story of the American welfare state has also been about who deserves to be a part of it. Mothers' pensions, one of the earliest examples of welfare in the United States, were the policy predecessors to programs like Aid to Families with Dependent Children (AFDC) (Mink, 1994). Neither program was originally intended to benefit Black families or Black children, nor were they intended to aid non-citizens. These programs were meant to aid the "deserving poor," which typically meant an average white family (Ward, 2005).

The New Deal, too, was marred by racial divisions. FDR needed Southern, segregationist support in Congress to pass the legislation. So, he allowed the exclusion of agricultural workers, who were predominately Black, from Social Security (Quadagno, 1994). Despite many welfare programs in the twentieth century benefitting large numbers of white Americans, the national narrative eventually began to suggest that most individuals on welfare in the United States were Black "welfare queens," directly resulting in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)—signed by President Bill Clinton and ending AFDC (Ward, 2005). Even though the majority of those who benefit from welfare programs in the U.S. are not Black, the narrative has proven to be a powerful factor.

The American perception of who is "deserving" of societal benefits is also important in the context of immigration. Just as with Black Americans, immigrants to America are often viewed as part of the "outgroup"—never fully part of society and thus never fully worthy of being supported by that society (Hawes & McCrea, 2018). This exclusion is in spite of significantly contributing to the economic health of America; immigrants account for nearly a third of all essential workers (Beyer, 2021; Reinberg, 2020). Indeed, studies show that states with more immigrants are more likely to have reduced welfare generosity, due to the reduced social capital in these settings (Hawes & McCrea, 2018). Many immigrants were also systematically left out of welfare benefits following the passage of PRWORA, which denied Medicaid benefits to those arriving in the United States after 1996 (Kaushal & Kaestner, 2005).

Welfare in the United States has also primarily been driven by means testing. While programs like Medicare (which is run at the federal level) have provided universal benefits, many programs, like Medicaid (which is run at the state level) have trended toward a more liberal welfare regime (Quadagno, 1994). This means-tested structure has included a wide range of cash centered programs, like AFDC, Temporary Assistance to Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP). Welfare is also Unemployment Insurance, the Earned Income Tax Credit, and Medicaid. Since the 1980s, through the Reagan administration, the Clinton administration, and beyond, there has been a decline in aid to the poorest families and single parent households, and an upward trend in the income level of welfare recipients (Moffitt, 2015). Most recently, under the Affordable Care Act (ACA), states have given "welfare" to those at income levels previously unseen by non-universal welfare programs. Nearly all these programs were purposefully designed to be exclusionary, and many

have faced criticism for not reaching those most in need due to racism and anti-immigrant sentiment (Burnham, 2007; Keigher, 1997).

Nearly all Americans do believe that some poor members of society deserve to be supported (Will, 1993). Few support cutting social programs entirely and most at least support the status quo of welfare spending (Gramlich, 2017). However, that generosity is often dependent upon the characteristics of the Americans being supported. *Are there two parents in the household? How many children are in the family? Are the parents unemployed? If so, are they actively looking for work? Is anyone in the family seriously disabled?* These are explicit questions ordinary Americans may ask themselves when thinking of who deserves government provided welfare. There are also more implicit questions regarding race, immigration status, and income that factor into the American definition of the "deserving poor" and who is worthy of more generous aid.

2.3.2 Partisanship

Medicaid expansion under the ACA is the most recent example of a national fight over health care related welfare. Expanding coverage to able bodied, poor adults has been successful in the long run, with just 12 states not participating as of 2021, but the road to that fragile success has been fraught and partisan. Of the 12 states that still have not expanded, just three have a Democratic governor and all have a Republican controlled legislature (Kaiser Family Foundation, 2021b; National Conference of State Legislatures, 2021). The early days of Medicaid expansion tell a very different story. Six states and the District of Columbia chose to participate early, in 2013, and just two had a Republican governor—they all had a Democrat controlled legislature (National Conference of State Legislatures, 2021; State Health Access Data Assistance Center, 2013). The story of how a bitter partisan fight, taken more than once to the

Supreme Court, ended with the majority of states choosing to participate is a complicated one. Ballot box initiatives, the involvement of interest groups, and split partisan control across states all played a role in the proportion of states participating increasing—even if partisan actors stood in the way of progress more than once (Barrilleaux & Rainey, 2014; Meyer-Gutbrod, 2020; Rocco et al., 2020).

The origins of the ACA are undoubtedly relevant to the partisan battle that ensued over the past decade. Passed without a single Republican vote in either the House or the Senate, the bill was largely seen as a Democratic victory and colloquially became known as "Obamacare." This partisan signaling was upheld by states, as 26 of them went on to sue the federal government on the grounds of unconstitutionality (*National Federation of Independent Business et al. V. Sebelius, Secretary of Health and Human Service, et al.*, 2012). Public opinion and racial resentment also served as "cross-pressures" with partisanship in early Medicaid expansion. States where more individuals identified as liberal were more likely to move towards Medicaid expansion than states with individuals who identified as conservative. Racial resentment scores are generally higher in Republican-controlled states, though there is variation within Democratic states. States with lower racial resentment were more likely to participate in Medicaid expansion. More practical factors in state participation, such as policy legacies and fiscal capacity, have not been significantly linked with likelihood to expand (Lanford & Quadagno, 2016).

2.4 Demographics, Partisanship, & Inclusive Design

There is evidence that demographics and partisanship, among other factors, play a role in determining how much CHIP funding a state allocates for its children (Tope & Hickman, 2012). This may be because public opinion data suggests that the dynamics of ethnocentrism and

wanting to benefit the "ingroup" is not limited just to adults, "What happens when programs designed to build human capital are targeted on black children? The first thing that happens is white support declines sharply: 70.1 percent of white Americans want to increase federal spending on preschool and early education for poor children; just 44.4 percent want to do the same for black children" (Kinder & Kam, 2009).

The concept of the "ingroup" in children's health overlaps with the definition of families that are considered "deserving." First, I believe that white children—the current ethnic majority in the United States—will be part of the "ingroup" and Black children—who are often shut out of benefits—will not. Second, I believe that children from "deserving poor" families will be part of the "ingroup," given the current upward trend in benefit allocation. Finally, I believe that native children will be part of the "ingroup," due to the systematic exclusion of immigrants—especially undocumented immigrants—from welfare benefits in the United States. I propose that this will lead states with less outgroup children to have more inclusive designs:

H1: *Whiter, richer states with fewer immigrants will choose a more inclusive CHIP design.*

While CHIP was passed under bipartisan circumstances in the late 1990s, much has changed in the past twenty-four years. Democratic state legislatures and Democratic governors often lead the charge in supporting programs that provide more benefits to more Americans. The ACA has both made health policy more divided and resulted in surprising state-level participation from Republican or split-controlled states. However, children are a unique beneficiary group. While one would assume that they are "likeable" from a policy perspective, they are also voiceless at

the ballot box. CHIP has received considerably less media coverage than the ACA over the past decade, and even basic funding for the program varies considerably by state (Tope & Hickman, 2012). Thus, there is less pressure for policymakers to cross partisan lines in support of more benefits for children. I propose that state CHIPs will follow traditional partisan leanings:

H2: *States with Democratic control in the legislature and a Democratic governor will choose a more inclusive CHIP design.*

2.5 Methods

2.5.1 fsQCA

To examine the combination of demographics and partisanship that result in a Medicaid CHIP design with more inclusive enrollment features, I use Fuzzy Set Qualitative Comparative Analysis (fsQCA), a software developed by Charles Ragin, Kriss Dass, and Sean Davey (Ragin, 2017). QCA is based on Boolean algebra and whether a case is in or out of a set. This method of analysis allows a researcher to determine the combination of conditions necessary to achieve a certain outcome. There are two types of QCA; crisp set (csQCA) and fuzzy set (fsQCA). Crisp set requires all data to be binary to indicate non-membership (0) or membership (1) in a set. Fuzzy set allows to data to be scaled between 0 to 1, again with 0 representing non-membership and 1 indicating membership.

I utilize this analysis approach because I intend to use the results of this study to inform case selection for a follow up, qualitative investigation of what motivates state decision making. When determining which factors are associated with Medicaid CHIP, I am certainly interested in

a state's racial makeup, but I am not *only* interested in this factor. Rather, I am interested in the *combination* of demographics and partisanship that influence a state's decision, making fsQCA a more appropriate choice than a traditional regression as my primary method of analysis. While linear regression allows the researcher to test the association between one or more independent variable(s) a dependent variable, it does not indicate *which* combination of variables are *necessary* to result in a specific outcome. fsQCA allows the user to examine the most predictive combination of independent variables in the causal story (Ragin, 2017). Second, the sample size of this study (n=51) is likely too small and underpowered for a traditional regression to yield meaningful results.

When interpreting fsQCA results, there are two key figures to assess: coverage and consistency. Coverage functions as fsQCA's external validity measure and consistency functions as fsQCA's internal validity measure. Coverage measures the proportion of cases that are covered by the solution. Consistency represents the extent to which a causal pathway leads to a selected outcome (Ragin, 2017). This figure is the most comparable to a traditional regression, the difference being that unlike a coefficient, consistency indicates the combination of variables necessary to result in the selected outcome. Consistency ranges from 0 to 1 and a higher consistency means that the set of variables is more predictive of the selected outcome. Most literature that utilizes fsQCA uses a consistency threshold of 0.7 as proof of a meaningful solution (Schneider & Wagemann, 2010). There is less consensus around a threshold for coverage as it is up to the researcher to decide how generalizable the results of a given study needs to be. Additionally, a "low" coverage score is not necessarily indicative of a meaningless result; the solution may still represent an important causal pathway.

Beyond coverage, and consistency, fsQCA also allows researchers to compare "complex" and "parsimonious" solutions and to view "exemplar cases" (Willison, 2019). Complex solutions include all independent variables that the researcher inputs into the model and the result will show the direction of each independent variable that results in the selected outcome. Parsimonious solutions still show the direction of an independent variable that results in the selected outcome, but only the most predictive variables are show in the final result. This allows researchers to determine which variables best explain the relationship between the cause and effect in a given study. "Exemplar cases" have a membership level of at least 0.5 in the set (i.e., causal pathway) and can be extremely useful in selecting concrete examples of the causal relationship for qualitative follow up[1].

The CHIP Type model explores how state demographics (Percent Black, Percent Immigrant, Percent Poor) and partisanship (Legislative Control, Governor Control) impact the CHIP type (Medicaid, Combination, Separate) states select. The CHIP & Inclusiveness model explores how state demographics and partisanship impact the CHIP type and inclusive enrollment features (Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, waiting periods, buy-in options, eligibility for non-citizens) states select. The CHIP Type and CHIP & Inclusiveness models correspond to H1 and H2 and are constructed to test the strength of the association between state demographics and partisanship with CHIP Type alone, and between state demographics and partisanship and CHIP Type in combination with other enrollment design features. I predict that these models will affirm H1 and H2 by showing that whiter, richer states

---

[1] For further discussion of the fsQCA method, see Appendix A.

with fewer immigrants and a Democrat controlled legislature and governor are more likely to select a Medicaid design with inclusive enrollment features.

2.5.2 Linear Regression

Although I use fsQCA as my primary method of analysis, I have also included a set of linear regressions as a robustness check. To complete this check, I use STATA Version 16. I run two linear regression models, which are identical to my two fsQCA models and similarly correspond to H1 and H2.

2.5.3 Program Design Variables

There are three major program design options for states: Medicaid, Separate, or Combination. A state that selects the Medicaid option covers all CHIP eligible children within its existing Medicaid program. A state that selects the Separate option covers all CHIP eligible children through a separate insurance program. A state that selects the Combination option covers some CHIP eligible children (up to a certain income level) through its existing Medicaid program, and other eligible children (usually on the higher end of the income cap) through a separate insurance program. For the purposes of this study, the 'CHIP Type' variable, which is the dependent variable in the CHIP Type model, was coded on a scale of 0-1 from least to most integrated into the state's existing health infrastructure. Separate states were coded as a 0 as CHIP is a completely separate program. Medicaid states were coded as a 1 because CHIP eligible children are covered by Medicaid and afforded the same protections. Combination states were coded as a 0.5 as this design includes aspects of Separate and Medicaid states. CMS provides annual reports on a state's CHIP design (CMS, n.d.-e).

While CHIP Type is the largest structural choice that states get to make in designing their CHIP

programs, several other enrollment features are also available. I am not interested in variables

that may affect utilization of services (i.e., copayments), thus the following variables are

included in my analysis because of their potential impact on enrollment and because there is little

known about their impact. The first four variables are concerned with the way that children

enroll. Presumptive Eligibility allows states to authorize qualified entities (e.g. health care

providers, community organizations, schools, etc.) to screen children for CHIP and enroll them

immediately if they are deemed eligible (CMS, 2021c). Continuous Eligibility allows states to

provide CHIP eligible children with continuous coverage for 12 months, regardless of changes in

family income (CMS, 2021d). Express Lane Eligibility allows states to expedite the eligibility

and renewal process for CHIP by relying on information from other Express Lane programs (e.g.

SNAP) (CMS, 2021b). States are also allowed to implement a waiting period of up to 90 days

prior to enrollment in order to reduce crowd out (CMS, n.d.-f). In this study, 1 indicates the use

of a given enrollment feature, while 0 indicates absence.

The last two variables make it easier for more children to enroll in CHIP. States have the option

to provide a buy-in option to families, which allows parents whose children would normally not

be eligible for CHIP (due to income caps) the ability to purchase public coverage (i.e., through

premiums and other co-insurance) if they meet other eligibility criteria (e.g., disability)

(MACPAC, 2020). This is often a cheaper and more comprehensive alternative to the private

market. States may also cover lawfully residing residents who are foreign-born (i.e., non-

citizens) through CHIP if they meet all other eligibility criteria (CMS, 2021a). Both of these

variables are coded 0 or 1, similarly to previous variables. While states have the option to

provide CHIP coverage to pregnant women, the available census data used in this study did not allow for differentiation, and thus inclusion, of this population in eligibility data. Additionally, this population is outside of my focus on children's coverage.

In the CHIP & Inclusiveness model, I utilize a comprehensive program variable that assigns more weight to CHIP Type (as this is the major program design choice for a state) with the following allocations: +0 for a Separate design, +0.2 for a Combination design, +0.4 for a Medicaid design, and +0.1 for Presumptive Eligibility, +0.1 for Continuous Eligibility, +0.1 for Express Lane Eligibility, +0 for a 90 day waiting period, +0.03 for a 60 day waiting period, +0.06 for a 30 day waiting period, +0.1 for no waiting period, +0.1 for a buy-in option, and +0.1 for eligibility for non-citizens. A state with a score of 0 would have a Separate design with no inclusive enrollment features and a 90-day waiting period (i.e. an unintegrated an exclusive design). A state with a score of 1 would have a Medicaid design with all of the available inclusive enrollment features and no waiting period (i.e. an integrated and inclusive design). This construction is necessary due to the 0-1 scale requirement for fsQCA variables.

These weights were assigned based on the findings of a 2005 congressionally mandated evaluation of CHIP conducted by Mathematica (Woolridge et al., 2005). Type of CHIP was given the most weight (0.2) because in the past, states have selected this aspect of design as a result of economic and policy environments. A state's type of CHIP also accounts for differences in the ability to impose higher premiums and cost sharing; Medicaid states do not have cost-sharing, and most do not have premiums, whereas separate states often have both and combination states have a mix. The remaining design aspects receive the same weight (0.1).

Since state CHIP design data was first collected in 1998 (the year following CHIP passage in Congress), there has been relatively little shift in which states have Presumptive Eligibility or Continuous Eligibility, especially compared to type of CHIP (Table 13). There has been more variation in waiting periods, but they do not apply to Medicaid states. The remaining policy options—Express Lane Eligibility, a buy in option, and eligibility for non-citizens—have not always available to states, making their individual impact unclear. Thus, the weighting reflects the proven impact of cost sharing and premiums through type of CHIP (as well as the considerable shift by states in this aspect of design over time), and the emerging impact of other available design tools.

2.5.4 State Demographics & Partisanship

All state demographics and partisanship were constructed and coded using 2018 data (in order to match 2018 CHIP data) from various sources, as described below. Like previous studies (Fording & Schram, 2020) of in-group centered politics and policy, I use a combination of variables to construct a prototypical "out-group" in the United States that accounts for common measures of inclusion in the American story: race (measured by the proportion of Black Americans in a state), nativity (measured by the proportion of foreign born Americans in a state), and class (measured by the proportion of poor Americans in a state). Percent Black was calculated by using the 'Race includes Black' variable in the U.S. Census. Percent Immigrant was calculated by using the 'Nativity' variable in the U.S. Census. Percent Poor was calculated using the 'Income to poverty' variable in the U.S. Census (Bureau, n.d.-a). Poverty was defined as being at or below 133% of the Federal Poverty Line (FPL) as this is the threshold for Medicaid expansion (The Patient Protection and Affordable Care Act, 2010).

Partisanship was calculated using data from the National Conference of State Legislatures (National Conference of State Legislatures, 2021). States with a Democrat controlled legislature were coded as a 0, states with a Republican controlled legislature were coded as a 1, and states with a divided legislature were coded as a 0.5. Nebraska and D.C. legislatures do not have partisan control by design, so they were excluded. States with a Democratic governor were coded as a 0 and states with a Republican governor were coded as a 1[2]. D.C. does not have a governor, so it was excluded. Table 1 details state demographics and partisan control.

Table 1: Demographics & Partisan Control by State in 2018

State	Percent Black	Percent Immigrant	Percent Poor	Legislative Control	Governor Control
Alabama	27.7%	3.3%	24.1%	R	R
Alaska	4.4%	7.8%	15.6%	R	I
Arizona	6.0%	13.4%	20.1%	R	R
Arkansas	16.2%	4.9%	25.5%	R	R
California	7.1%	26.8%	19.0%	D	D
Colorado	5.5%	9.8%	14.9%	Divided	D
Connecticut	12.7%	14.6%	14.9%	D	D
D.C.	47.7%	14.1%	20.6%	N/A	N/A
Delaware	24.2%	9.3%	17.1%	D	D
Florida	17.5%	21.0%	20.2%	R	R
Georgia	33.2%	10.1%	21.1%	R	R
Hawaii	3.7%	18.6%	13.8%	D	D
Idaho	1.3%	6.0%	19.7%	R	R
Illinois	15.4%	14.2%	17.7%	D	R
Indiana	11.1%	5.4%	19.1%	R	R
Iowa	4.7%	5.7%	16.7%	R	R
Kansas	7.4%	7.1%	18.6%	R	R
Kentucky	9.5%	3.8%	23.5%	R	R
Louisiana	33.6%	4.11%	26.4%	R	D
Maine	2.0%	3.7%	16.7%	Divided	R
Maryland	32.0%	15.0%	12.7%	D	R
Massachusetts	9.6%	17.3%	14.2%	D	R
Michigan	15.3%	6.7%	20.2%	R	R
Minnesota	8.0%	8.6%	14.7%	R	D
Mississippi	38.9%	2.5%	27.5%	R	R

---

[2] In 2018, Alaska had an independent governor, Bill Walker. Governor Walker was coded as a Democrat because of his administrative support for Medicaid expansion (Goodnough, 2015).

Missouri	13.0%	4.3%	19.3%	R	R
Montana	0.8%	2.2%	19.8%	R	D
Nebraska	6.0%	7.2%	17.4%	N/A	R
Nevada	11.5%	19.5%	19.6%	D	R
New Hampshire	2.5%	6.1%	11.2%	R	R
New Jersey	15%	22.9%	14.8%	D	D
New Mexico	2.9%	9.4%	2.8%	D	R
New York	17.4%	22.8%	19.4%	Divided	D
North Carolina	23.1%	7.9%	20.7%	R	D
North Dakota	4.0%	4.8%	14.6%	R	R
Ohio	14.4%	4.7%	19.8%	R	R
Oklahoma	9.3%	6.0%	22.6%	R	R
Oregon	2.9%	10.2%	18.7%	D	D
Pennsylvania	12.7%	7.3%	17.6%	R	D
Rhode Island	8.2%	13.7%	17.3%	D	D
South Carolina	28.0%	5.0%	22.0%	R	R
South Dakota	2.9%	3.4%	19.6%	R	R
Tennessee	18.0%	5.3%	22.5%	R	R
Texas	13.4%	17.2%	22.0%	R	R
Utah	1.9%	8.4%	15.2%	R	R
Vermont	2.0%	4.8%	15.2%	D	R
Virginia	21.3%	12.5%	15.0%	R	D
Washington	5.6%	14.7%	15.5%	D	D
West Virginia	5.1%	1.5%	25..6%	R	R
Wisconsin	7.6%	5.1%	16%	R	R
Wyoming	1.2%	3.1%	15.6%	R	R

2.6 Results

Table 2 shows the results of the CHIP Type model, which tests the combination of state

demographics (Percent Black, Percent Immigrant, Percent Poor) and partisanship (Legislative

Control, Governor Control) needed to result in a Medicaid CHIP Type. Arrows indicate the

direction of the variable (e.g., ↓ % Black indicates low percent Black), as fsQCA does not

provide coefficients for individual variables as in a traditional regression. The complex solution–

–which reports the result of all tested independent variables—shows that whiter, richer states

with less immigrants are more likely to select a Medicaid design. A Democrat controlled

legislature and Republican governor are also included in this solution. The coverage is moderate,

indicating that this pattern represents roughly one third of states. The consistency is above 0.7, which points to the greater likelihood of this causal pathway to result in a Medicaid design. Exemplar states for this model are Vermont, Massachusetts, Nebraska, Illinois, New Mexico, and Maryland. Each of these states ranked below average in at least one state demographic and had a Democrat controlled legislature and a Republican governor in 2018. The parsimonious solution shows that partisan control of the legislature (D) and governorship (R) are the two most salient predictors of a Medicaid design. The coverage of this solution is roughly the same, but the consistency is slightly lower, indicating that demographics are still be useful in explaining which states choose a Medicaid design.

Table 2: CHIP Type Model (fsQCA)

Solution Type	Program Variables Tested (DV)	State Variables Tested (IVs)	Salient IVs & Direction	Coverage	Consistency	Exemplar States
Complex	CHIP Type	% Black, % Immigrant, % Poor, Leg. Control, Gov. Control	↓ % Black, ↓ Immigrant, ↓ % Poor, Leg. Control (D), Gov. Control (R)	0.348	0.772	VT, MA, NE, IL, NM, MD, NV
Parsimonious	CHIP Type	% Black, % Immigrant, % Poor, Leg. Control, Gov. Control	Control (D), Gov. Control (R)	0.379	0.688	VT, MA, NE, IL, NM, MD, NV

The CHIP & Inclusiveness model (Table 3) tests the combination of state demographics (Percent Black, Percent Immigrant, Percent Poor) and partisanship needed to result in a Medicaid CHIP Type with inclusive enrollment features (Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, no waiting periods, a buy-in option, eligibility for non-citizens). Again, whiter, richer states with fewer immigrants are more likely to select a Medicaid design with inclusive enrollment features. These states also have a Democrat controlled legislature and Republican

governor. The coverage in both the complex and parsimonious solutions is lower than in the

CHIP Type model, meaning that the relationship represents less states than the first one (between

demographics and partisanship, and CHIP type alone). However, the strength of the relationship

shown through the consistency in the complex solution suggests that this pattern is still

predictive of a Medicaid design and inclusive enrollment features. Exemplar states for this model

are Vermont, Massachusetts, Nebraska, Illinois, New Mexico, and Maryland. None of these

states has a waiting period and each has at least one other inclusive enrollment feature. The

consistency of the parsimonious solution is below the 0.7 threshold, which suggests that state

partisanship alone may not be enough to predict whether a state has an inclusive CHIP design.

Table 3: CHIP & Inclusiveness Model (fsQCA)

Solution Type	Program Variables Tested (DV)	State Variables Tested (IVs)	Salient IVs & Direction	Coverage	Consistency	Exemplar States
Complex	CHIP Type, Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, Waiting Period, Buy-in Option, Non-Citizens	% Black, % Immigrant, % Poor, Leg. Control, Gov. Control	↓ % Black, ↓ Immigrant, ↓ % Poor, Leg. Control (D), Gov. Control (R)	0.204	0.705	VT, MA, NE, IL, NM, MD, NV
Parsimonious	CHIP Type, Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, Waiting Period, Buy-in Option, Non-Citizens	% Black, % Immigrant, % Poor, Leg. Control, Gov. Control	Control (D), Gov. Control (R)	0.204	0.575	VT, MA, NE, IL, NM, MD, NV

Table 4 shows the linear regression results for the CHIP Type model, which tests impact of state demographics and partisanship on CHIP type alone[3]. Percent Immigrant and Percent Poor are in the expected, negative direction—indicating that richer states with less immigrants select a Medicaid design. Percent Black is in the unexpected, positive direction—indicating that states with more Black children select a Medicaid design. Together, these demographic results partially align my fsQCA results. While Legislative Control is in the expected negative control, Government Control is not. States with Democrat controlled state legislatures and Republican governors are more likely to select a Medicaid design, which is consistent with my fsQCA results. None of these results are statistically significant, which is expected, given the sample size.

Table 4: CHIP Type Model (Linear Regression)

CHIP Type	Coef.	Std. Error	P>|t|
Percent Black	.4484879	.3254674	0.175
Percent Immigrant	-.52836265	.6815339	0.442
Percent Poor	-.9469565	.9537885	0.326
Legislative Control	-.0760315	.0929393	0.418
Gubernatorial Control	.1072138	.0745767	0.157
Constant	.7212814	.2025226	0.001

Notes: $F(5,45) = 0.87$; Prob > F = 0.5102; $R^2 = 0.0879$

The results for the CHIP & Inclusiveness model (which shares the same DV as its counterpart in the fsQCA analysis) are shown in Table 5. This model tests the relationship between state demographics and partisanship and CHIP Type along with inclusive enrollment features. The results for state demographics are similar to those found in the CHIP Type model. Richer states with fewer immigrants are more likely to select a Medicaid design, as are states with more Black

---

[3] "CHIP Type alone" is a binary variable

children. This is partially consistent with my fsQCA results. The results for partisanship indicate that having a Democrat controlled legislature and Democratic governor both result in higher enrollment rates, which is partially consistent with my fsQCA results. None of these results are statistically significant, which is expected, given the sample size.

Table 5: CHIP & Inclusiveness Model (Linear Regression)

CHIP Type & Enrollment Features	Coef.	Std. Error	P>|t|
Percent Black	.1080162	.1925751	0.578
Percent Immigrant	-.1217026	.4032553	0.764
Percent Poor	-.0522587	.5643451	0.927
Legislative Control	-.0915119	.0549911	0.103
Gubernatorial Control	-.042536	.0441261	0.340
Constant	.5397259	.1198302	0.000

Notes: $F_{(5,45)} = 1.30$; Prob > F = 0.2795; $R^2 = 0.1265$

2.7 Discussion

Overall, I find support for H1 and partial support for H2. States with fewer Black children, households living in poverty, and immigrants are more likely to select a Medicaid design with more inclusive enrollment features. An exemplar state for these models is New Mexico, which has a population that is whiter, richer, and more native than the national average. New Mexico also has a Medicaid design, Continuous Eligibility, and provides coverage to children who are not citizens. Demographics matter and this may be due to states wanting to expand coverage and enroll more children that they find deserving—that is, white children from higher working poor to middle class households who were born in the United States. If this is true, they achieve this by integrating CHIP into their existing health infrastructure (Medicaid) and making it easier for these children to enroll and stay enrolled. The fact that states with a Medicaid CHIP design by default do not have premiums or cost sharing makes enrolling and keeping children significantly easier (CMS, n.d.-a).

Partisanship also matters. A Democrat controlled legislature seems to be necessary, but a Republican governor is as well. In fact, both parsimonious fsQCA solutions showed that partisanship is even more necessary for a Medicaid design than demographics. States like Illinois and Vermont share the aforementioned state demographics and this combination of state partisanship. This result is somewhat surprising. While I expected to find that a Democrat controlled legislature would be more common in states with inclusive design, I did not expect Republican governors to be predictive of this result. This may point to the more significant power of state legislatures in children's health and the willingness of governors to work in a bipartisan matter in this area of policy.

Of course, there is a landmark example of how partisan actors do not always act in expected ways: Massachusetts's Chapter 58 Health Care Reform. In 2006, the Democrat-controlled state legislature and the Republican governor, Mitt Romney, worked together to effectively pass universal health coverage in Massachusetts (Chapter 58 of the Acts of 2006, 2006). The sweeping legislation was a comprehensive solution to a practical problem: at the time of its passage, Massachusetts had over half a million uninsured residents (nearly 10% of the population) (Nelson & Rushakoff, 2019). Due to a federal mandate to provide care regardless of insurance status (CMS, 2021e), many uninsured individuals in Massachusetts used emergency rooms as their main source of care, resulting in a higher price tag to taxpayers (a problem that was also true nationally). Although Romney would go on to disparage the structurally similar ACA less than a decade later, the passage of "Romneycare" was seen as a gubernatorial success through bipartisanship at the time.

The exemplar states (Table 6) found in the CHIP Type model and the CHIP & Inclusiveness

model—Vermont, Massachusetts, Nebraska, Illinois, New Mexico, and Maryland—represent

populations with similar demographics and nearly identical legislative and gubernatorial

control[4]. These states point to the possibility that there is a distinct trend in CHIP politics.

Unified party control of the state is not solely predictive of whether a state will adopt a Medicaid

program design with inclusive enrollment features. In fact, the combination of below average

racial, poverty, and nativity demographics (along with a Democrat controlled legislature and

Republican gubernatorial control) create the most likely scenario for a state to select this type of

design and enroll more children. Future research should include a qualitative investigation into

why state administrators and policymakers choose certain program designs as a method of

triangulation. It is important to determine whether state policymakers believe they are offering a

program that will best meet the needs of their state's children.

Table 6: Comparison of Exemplar States

	Vermont	Massachusetts	Nebraska	Illinois	New Mexico	Maryland
Black	2.0%*	9.6%*	6.0%*	15.4%	2.9%*	32.0%
Poor	15.2%*	14.2%*	17.4%*	17.7%*	9.4%*	15.0%*
Immigrant	4.8%*	17.3%	7.2%*	14.2%*	2.8%*	12.7%
Leg. Control	D	D	N/A	D	D	D
Gov. Control	R	R	R	R	R	R
CHIP Type	Medicaid	Combination	Combination	Combination	Medicaid	Medicaid

Notes: * indicates below the national average

---

[4] Nebraska has a unicameral, nonpartisan state legislature (Nebraska Legislature, n.d.).

A limitation to this analysis is my use of fsQCA. This method of analysis is not a regression, so it cannot provide specific estimates of the impact of partisanship and demographics on state choice. However, I use it for three key reasons. First, it provides a comprehensive picture of the *combination* of partisan and demographic factors that influence state decision making. By producing both complex and parsimonious solutions, the method shows the comparative strength of each relationship and the necessary variables across states. Second, the small n in this study means that any result found through traditional regression will more than likely be underpowered. This is evidenced by the fact that my regression results mostly align with my fsQCA findings (with the key exception of race) but are not statistically significant. Finally, the identification of exemplar states will aid in subsequent, qualitative investigations into state decision making.

2.8 Conclusion

The Children's Health Insurance Program occupies a unique space in the world of health politics. A hallmark of what is possible under bipartisan work in Congress, the program was widely celebrated in its infancy in 1997. However, in the wake of the ACA and its contentious politics during the Obama years and beyond, CHIP is often forgotten in policy and political research. This has happened despite the considerable policy flexibility granted to states in the design of their CHIP programs. As it happens, states do use that flexibility, and it is not always to meet the needs of their population's children—the overarching purpose of the Children's Health Insurance Program.

Chapter 3 Program Design and Enrollment in the Children's Health Insurance Program

3.1 Introduction

Established in 1997, the Children's Health Insurance Program (CHIP) provides health care to nearly ten million children in all 50 states and the District of Columbia (Balanced Budget Act of 1997, 1997). These children come from families with incomes too high to qualify for Medicaid and who lack employer-based coverage options. CHIP was passed as a bipartisan compromise during the Clinton Administration and offers states the ability to choose from three different program designs: a CHIP integrated into the state's existing Medicaid program, a separate CHIP, or a combination of the two in which children are placed in Medicaid or a separate CHIP based on income/age eligibility. In addition to the primary program design, states have flexibility in setting income eligibility guidelines, adopting inclusive enrollment strategies (e.g., Presumptive Eligibility), and cost sharing features, among other features. Just as with Medicaid, there are federal standards required of each state, but considerable variation exists beyond that.

While CHIP has been broadly successful, recent trends warrant concern that the effects may not be lasting. In the late 1990s, 15% of American children, and 23.8% of poor children, were uninsured (Bennefield, 1998). That number when down to just 6% in 2018 (Berchick et al., 2019; Hoag et al., 2011). The number of uninsured children reached an all-time low in 2016 but has risen over the last few years (Alker & Corcoran, 2020)—a trend that is especially troubling in the context of the Covid-19 pandemic. The rise in uninsured children, coupled with the

availability of new methods of streamlined enrollment in the last decade (e.g., Express Lane Eligibility) and state expansion of Medicaid have created the need to better understand which design features are most successful in increasing enrollment in CHIP.

The policy flexibility extended to states through CHIP is intended to allow states to adapt to local, regional, and demographic needs in order to meet the same goal: increasing the number of children enrolled in CHIP and thus decreasing the 4.4 million children who are uninsured in the United States (Alker & Corcoran, 2020). My question is focused on which combination of program design options results in higher enrollment. *How does state program design impact enrollment rates?* Through the use of fuzzy set Qualitative Comparative Analysis (fsQCA), I find that while CHIP type (Medicaid, Separate, Combination) matters, not all available enrollment features are needed to achieve high enrollment rates.

3.2 Background

Premiums are a cost sharing method design option available to states to reduce the cost of publicly insuring individuals who are children not on Medicaid. States that select this option often implement fees on a sliding scale and only charge premiums for families at higher income levels. 71% of children on CHIP do not face any premiums and those that do often benefit from a monthly family cap, regardless of the number of children (Gresenz et al., 2013). In a study of how premiums in Medicaid and CHIP affected enrollment from 1999-2010, premiums had a small but significant effect. For families above 150% FPL, a $10 increase in premiums resulted in a 1.6% decrease in Medicaid/CHIP enrollment. For families 101-149% FPL, the premium increase resulted in a 6.7% decrease in enrollment and a 3.3% increase in the uninsured rate, with the effect being greater for children whose parents did not have access to other coverage

through an employer (Abdus et al., 2014). The effects of a premium increase can be lasting, even if the increase in value is small, though children with chronic or acute health concerns are often less sensitive to changes in cost sharing (Herndon et al., 2008). In some cases, parents will disenroll from their own health coverage in order to afford their child's increased premiums (Hendryx et al., 2012).

Though the vast majority of children enrolled in CHIP do not face premiums, when premiums are introduced by states they can represent one of the top reasons for children leaving the program (Marton, 2007). However, premiums do not affect all children equally, even in states where nearly all children have access to health insurance, "Despite the importance of affordability, there is no single, universally agreed-on standard that discriminates between coverage that is or is not affordable…In the absence of subsidies, health insurance premiums are inherently regressive, because premiums vary much less than incomes do" (Gresenz et al., 2011). This disparate effect of premiums means that the choices parents make in the wake of premiums are often income dependent. Families at higher income levels may choose to enroll their children in private health insurance (Nikolova & Stearns, 2014). Children at lower incomes may either regulate their income to become eligible for a "free" version of Medicaid/CHIP, or become uninsured, though the evidence on both outcomes is mixed (Saloner et al., 2016).

Cumbersome application processes may also deter parents from enrolling their children in CHIP, even if eligible. Programs like Express Lane Eligibility (ELE) and Presumptive Eligibility (PE) are intended to speed up the application process and use existing bureaucratic infrastructure to reduce this administrative burden on enrollees. In a study of comparison study of eight states that

did or did not implement ELE, states that did implement ELE saw a 4.2% increase in Medicaid/CHIP enrollment and a 5.6% increase in Medicaid enrollment alone (Blavin et al., 2014). Following enrollment, "most ELE enrollees accessed Medicaid or CHIP services, tended to access a variety of services, and used those services repeatedly, suggesting that they are deriving substantial value from public health insurance coverage" (Colby & Natzke, 2015). However, attempting to examine the effect of a singular enrollment program can prove challenging, as "the experience for any individual state could vary widely due to differences in policy design, implementation, or its target population" (Blavin et al., 2014). Indeed, in a study of the use of Presumptive Eligibility in North Carolina, the program was only used for 18% of children, when it could have benefited an additional 66% (Mott & Dunst, 2006). This is likely because ELE and PE each represent just one aspect of a state's CHIP design.

Who can enroll also represents an important aspect of a state's CHIP design. The ACA prevents undocumented immigrants from obtaining coverage through public insurance (i.e., Medicare, Medicaid, and CHIP) or from private state exchanges—leaving many to rely on "charity care" from hospitals, which means the care they receive is often tertiary. Legal immigrants are also excluded from public insurance for their first five years in the United States, though they may obtain private insurance through state exchanges. These exclusions stem from welfare reform in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (Lurie, 2008). In a study of six states with high populations of Non-Permanent Residents (NPRs) and Permanent Residents (PRs) from 1996-2001, the uninsured rate among PRs increased 4.4% and 11.5% among NPRs. This effect was even more pronounced for poorer immigrants and families in

which the head of household lacked a household degree. While welfare reform was intended to target adults, the "chilling effect" of such policies affected children anyways:

> One feature of the argument for a chilling effect is that due to welfare reform, parents who are ineligible for coverage may cause their children to forgo coverage (and become uninsured) even when the children are eligible (either because they are citizens, pre-enactment PRs, or their state provides public coverage to NPRs). This can be considered a spillover effect: the ineligibility of the parents reduced the probability of the children being covered by public insurance (Jerome-D'Emilia & Suplee, 2012).

The literature that examines health outcomes of undocumented and non-citizen children is already sparse, given the difficult nature of data collection. Evidence of whether CHIP's allowance for coverage of non-citizens increases enrollment is similarly lacking (U.S. Department of Health & Human Services, n.d.).

Though little research exists on the effect of offering a buy-in option for CHIP on enrollment, there is some evidence from Massachusetts that such an offering can be beneficial to previously ineligible groups. Massachusetts allows children with special health care needs to buy into CommonHealth, the state's Medicaid program, either as primary insurance or as supplemental insurance. In a 2019 survey of a CommonHealth buy-in option for children with disabilities, many parents reported that the buy-in option provided access to care that addressed their child's needs that would otherwise go unmet. While some parents raised issues about health providers accepting Medicaid coverage, many reported that access to the coverage was a financial benefit and that the sliding fee premiums made the buy-in option affordable (Hirschi et al., 2019).

In *Administrative Burden*, Herd & Moynihan explain that the level of administrative burden that states place on eligible individuals significantly impacts whether they will enroll (2018). I propose that states that select a Medicaid design place less of an administrative burden on CHIP eligible children and their families. This reduced administrative burden is seen through a wider eligibility range, with a higher average Federal Poverty Level limit than combination states with a mix of Medicaid and separate CHIP enrollees. Children in Medicaid designed CHIP states are also not subject to broader cost sharing, making it more likely that children will enroll and stay enrolled in the program from year to year. I believe this program design, coupled with administrative easing through specific enrollment features outlined below, will lead to higher enrollment in states that select a Medicaid CHIP design:

H1: *States that select a Medicaid program design will have higher enrollment rates.*

Overall, lessening the administrative burden in public health insurance has been shown to increase enrollment. Fox, Feng, & Stazyk found that states which eased burdens more (through options such as income eligibility and online access) saw a greater increase in public insurance enrollment and that this easing mattered more for children's enrollment (Fox et al., 2020). In addition to the flexibility to choose a general CHIP design, states also have specific enrollment features available to them, such as ELE. Presumptive Eligibility has the potential to boost enrollment by allowing qualified entities such as hospitals to enroll eligible children (CMS, 2021c). Sign-ups in emergency departments have been shown to increase renewals by 16% and increase the likelihood of utilization, underscoring the need to implement such linkage programs (Kanak et al., 2015). Keeping children enrolled is also important to reducing churning and can be

achieved through autoenrollment options such as Continuous Eligibility (CMS, 2021d). A study

of Wisconsin's CHIP reform, Badger Care Plus, also found that although a disenrollment gap

exists between traditional enrollees and auto-enrollees, this difference declined at lower income

levels (Leininger et al., 2011).

Given the evidence that each of these design options increases the likelihood of enrollment and

renewal, I predict:

H2: *States that offer more inclusive enrollment features will have higher enrollment rates.*

3.3 Methods

3.3.1 fsQCA

To determine which program design features are associated with higher enrollment rates, I use

Fuzzy Set Qualitative Comparative Analysis (fsQCA), a software developed by Charles Ragin,

Kriss Dass, and Sean Davey (Ragin, 2017). QCA is based on Boolean algebra and whether a

case is in or out of a set. This method of analysis allows a researcher to determine the

combination of conditions necessary to achieve a certain outcome. There are two types of QCA;

crisp set (csQCA) and fuzzy set (fsQCA). Crisp set requires all data to be binary (0-1) in order to

indicate non-membership (0) or membership (1) in a set. Fuzzy set allows data to be scaled

between 0 to 1, again with 0 representing non-membership and 1 indicating membership.

I utilize this analysis approach for two major reasons. First, I intend to use the results of this

study to inform case selection for a follow-up, qualitative investigation of what motivates state

decision making. When determining which factors are associated with higher enrollment rates, I am certainly interested in the type of CHIP a state selects, but I am not *only* interested in this decision. Because states have several policy options available to them, I am interested in the *combination* of policy options, making fsQCA a more appropriate choice than a traditional regression as my primary method of analysis. fsQCA allows the user to examine the most salient combination of independent variables in the causal story by determining which variables are most likely to result in a selected outcome and sorting through potential "cases" (Ragin, 2017). Second, the sample size of this study (n=51) is likely too small and underpowered for a traditional regression to yield meaningful results.

When interpreting fsQCA results, there are two key figures to assess: coverage and consistency. Coverage functions as fsQCA's external validity measure and consistency functions as fsQCA's internal validity measure. Coverage measures how much of the selected outcome is covered/explained by the solution as a whole and by each solution term. In the case of CHIP, this is the proportion of cases represented by the relationship. Consistency represents the extent to which a causal pathway leads to a selected outcome (Ragin, 2017). This figure is the most comparable to a traditional regression, the difference being that, unlike a coefficient, consistency indicates the combination of variables most likely to result in a selected outcome. There is also more nuance in assessing the strength of the relationship shown by consistency, as compared to a coefficient. In a traditional regression, certain p-values indicate statistical significance. In fsQCA, there is no threshold for significance. Rather, researchers can compare across different solutions to determine which combination of variables has a higher consistency. Finally, because

fsQCA is predicated on membership in a set, output also includes a list of cases with a membership level of at least 0.5, sometimes referred to as "exemplar cases" (Willison, 2019).

The Enrollment model explores how CHIP type and inclusive enrollment process features (Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, waiting periods) impact enrollment rates. The Eligibility model explores how CHIP type and inclusive enrollment eligibility (buy-in option, eligibility for non-citizens) impact enrollment rates. The enrollment and eligibility models correspond to H1 and H2 and are constructed to determine the combination of program design options needed to achieve higher enrollment rates. I predict that the Enrollment and Eligibility models will affirm H1 and H2 by showing that a state that selects a Medicaid design with inclusive enrollment features will have higher enrollment rates.

3.3.2 Linear Regression

Although I use fsQCA as my primary method of analysis, I have also included a set of linear regressions as a robustness check. To complete this check, I use STATA Version 16. I run two linear regression models. The Enrollment model examines the association between CHIP type (Medicaid, Separate, Combination) and enrollment rates. Unlike in fsQCA, I am able to use linear regression in the Enrollment model to test the impact of CHIP Type alone on enrollment rates. I predict that the Enrollment model will support H1 and show that states that select a Medicaid design have higher enrollment rates. The Eligibility model examines the association between CHIP type (Medicaid, Separate, Combination) and inclusive enrollment features (Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, waiting periods, buy-in options, eligibility for non-citizens) and enrollment rates, and corresponds to H2. I predict that

the Eligibility model will affirm H2 by showing that states with a Medicaid design and inclusive enrollment features have higher enrollment rates.

3.3.3 Program Design Variables

There are three major program design options for states: Medicaid, Separate, or Combination. A state which selects the Medicaid option covers all CHIP eligible children within its existing Medicaid program. A state which selects the Separate option covers all CHIP eligible children through a separate insurance program. A state which selects the Combination option covers some CHIP eligible children (up to a certain income level) through its existing Medicaid program, and other eligible children (usually on the higher end of the income cap) through a separate insurance program. In my fsQCA analysis, the 'CHIP Type' variable was coded on a scale of 0-1 from least to most integrated into the state's existing health infrastructure, with 0 = Separate, 0.5 = Combination, and 1 = Medicaid. In my regression analysis, I use dummy variables, with Medicaid as the reference group, to gauge the effect of CHIP type more accurately. CMS provides annual reports on a state's CHIP design (CMS, n.d.-e).

While CHIP Type is the largest structural choice that states get to make in designing their CHIP programs, several other enrollment features are also available. I am not interested in variables that may affect utilization of services (i.e. copayments or premiums), because the difference between a Medicaid and a Combination/Separate state captures that aspect of program design[5]. Thus, the following variables are included in my analysis because of their potential impact on enrollment and because there is little known about their impact. The first four variables are

---

[5] Medicaid states cannot implement cost-sharing and the majority of premiums are present in Combination and Separate states.

concerned with the way that children enroll. Presumptive Eligibility allows states to authorize

qualified entities (e.g. health care providers, community organizations, schools, etc.) to screen

children for CHIP and enroll them immediately if they are deemed eligible (CMS, 2021c).

Continuous Eligibility allows states to provide CHIP eligible children with continuous coverage

for 12 months, regardless of changes in family income (CMS, 2021d). Express Lane Eligibility

allows states to expedite the eligibility and renewal process for CHIP by relying on information

from other Express Lane programs (e.g. SNAP) (CMS, 2021b). States are also allowed to

implement a waiting period of up to 90 days prior to enrollment in order to reduce crowd out

(CMS, n.d.-f). In this study, 1 indicates the use of a given enrollment feature, while 0 indicates

absence.

The last two variables make it easier for more children to enroll in CHIP. States have the option

to provide a buy-in option to families, which allows parents whose children would normally not

be eligible for CHIP (due to income caps) the ability to purchase public coverage (i.e. through

premiums and other co-insurance) if they meet other eligibility criteria (e.g. disability)

(MACPAC, 2020). This is often a cheaper and more comprehensive alternative to the private

market. States may also cover lawfully residing residents who are foreign-born (i.e. non-citizens)

through CHIP if they meet all other eligibility criteria (CMS, 2021a). Both of these variables are

coded 0 or 1, similarly to previous variables. While states have the option to provide CHIP

coverage to pregnant women, the available census data used in this study did not allow for

differentiation, and thus inclusion, of this population in eligibility data. Additionally, this

population is outside of my focus on children's coverage. Table 7 shows which design features

have been implemented by states.

Table 7: Program Variables by State in 2018

State	Type of CHIP	Presumptive Eligibility	Continuous Eligibility	Express Lane Eligibility	Waiting Period	Buy-in Option	Non-Citizens Allowed	Enrollment
AL	C	No	Yes	No	None	No	No	55%
AK	M	No	No	No	None	No	No	91%
AZ	C	No	No	No	90 days	No	No	75%
AR	C	No	Yes	No	90 days	No	Yes	58%
CA	C	Yes	Yes	No	None	No	Yes	35%
CO	C	Yes	Yes	Yes	None	No	Yes	54%
CT	S	Yes	No	No	None	No	Yes	24%
D.C.	M	No	No	No	None	No	Yes	56%
DE	C	No	Yes	No	None	No	Yes	35%
FL	C	No	Yes	No	60 days	Yes	No	53%
GA	C	No	No	No	None	No	No	40%
HI	M	No	No	No	None	No	Yes	30%
ID	C	No	Yes	No	None	No	No	48%
IL	C	Yes	No	No	90 days	No	No	28%
IN	C	No	No	No	90 days	No	No	29%
IA	C	Yes	Yes	No	30 days	No	No	41%
KS	C	Yes	Yes	No	90 days	No	No	43%
KY	C	No	No	No	None	No	No	38%
LA	C	No	Yes	No	90 days	No	No	36%
ME	C	No	Yes	No	90 days	Yes	Yes	64%
MD	M	No	No	No	None	No	Yes	37%
MA	C	Yes	No	Yes	None	Yes	Yes	84%
MI	C	No	No	No	None	No	No	19%
MN	C	No	No	No	None	No	Yes	18%
MS	C	No	Yes	No	None	No	No	57%
MO	C	Yes	No	No	None	No	No	22%
MT	C	Yes	Yes	No	None	No	No	38%
NE	C	No	No	No	None	No	Yes	58%
NV	C	No	Yes	No	None	No	No	62%
NH	M	No	No	No	None	No	No	37%
NJ	C	Yes	Yes	No	90 days	No	Yes	41%
NM	M	No	Yes	No	None	No	Yes	12%
NY	C	Yes	Yes	No	None	Yes	Yes	45%
NC	C	No	Yes	No	None	No	Yes	49%
ND	C	No	Yes	No	90 days	No	No	76%
OH	M	No	No	No	None	No	Yes	53%
OK	C	No	No	Yes	None	No	No	91%
OR	C	Yes	Yes	No	None	No	No	58%
PA	C	No	Yes	No	None	Yes	Yes	44%
RI	C	No	No	No	None	No	No	78%
SC	M	No	No	Yes	None	No	Yes	47%
SD	C	No	No	No	90 days	No	No	55%
TN	C	No	Yes	No	None	No	No	24%
TX	C	No	Yes	No	90 days	No	No	79%
UT	C	No	Yes	No	90 days	No	No	33%
VT	M	No	No	No	None	No	Yes	27%
VA	C	No	No	No	None	No	Yes	76%
WA	S	No	Yes	No	None	No	Yes	29%
WV	C	No	Yes	No	None	No	Yes	25%
WI	C	No	No	No	None	No	Yes	45%

| WY | C | No | Yes | No | 30 days | No | Yes | 32% |

Sources: Type of CHIP (CMS, n.d.-b); Presumptive Eligibility(CMS, 2021c); Continuous Eligibility (CMS, 2021d); Express Lane Eligibility (CMS, 2021b); Waiting Period (CMS, n.d.-f); Buy-in Option (The National Academy for State Health Policy, n.d.); Non-Citizens Allowed (CMS, 2021a); Enrollment (Berchick et al., 2019; CMS, n.d.-d; MACPAC, n.d.-b)

3.3.4 Enrollment Rates

The outcome variable of interest in this study is the annual rate of CHIP enrollment in each state. The numerator, Number Enrolled, is the number of unduplicated children enrolled in CHIP in 2018 in a given state. This data was sourced from the Centers for Medicare & Medicaid Services (CMS) and represents the number of unduplicated children enrolled in CHIP in each state (n.d.-b). The denominator, Number Eligible, is the number of children eligible for CHIP based on household income in 2018 in a given state. This figure is the sum of children in each age category and FPL range in each state. Age categories and FPL ranges were sourced from the Medicaid and CHIP Payment and Access Commission (MACPAC) (n.d.-b). The data for each state was sourced using the 'Income to poverty' variable in the U.S. Census (Bureau, n.d.-a). I selected data from 2018 only for two reasons. First, at the time of this writing, the most recently available data for CHIP is from the year 2018. Second, several policy features that I am interested in have not been available to states throughout the entire existence of CHIP and I am primarily interested in the policy options *currently* available to states. Express Lane Eligibility and eligibility for non-citizens was introduced in the Children's Health Insurance Reauthorization Act of 2009 (2009). Analyzing data from 2018 allows states sufficient time to implement these policy options. Additionally, CMS does not provide data on program changes

beyond the previous year of enrollment.[6] The final version of this variable is as follows and reflects the number of eligible children enrolled in CHIP in 2018 in each state:

$$\frac{\text{\# of children enrolled in CHIP}}{\text{\# of CHIP eligible children}}$$

3.4 Results

Table 8 shows the results for my Enrollment model, which examines the inclusive enrollment features (Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, waiting period) and CHIP type (Separate, Combination, Medicaid) intended to facilitate higher enrollment. Only a Medicaid CHIP type and having no waiting period are more likely to result in higher enrollment. In fact, many states with higher enrollment have not implemented Presumptive Eligibility or Continuous Eligibility. This pattern only covers a third of states and the consistency indicates that this design combination is very predictive of state enrollment rates. Exemplar states for this model are Alaska, Ohio, South Carolina, D.C., Hawaii, Vermont, New Hampshire, and Maryland. Each of these states has a Medicaid design and no waiting period and above average enrollment rates, despite not implementing Presumptive Eligibility, Continuous Eligibility, or Express Lane Eligibility[7]. There was no parsimonious solution for this model (likely due to the high consistency value), indicating that each tested IV was predictive of higher enrollment.

---

[6] See Appendix B for a lengthier discussion of annual trends in IVs/DVs.
[7] South Carolina does have Express Lane Eligibility.

Table 8: Enrollment Model (fsQCA)

Solution Type	(DV)	Program Variables Tested (IVs)	Salient IVs & Direction	Coverage	Consistency	Exemplar States
Complex	Enrollment	CHIP Type, Presumptive Eligibility, Continuous Eligibility, Express Lane Eligibility, Waiting Period	Medicaid, no Presumptive Eligibility, no Continuous Eligibility, no Waiting Period	0.324	1.000	AK, OH, SC, DC, HI, VT, NH, MD

The Eligibility model tests the combination of CHIP Type (Medicaid, Combination, Separate) and inclusive eligibility features (a buy-in option, eligibility for non-citizens) available to states. Table 9 shows the results of the complex and parsimonious solutions for this model. The complex solution shows that a Medicaid design and no inclusive eligibility features are more likely to result in higher enrollment rates. The coverage is high, representing roughly two-thirds of states. The consistency is also high, indicating that this pattern is very predictive of enrollment rates. The parsimonious solution, which represents fewer states but has an even higher consistency, shows that Medicaid design is the most predictive of higher enrollment rates. The exemplar states for this model are Alaska and New Hampshire—states with a Medicaid design, no buy-in option or eligibility for noncitizens, and high enrollment rates.

Table 9: Eligibility Model (fsQCA)

Solution Type	(DV)	Program Variables Tested (IVs)	Salient IVs & Direction	Coverage	Consistency	Exemplar States
Complex	Enrollment	CHIP Type, Buy-in Option, Non-Citizens	Medicaid, no buy-in option, no eligibility for non-citizens	0.664	0.753	AK, NH
Parsimonious	Enrollment	CHIP Type, Buy-in Option, Non-Citizens	Medicaid	0.310	0.787	AK, NH

One benefit of utilizing both fsQCA and linear regression in this study, is that I can leverage the analytical benefits of each option. While fsQCA can tell me which variables are necessary for higher enrollment rates, it is not possible to determine the precise impact of one variable alone. Table 10 shows the results of my CHIP Type Model through linear regression. Separate CHIP states have lower enrollment than Medicaid state. However, combination states have slightly higher enrollment rates than Medicaid states. This partially confirms my fsQCA results, though the results are not significant—which is expected given the small *n*.

Table 10: CHIP Type Model (Linear Regression)

Enrollment	Coef.	Std. Error	P>|t|
Combination	.0482982	.0684702	0.484
Separate	-.1661146	.1450825	0.258
Constant	.4335345	.0618634	0.000

Notes: $F(2, 48) = 1.43$; $Prob > F = 0.2500$; $R^2 = 0.0561$

When I examine all possible enrollment and eligibility design options in the Comprehensive Design Model (Table 11), I find some confirmation of what I found through fsQCA. Again, separate CHIP states have lower enrollment rates, but combination states have slightly higher enrollment rates, compared to Medicaid states. Presumptive Eligibility, Continuous Eligibility, and eligibility for noncitizens are not associated with higher enrollment rates. However, a buy-in option as well as Express Lane Eligibility, *are* associated with higher enrollment rates. As with the CHIP Type model, many of the results are not statistically significant, which is expected given the small sample size. The effect of ELE on enrollment is notably significant.

Table 11: Comprehensive Design Model (Linear Regression)

Enrollment	Coef.	Std. Error	P>|t|
Combination	.0403143	.0811337	0.622
Separate	-.0796597	.1499173	0.598
Presumptive Eligibility	-.0696554	.0671358	0.306
Continuous Eligibility	-.0361261	.0573215	0.532
Express Lane Eligibility	.1924262	.0924656	0.044[*]
Waiting Period	.0000214	.0007732	0.978
Buy-in Option	.1219073	.1019013	0.238
Noncitizens	-.0728887	.0606456	0.236
Constant	.472859	.0765608	0.000

Notes: $F_{(8,41)} = 1.28$; Prob > F = 0.2794; $R^2 = 0.2001$; * $p \leq .05$; Interactions were not significant and are included in Appendix C

The high standard errors and lack of statistical significance across most of my linear regression models lend support to my choice to use fsQCA as my main method of analysis. Given the small sample size, it is unsurprising that many of the results described above are not significant, even if many of these results align with my fsQCA findings. Additionally, linear regression, unlike fsQCA, cannot provide the user with a result that shows the combination of variables necessary for a given outcome. However, the ability to test the effect of CHIP type alone through linear regression was informative and affirmed my theory that this design choice matters and can make an impact on enrollment rates, even if other enrollment features are less predictive. The finding that ELE significantly affects enrollment is also informative.

One final enrollment feature available to states is the ability to charge premiums for children at higher income thresholds. Given the existing literature surrounding the potential negative effect of premiums on enrollment, I introduce this design element into my comprehensive design model

to test the effect on enrollment. Table 12 shows that not only do premiums have an effect on CHIP enrollment, that effect, similar to ELE, is statistically significant.

Table 12: Comprehensive Design Model with Premiums (Linear Regression)

Enrollment	Coef.	Std. Error	P>|t|
Combination	.0774945	.0805662	0.342
Separate	-.0001471	.1502252	0.999
Presumptive Eligibility	-.0556652	.0652249	0.399
Continuous Eligibility	-.0314992	.0554136	0.573
Express Lane Eligibility	.1907771	.0893128	0.039*
Waiting Period	.0001787	.000751	0.813
Buy-in Option	.1616663	.1004353	0.115
Noncitizens	-.0707671	.058585	0.234
Premiums	-.1143795	.057554	0.054*
Constant	.4962957	.0748816	0.000

Notes: $F_{(9,40)} = 1.66$; Prob > F = 0.1313; $R^2 = 0.2720$; * $p \leq .05$

3.5 Discussion

I find support for H1 and partial support for H2. The CHIP type (Medicaid, Separate, Combination) that states select does matter and a Medicaid design is associated with higher enrollment rates. This lends support to my theory that states that integrate their CHIP programs into their existing Medicaid infrastructure are more successful in enrolling and reenrolling children, though combination states (which enroll some of their CHIP kids through Medicaid) are also capable of high enrollment rates. There is little literature on how CHIP design impacts enrollment, but previous studies that examine the effect of premiums may help illuminate this phenomenon. Premiums—which I was able to confirm have a significant, negative impact on enrollment—are present in just two Medicaid states but over half of combination states. This may explain some of the mixed results on CHIP design.

Other enrollment features available to states are not always needed to achieve high enrollment rates. Only four states have implemented Express Lane Eligibility, though the impact of implementing ELE is significant and positive, a confirmation of previous work. A state does not need to offer Presumptive Eligibility or Continuous Eligibility to achieve higher enrollment rates. Reduced waiting periods—especially when combined with a Medicaid program design— *do* result in higher enrollment rates, suggesting that reducing some aspects of administrative burden continues to be beneficial to children, like in previous studies of CHIP.

A buy-in option and eligibility for noncitizens are not necessary either. A buy-in option may not be needed because of the introduction of the health care marketplace in the Affordable Care Act; CHIP is no longer the only option for the parents of children ineligible for Medicaid as it may have been in the late 1990s. Additionally, states may not feel the need to offer CHIP to more children or be concerned about lower enrollment rates due to fears of crowd out. This may explain states' variation in income caps in CHIP eligibility (MACPAC, n.d.-a). Offering higher income caps in CHIP eligibility may result in parents substituting dependent coverage for their child with public insurance through CHIP because of lower premiums and cost sharing.
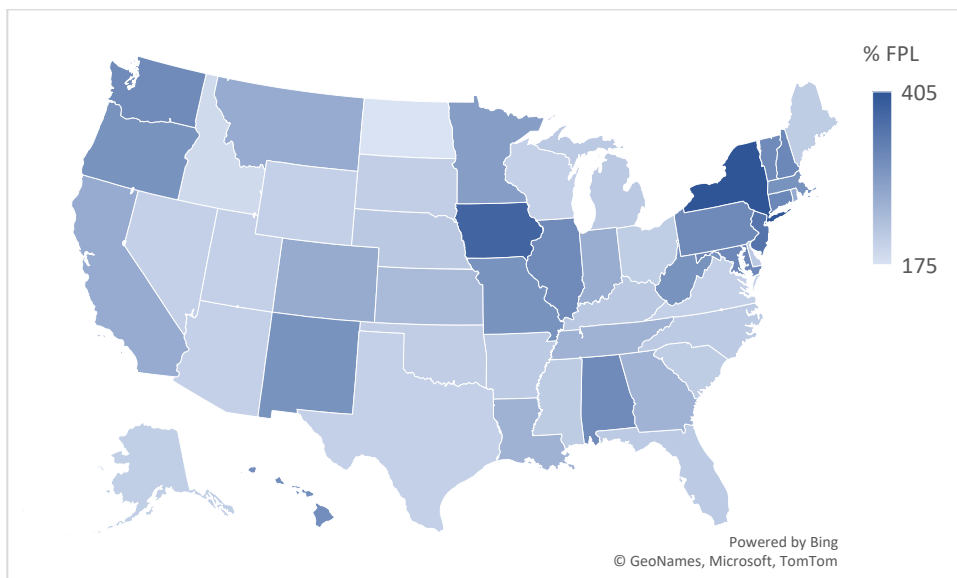
Figure 2: Income Caps in CHIP

Since states first rolled out their CHIP programs in 1998, there has been considerable change, both in the options available to them and the choices that they make (Table 13). This is proof that states utilize the flexibility afforded to them under the law. However, low take-up of design options such as Express Lane Eligibility, which significantly increases enrollment, begs the question of what else states are doing to increase enrollment. Navigators and lowering or eliminating premiums may help states meet the program's goal of insuring more children. On the other hand, states also may not be concerned about low enrollment rates. They may either place confidence in other market options for children's insurance or not mark high enrollment rates for children as a state priority. Subsequent, qualitative research should examine how different states set enrollment goals and use internal or external resources to meet them, if at all.

Table 13: Changes in CHIP by State

State	Type of CHIP[1]	Presumptive Eligibility[2]	Continuous Eligibility[2]	Waiting Period[3]
Alabama	Combination	No	Yes	None*
Alaska	Medicaid	No	No	None*
Arizona	Combination*	No	No*	90 days
Arkansas	Combination**	No	Yes*	90 days*
California	Combination	No	Yes	None*
Colorado	Combination*	Yes*	Yes	None*
Connecticut	Separate**	Yes*	No*	None*
D.C.	Medicaid**	No	No	None*
Delaware	Combination**	No	Yes	None*
Florida	Combination	No	Yes*	60 days**
Georgia	Combination*	No	No	None*
Hawaii	Medicaid	No	No	None
Idaho	Combination**	No	Yes	None
Illinois	Combination	Yes*	No*	90 days
Indiana	Combination	No	No*	90 days
Iowa	Combination	Yes*	Yes	30 days*
Kansas	Combination	Yes*	Yes	90 days**
Kentucky	Combination	No	No	None
Louisiana	Combination	No	Yes	90 days**
Maine	Combination	No	Yes	90 days
Maryland	Medicaid*	No	No	None*
Massachusetts	Combination	Yes	No	None
Michigan	Combination	No*	No*	None*
Minnesota	Combination	No	No	None*
Mississippi	Combination	No*	Yes*	None
Missouri	Combination**	Yes*	No	None*
Montana	Combination	Yes*	Yes	None*
Nebraska	Combination**	No	No*	None
Nevada	Combination*	No	Yes	None*
New Hampshire	Medicaid**	No	No	None*
New Jersey	Combination	Yes	Yes*	90 days*
New Mexico	Medicaid**	No	Yes	None
New York	Combination	Yes	Yes*	None
North Carolina	Combination*	No	Yes	None*
North Dakota	Combination	No	Yes	90 days*
Ohio	Medicaid	No	No	None
Oklahoma	Combination**	No	No	None
Oregon	Combination	Yes*	Yes*	None*
Pennsylvania	Combination*	No	Yes	None

Rhode Island	Combination**	No	No	None
South Carolina	Medicaid	No	No*	None
South Dakota	Combination**	No	No	90 days
Tennessee	Combination**	No	Yes	None
Texas	Combination	No	Yes	90 days
Utah	Combination*	No	Yes	90 days
Vermont	Medicaid	No	No	None
Virginia	Combination	No	No	None*
Washington	Separate	No	Yes	None*
West Virginia	Combination	No	Yes	None*
Wisconsin	Combination	No	No	None*

Notes: Wyoming did not have a fully operational CHIP in 1998. [1] * indicates transition to a more integrated program design/** indicates transition to a less integrated program design; [2] * indicates change; [3] * indicates reduction or elimination of waiting period/**indicated increase or introduction of waiting period
Sources: 2018 data (see Table 7); Type of CHIP 1999 data (Goggin, 1999); Presumptive Eligibility 2002 data (Klein, 2003); Continuous Eligibility & Waiting Period 2001 data (Bansak & Raphael, 2007)

3.6 Limitations

There are two limitations in this analysis. First, I only examine data from 2018. I do this because there is considerable literature surrounding CHIP upon its passage in the late 1990s. I also selected this year because some of the enrollment features available have only been available to states in recent years and the introduction of Medicaid expansion means that many states that were once Separate design states are now Combination design states. Additionally, CMS does not release program variable information beyond the most recent year, making it impossible to track all changes in program design options over time for a consistent and comprehensive analysis. However, while this choice may seem like a limitation to my analysis, it keeps the focus on the current impact of states' choices. States currently have many enrollment and eligibility features available to them to ease administrative burden and increase enrollment, yet they do not always choose to implement them.

The second limitation to this analysis is my small *n*, which is common in state-based studies. To account for this, I use fsQCA, an ideal method for case selection. This method of analysis is not a linear regression and cannot give exact predictions of how much enrollment will increase if a specific enrollment feature is used. It can, however, provide a comprehensive picture of which combination of options available to states are necessary for higher enrollment rates—which is precisely what I am interested in. Given the aim of this paper and the small *n* in this study, it is an appropriate choice that largely answers my research questions. I also supplement this through my use of linear regression to affirm many of these results and I am still able to find two significant results.

3.7 Conclusion

Overall, I find that program design matters and many individual enrollment features matter less in terms of increasing enrollment. This may be because the greatest amount of administrative easing comes from the difference between a Medicaid and separate program design. Medicaid is an enormous component of state policy infrastructure and has considerable state capacity associated with it. Individual enrollment features, such as Presumptive Eligibility, may not be necessary for states to implement to achieve higher enrollment rates if they have other methods of achieving increasing enrollment—though enrollment is higher in states with Express Lane Eligibility and no premiums. States also may have different priorities in CHIP. However, states utilize the flexibility granted to them in the Children's Health Insurance Program and that there is more than one way to improve enrollment rates.

Chapter 4 CHIP Policy Flexibility in Nebraska, Maryland, and Washington

4.1 Introduction

The primary goal in establishing the Children's Health Insurance Program in 1997 was to reduce the number of uninsured children in the United States. There is ample evidence that progress has been made towards this goal, albeit at an increased cost to states (Zimmer, 2011). A less explicit goal, evident by the design of the federal legislation, was to allow states flexibility in how they achieved that goal. While states must meet certain federal requirements in terms of benefits to children, the mechanism by which they provide those benefits and enroll eligible children is variable. Like much of the literature on CHIP, many previous studies that explore state decision making examine the first decade of the program and have a limited scope of variables that potentially affect enrollment. Previous state comparisons found that early CHIP decision making was correlated with state capacity and previous programmatic experience (Mcgrath, 2009). The first few years of CHIP also served as an opportunity for states to serve as policy laboratories during the implementation phase. Rather than learn from states that were physically close, states were more likely to learn from states that implemented successful policies and were similar on a political, demographic, and budgetary basis. For a limited number of program variables, legislative actions seemed to matter more in state decision making (Volden, 2006). In the past, some of the state choices surrounding CHIP have been regarding concerns about crowd out, though there is little evidence that state policy choices affect crowd out rates (Bansak & Raphael, 2007). There is, however, evidence that state policy decisions in CHIP have the potential to

increase a child's access to regular medical and dental care (Kenney, 2007) and that the increase will result in significant savings for poorer families (Shaefer et al., 2011).

In "Demographics and Partisanship in the Children's Health Insurance Program," I examined how demographics and partisanship impact state program design in CHIP. I found that whiter, richer states with fewer immigrants often had a more inclusive CHIP design. A Democratic legislature and Republican governor were also associated with a more inclusive CHIP design. In "Program Design and Enrollment in the Children's Health Insurance Program," I examined the relationship between inclusive program design and enrollment. I found states that select a Medicaid design, implement Express Lane Eligibility, and waive premiums are more likely to see higher enrollment rates in their CHIPs. A remaining inquiry from both studies is *why* states make the policy design choices they do and how various stakeholders approach state decision making in CHIP.

To answer that question, I select three case studies: Nebraska, Maryland, and Washington. Each state represents a different type of CHIP and all three are exemplar states in my previous work. Again, I find that partisanship matters. While nearly all legislators may vocally affirm their support for children's health, ideological differences over funding are familiar. I also find that states take advantage of the policy flexibility afforded to them by the federal government in the Children's Health Insurance Program and that Nebraska's approach to CHIP is quite varied from Maryland's and Washington's. Each state's values and other health policies factor into this variation. Finally, I surprisingly find that many individuals are underinformed about CHIP, even when they have the authority to change their state's program. Unlike adult Medicaid or other

health policies, CHIP is often a low conflict issue—as long as it does not attract too much attention.

4.2 Methods

4.2.1 Case Selection

As with any case selection, it is impossible to choose a set of perfectly representative cases, just as it is often infeasible to study every possible case (in this case, every state). With that limitation in mind, I attempt to choose a representative state for each type of CHIP: Medicaid, separate, and combination. I consider both the results of my previous analyses (which includes states identified as exemplars) and a state's capacity for being broadly representative in other ways. I also weigh my three case choices against each other, ensuring that together they represent a comprehensive picture of state decision making in CHIP. Each case study is an example of a particular path a state might take but should not be considered generalizable to all other states.

Nine states currently have Medicaid CHIPs: Alaska, New Mexico, Ohio, South Carolina, D.C., Hawaii, Vermont, New Hampshire, and Maryland (CMS, n.d.-b). Of those states, three— Vermont, New Mexico, and Maryland—are exemplar states for demographic and partisan factors. All three states are richer than the national average, all three have a Democratic legislature and Republican governor, Vermont and New Mexico are less Black, and Vermont and New Mexico have fewer immigrants (Bureau, n.d.-a) (National Conference of State Legislatures, 2021). All three states have similar, below average CHIP enrollment (CMS, n.d.-d). Maryland and Vermont also have below average uninsured rates for children, but New Mexico's is higher than most states ("Health Insurance Coverage of Children 0-18," 2020) ("Vermont State Profile," 2019). For the case of a Medicaid CHIP, I have selected Maryland for its population size (6.1

million, which is roughly the size of an average American state), its characteristics as an exemplar state, and its representation of the East Coast. Maryland also has a significant Black population (32%), making it an interesting deviation in that aspect (Bureau, n.d.-d).

In the early days of CHIP, many more states had a separate program from their existing Medicaid program. However, as time has gone on, and especially in the wake of the Affordable Care Act (ACA), many states have shifted to becoming combination states. Only two states—Washington and Connecticut—have maintained a separate CHIP (CMS, n.d.-b). Both states have: Democratic control in the legislature and Democratic governors, an average immigrant population, and below average Black and poor populations, making neither an exemplar for demographic or partisan factors that might predict CHIP design (Bureau, n.d.-a) (National Conference of State Legislatures, 2021). Neither of them are exemplar states for CHIP enrollment either, at just 29% in Washington and 24% in Connecticut (CMS, n.d.-d). However, both have the same low uninsured rate for children—2.5%, which is half the national average ("Health Insurance Coverage of Children 0-18," 2020). This suggests that while separate CHIP states may not enroll a significant number of eligible children in the program, these states are still committed to making sure children have access to health insurance in some way. For the case of a separate CHIP, I have selected Washington for its population size (7.6 million) (Bureau, n.d.-d), its portions of rurality, and its representation of the West Coast.

The majority of states now have a combination CHIP, meaning that some children are enrolled through traditional Medicaid, and some are enrolled through a separate CHIP. This is partially due to the passage of the ACA, which raised the Medicaid cap in many states (The Patient

Protection and Affordable Care Act, 2010). Of the forty states that have a combination CHIP, three are exemplar states for demographic and partisan factors: Massachusetts, Illinois, and Nebraska. All three are richer than the national average but differ in the remaining aspects. Massachusetts and Nebraska are whiter, while Massachusetts and Illinois have more immigrants (Bureau, n.d.-a). Nebraska shares Republican gubernatorial control with the other two states but features a unicameral legislature (which is technically nonpartisan) rather than a Democratic one (National Conference of State Legislatures, 2021) (Nebraska Legislature, n.d.). All three states also differ in their insurance coverage of children. Illinois has below average rates for CHIP enrollment (49%) and uninsured kids (3.2%). Nebraska has average CHIP enrollment (58%) and an above average uninsured rate for kids (6.1%). Massachusetts stands apart with both high CHIP enrollment (84%) (CMS, n.d.-d) and a very low uninsured rate for kids (1.1%) ("Health Insurance Coverage of Children 0-18," 2020). However, this is likely due not to CHIP, but rather to Massachusetts' health care reform aimed at covering all residents in 2006 (Chapter 58 of the Acts of 2006, 2006). While Massachusetts represents an excellent example of the push for universal coverage, it is not a representative state for CHIP. For the case of a combination CHIP, I have selected Nebraska for its population size (at 1.9 million, it represents a smaller state) (Bureau, n.d.-d), its significant portions of rurality, and its representation of the Midwest. Nebraska also has the potential to represent a state that does a good job of enrolling eligible children in CHIP, but not in insuring that every child has access to care. Between Nebraska, Washington, and Maryland, many of the demographic and partisan aspects of the United States are represented, making these case studies better suited to generalizability.

Triangulation is an important component of rigor in qualitative data; it helps add internal validity that is often built into traditional quantitative methods (Leech & Onwuegbuzie, 2007). It is achieved by using multiple sources of qualitative data (or quantitative, if one is using mixed methods) and multiple methods, if possible. Triangulation is built into this study at two levels. First, I examine the perspective of three groups of stakeholders in state children's health: legislators, administrators, and those at nonprofits. This triangulation helps to ensure that I present a clear picture of a state's approach from legislation to administration, to those that fill in the gaps. Second, I test the claims of my interviewees against the legislation they create and the policies they implement.

4.2.2 Interviews

To examine the perspective of stakeholders in state children's health, I conducted semi-structured interviews with a range of individuals in each state. I selected semi-structured interviews because surveys or set questions would have reduced the ability to adapt to an individual interviewee's expertise, their answers to previous questions, or the gaps left by previous interviewees. Thus, the interview process was iterative. For example, after completing an interview with a legislator in a particular state, it became clear which questions were most pressing to ask an administrator in that same state. Over the course of these interviews, I was able to gather a more comprehensive picture of state decision making in CHIP across the three states.

Interview invitations were sent to legislators on committees related to CHIP in each state, as well as state health administrators with CHIP oversight and nonprofits that work in children's health. Each potential interviewee was sent an interview invitation via email explaining the nature of the

study and why they were selected as a potential interviewee. If after two weeks there was no response, a second follow up email was sent. Many offices were physically closed during the Covid-19 pandemic in 2021, meaning that following up via phone was only possible for some potential interviewees. In the interest of everyone's health and safety, all interviews were conducted virtually, either via Zoom or over the phone (depending on interviewee preference).

Prior to sending out interview invitations, I applied to the Institutional Review Board at the University of Michigan. I was granted an exemption, as my study does not include any vulnerable populations. This study is also constructed to ensure the anonymity of each interviewee. Each interviewee that agreed to an interview also consented to recording over Zoom (if applicable). I was the sole individual with access to both the Zoom recordings of interviews and the interview transcripts. In reporting the results of these interviews, all names of individuals and organizations (e.g., a particular nonprofit or a particular state legislative chamber) have been omitted to reduce traceability to the interview source. Other characteristics that could contribute to traceability have also been omitted.

Interview transcripts were analyzed using inductive thematic analysis in Dedoose software. First, each interview was read for potential codes without categories. Next, codes were condensed, refined, and categorized into "Administrative Themes," "Legislative Themes," and "Broader Themes." Each code was then defined to construct a codebook for consistency. Interviews were coded according to the codebook and codes were not mutually exclusive (i.e., a passage could have four different codes associated with it). Descriptive statistics and representative quotes for each code were collected.

4.2.3 Legislation

To determine if the claims made by legislators in interviews were accurate, I examined the legislation brought forward in each state related to CHIP from 1997 – 2020. Using each state legislature website, I searched all bills related to "children's health" (with all possible iterations of the words) from 1997 (the year CHIP was passed federally) to 2020 in order to be as inclusive as possible. Bills were included from both chambers in Washington and Maryland and the unicameral chamber in Nebraska. These search techniques produced an initial set of bills per state, which were then read thoroughly, and irrelevant bills were removed. Each bill was coded for themes related to CHIP design features, which were not mutually exclusive. The year, chamber, and committee for each bill were also recorded.

Unlike the semi-structured interviews in this study, legislation was reviewed using a deductive thematic analysis. Themes were constructed using the various aspects of CHIP design available to states: creating a CHIP, increasing or reducing CHIP funding, improving enrollment, increasing or reducing eligibility, increasing provider reimbursement, increasing or reducing cost to families, and increasing access to care. Of course, many other bills were presented by legislatures from 1997 – 2020 that related to children's health (e.g., reducing environmental hazards). However, bills were removed if they were unrelated to children's health insurance coverage or access. This included bills that were aimed at overall health insurance in a state without particular attention to children.

4.2.4 Administration

I assess each state administration's commitment to CHIP, in comparison to their interview statements, by analyzing available annual reports on CHIP, as well as application information on

their website, and program design information provided by the states to CMS. For all three states, the information provided on the website only reflects current policies and reports range from 2014-2020. Each document or piece of media was analyzed using evaluative qualitative text analysis, which involves assessing text for pre-selected characteristics and ordinal strength. In this case, I use the following characteristics, which overlap with the themes explored in the interviews and the legislative search: commitment to increasing enrollment, commitment to increasing access to care, commitment to reducing cost to families, and commitment to reducing disparities. Excluded characteristics (e.g., commitment to increasing program funding) reflect issues that are controlled by the legislature rather than the administration. Each characteristic for each state can be ranked as strong, moderate, or weak. If strong, the state meets all criteria in the definition. If moderate, the state is missing one aspect in the definition. If weak, the state is missing all or multiple criteria in the definition. Table 14 details the definition for each characteristic:

Table 14: Characteristics in Administrative Documents

Characteristic	Definition
Commitment to increasing enrollment	Includes detailed enrollment data; includes multiple ways to enroll; includes features that encourage enrollment
Commitment to increasing access to care	Mentions access to care; includes standardized measurement
Commitment to reducing cost to families	No premiums; no cost sharing

Commitment to reducing disparities	Includes data on health disparities; details how the state will work to reduce health disparities

4.3 Results

4.3.1 Interviews

Many potential interviewees did not respond via email or phone, though this varied by state (Figure 3). Nebraska had the highest initial response rate (63%), which is likely because most Nebraska offices were open during the pandemic and had accessible phone lines. Of those who responded to the invitation, the most common reason for declining an interview was that the individual felt they lacked knowledge about CHIP. This response came from committee members or other individuals who often sat on or lead committees related to CHIP or individuals at organizations that list children's health access as a priority. A smaller number of individuals declined interviews based on a personal rule of not participating in research interviews. Others initially agreed but were lost due to follow up. Ultimately, the response rates for completed interviews are: 21% in Nebraska, 6% in Maryland, and 22% in Washington. An additional interview was added in New Mexico—which is also a Medicaid CHIP state—to supplement the Maryland interviews (Figure 3). Interviews across all three states included legislators, staff members at nonprofits, administrators, and other individuals familiar with CHIP. A snowball method was used that included initial invitations being sent to individuals in relevant roles and subsequent invitations sent based on recommendations from previous interviewees.
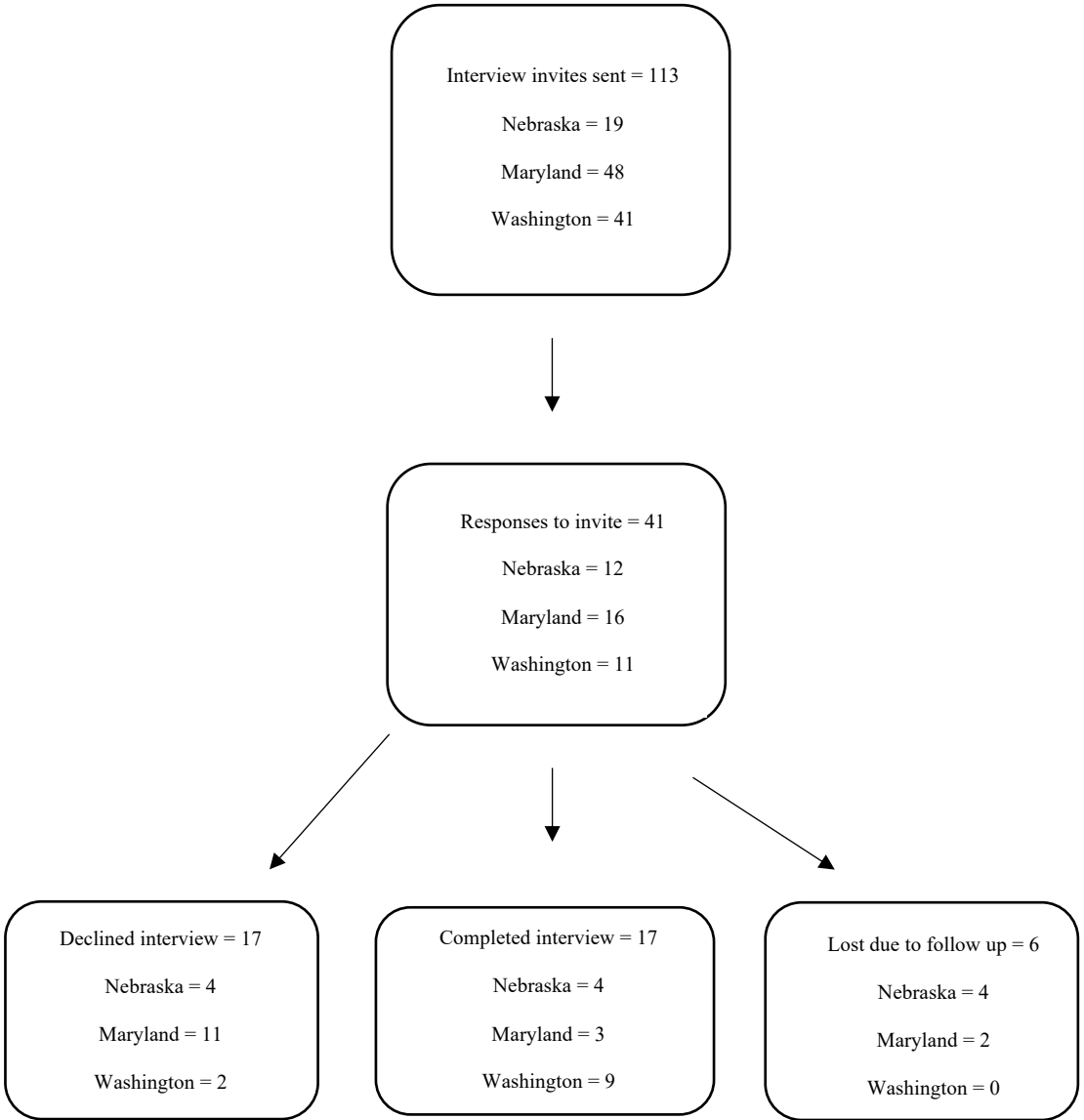
Note: One interview was conducted with a New Mexico legislator to supplement the Maryland interviews (19 individuals in New Mexico were sent invites; 2 responded, 1 declined an interview, 1 completed an interview, and 0 declined). New Mexico and Maryland are both Medicaid CHIP states.

Figure 3: Interviewees by State

Responses from administrators often pointed to the robustness of their state's CHIP. One

Nebraska administrator remarked, "[We] have a really robust benefit package. We probably have

one of the most generous ones in the country" (Table 15). This declaration of a commitment to

children's health came in states with high uninsured rates for children (Nebraska) and states with

low rates (Washington) alike. However, administrators differed in their description of their

office's role in CHIP success. Nebraska's CHIP was described as sufficiently generous, needing

little change from year to year to make sure the program was reaching eligible children.

Washington's administrators instead detailed ways that they were constantly working to make

the program more accessible to children and families. For example, the state waived premiums

for all CHIP eligible children during the pandemic. Washington has also committed to covering

all children, regardless of citizenship and making the user side of enrollment seamless:

> It should be exactly the same; the service delivery option is going to be a little different.
> So, if they're not covered under federal Medicaid or CHIP, they're not enrolled in a
> managed care plan here in Washington, so they get their coverage delivered fee for
> service.

Maryland, a Medicaid CHIP state, also treats children the same on the administrative side of the

program, "Maryland doesn't have a separate CHIP program…So, we cover it as…an expansion

of our children eligibility groups. And so, I don't think we treat it any differently."

Partisan tension was evident in all three state legislatures, from CHIP's establishment through

today. In Nebraska, a partisan divide exists between some Democratic legislators and the

administration, as well as within the unicameral legislature. One legislator remarked on the

power of the governor's agenda, "there's a major issue in our state with…our current

governor…he doesn't have a lot of respect for separate branches of government," and

contradicted the administration's claims of a generous state package for children, "No I don't

feel like it's accurate…I think we're doing okay; we can be doing so much more. And I think,

you know, part of the issue is…the Department of Health and Human Services." Much of the

partisan divide was attributed to ideological differences over the budget, not over differences in

children's health. This budget-related tension was also present in Washington, which has both

Democratic control in the legislature and a Democratic governor [and has since at least 2006;

(National Conference of State Legislatures, 2021)], "Did they [Republican legislators] support

this in the budget? The answer is probably going to be no. Did they support it as

recommendations coming out of the [behavioral health] workgroup? Yes." This finding was

especially surprising in Washington, a state that passed the Cover All Kids Act in 2007. This

persistent partisan divide pointed to CHIP often being a casualty of greater ideological splits on

spending, even when the issue of children's health is less divisive. In Maryland, CHIP's

intertwined nature with Medicaid has turned into a benefit, "They're [the legislature] is very

supportive of Medicaid expansion, and they would be resistant to any type of restrictions or

increased cost sharing" and the Republican governor has more or less acquiesced to this

commitment.

Aside from partisanship in children's health, a question that garnered varying reactions from

respondents was whether CHIP is a state priority. Some interviewees were frank from the outset

that CHIP rarely comes up in their committee, "I just want to say, and I hope this was conveyed,

that I'm not an expert on the details of CHIP." Others reiterated the important role that the legislature plays in children's health, "it's our responsibility to ensure that kids are well taken care of in our state." One notable area where many legislators agreed there is significant work to do is in behavioral health, largely because of a lack of providers and low reimbursement rates—which the state has control over. A lack of providers who service public health insurance enrollees is a recurring issue for states:

> We know that many across the board reimbursement rates have failed to keep up with the cost of providing care. The cost of providing care has skyrocketed for reasons outside of the provider's control. So, we also know that we have workforce shortages, particularly in behavioral health, because people can't afford to take on more clients.

And although interviewees in different sectors raised this issue, administrators reiterated that the power to raise reimbursement rates largely lies with legislators.

Many broader themes from interviewees centered on how outcomes for kids are often not the same and how citizenship, zip code, and race can play a role in determining access to care:

> It is not equal, given that the majority of Nebraska's population is white. So yes, there are going to be white uninsured kids. But the health centers are located in underserved areas, which happened to be the same areas that have been redlined, especially here in Omaha. And so, with that, they're going to have more black and brown populations, ethnicities

that are residing in these underserved areas, not a coincidence…then many of the

uninsured, yes, are going to be children of color.

Still, the most common response to questions of health equity in CHIP was that there simply is

not enough data available to know the full extent of disparities, as race is an optional form on

public health insurance enrollment forms and undocumented children are not eligible for

coverage. When asked what should be done about disparities in children's health, most

respondents agreed that better data is needed, but that they were unsure of how to obtain it. One

children's health advocate in Washington who had worked on Cover All Kids stated, "I've now

come to realize that those kind of universal, one size fits all things are often not solutions to

ending disparities."

Table 15: Themes from Semi-Structured Interviews

Theme	n (%)	Example Quote
Administrative Themes	n = 99	
CHIP as an administrative priority	18 (18.2)	"[We] have a really robust benefit package. We probably have one of the most generous ones in the country."
Enrollment	23 (23.2)	"We in Washington, we have a pretty comprehensive navigator network under the Affordable Care Act…And they sit in a variety of organizations from, you know, FQHCs, to community-based clinics, hospitals, public health entities, the plans, so they're kind of all over."
Evaluation	15 (15.1)	"I think the legislator's role is to provide the data to communities so that they can make better decisions about what to do."
Federal government	19 (19.2)	"It didn't require legislation to do it. And I don't even know whether we formally did rulemaking to do that. I think it was just, the Feds said it was okay to do it."
Program design	24 (24.2)	"We actually had to move pretty quickly. And we decided…to waive premiums altogether. And so that's what we've been doing for the last two years. That was huge."
Legislative Themes	111	
Budget	27 (24.3)	"Partially it is, again, because it all boils down to funding and where the money is coming from."
CHIP as a legislative priority	41 (36.9)	"My personal stance is that I think that, you know, as the state governing body, it's our responsibility to ensure that kids are well taken care of in our state."

Lack of CHIP knowledge	4 (3.6)	"I just want to say, and I hope this was conveyed, that I'm not an expert in the details of CHIP."
Partisanship	39 (35.1)	"Did they [Republican legislators] support this in the budget? The answer is probably going to be no. Did they support it as recommendations coming out of the workgroup? Yes."
Broader Themes	257	
Advocacy	38 (14.8)	"And they started asking us, do you think there'll be an impact for CHIP kids here? And they're like, oh, wow, yeah. And we had to scramble to try and pull that together."
Behavioral Health	27 (10.5)	"I think a focus of a lot of other legislators right now is just expanding access to health care in general. But again, especially when we talk about kids expanding access to mental and behavioral health care, because I think that's where the state is significantly lacking."
Citizenship	20 (7.8)	"Well, people who are undocumented are definitely. I mean, that's sort of our last, I guess I shouldn't say last, but that's a missing group from folks who have access to public insurance in the state."
Covid-19 pandemic	20 (7.8)	"Covid has affected our enrollment…it's hard to tell, because part of it is because of the public health emergency."
Health equity	35 (13.6)	"I've now come to realize that those kind of universal, one size fits all things are often not solutions to ending disparities."
Providers	58 (22.6)	"One thing we got really heavily lobbied on, and we did improve in the last budget cycle was pediatric primary care Medicaid rates…I mean, we are very low as a state."
State administration-legislature collaboration	23 (8.9)	"Often what we'll do is get the legislature to direct the Health Care Authority to seek a waiver…To do whatever it is you want them to do."
State norms & values	36 (14.0)	"So, I think in Maryland, given how…supportive they are of Medicaid, how they are very supportive of children's issues, they would never allow us to create a different package for CHIP that was more stringent, that just wouldn't even be in the cards."

4.3.2 Legislation

From 1997 – 2021, the Nebraska legislature put forth 75 bills related to CHIP (Figure 4). This smaller number is likely due to the fact that Nebraska has just one legislative chamber, while Maryland and Washington have the traditional two. Most of these bills were put forth by the Health & Human Services or Appropriations committees. The appropriations bills each year, from 1999-2020, all had one CHIP related purpose: to increase program funding for the next fiscal year. Starting at just $10,417,735 in 1999, Nebraska's CHIP budget increased to $125,946,106 in 2020. Although the state's general fund has decreased at several points

throughout the years, the overall program fund has continued to increase due to Nebraska's high enhanced FMAP, which was 84.14% in 2020.

The non-budget, CHIP related bills brought forward by Nebraska's legislature have been a mix of different aims, including increasing access to care, increasing eligibility, and improving enrollment. Bills aimed at increasing access to care were nearly all focused on increasing access to behavioral health care and cited mental health as an underserved area in the state.
Bills aimed focusing on eligibility increased the family income threshold to qualify for CHIP and extended coverage to lawfully residing children or lawfully residing pregnant mothers. However, some made enrollment more difficult on families by shortening the period that children are continuously enrolled in CHIP.

Reducing health costs to families was not a legislative priority of the Nebraska legislature; only seven bills addressed the issue over the course of two decades. A recent derailment of a bill aimed at reducing the cost to families of children with severe developmental disabilities showcases how pressure from the administration often interferes with Nebraska's "nonpartisan" legislature. LB 376, which was introduced in 2021 by Democratic Senator Machaela Cavanaugh, would have leveraged state funds to allow disabled children to stay in their homes and increased health care eligibility for disabled children regardless of family income (Legislative Bill 376, 2021). Despite receiving a bipartisan push out of committee, the bill was filibustered and killed by Republican senators (admin, 2021), an action Senator Cavanaugh claims was deliberate, "Everyone knows the open secret that the governor called a whole bunch of senators yesterday and told you all to kill my bill" (Ozaki, 2021).

The findings from the legislation are largely in line with many of the responses from my interviews with those in Nebraska. Legislators have committed to funding children's health, though that is mostly the extent of their commitment. They do not seek out large increases in eligibility, coverage of immigrants, or finding ways to reduce costs to families.
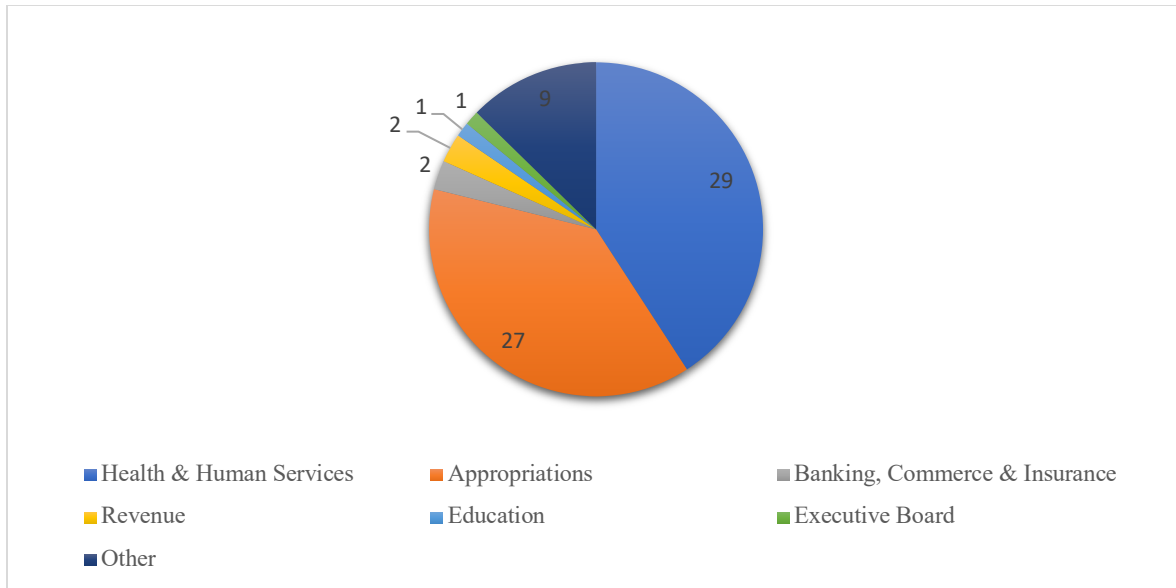

Figure 4: Nebraska CHIP Legislation by Committee

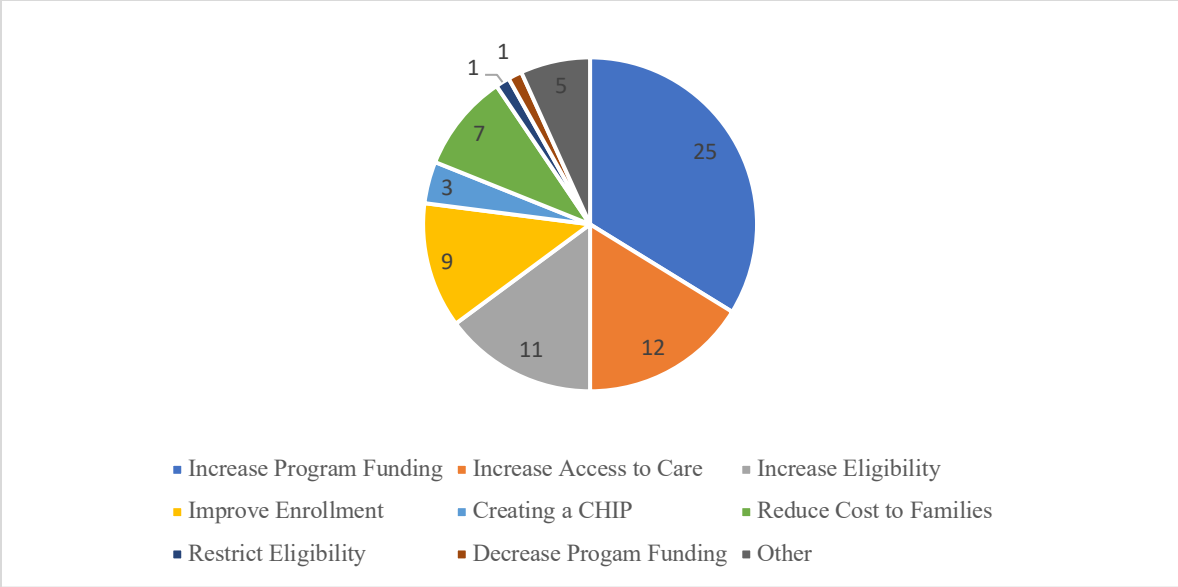Notes: Search total = 581; Relevant legislation analyzed = 75

Figure 5: Nebraska CHIP Legislation by Theme

Like Nebraska, many of the bills put forth by the Maryland state legislature were sponsored by

the Health & Government Operations and Finance committees. However, the aim of most bills

was either to increase eligibility or to improve enrollment. A common mechanism across many

Maryland bills was to increase outreach related to Medicaid/CHIP enrollment by connecting the

application process to existing paperwork that parents already encountered. For example, HB

1024 proposed including a state health insurance form along with existing school forms for lunch

program eligibility. The legislature repeatedly increased the income eligibility cap in CHIP, at

one point to 400% FPL. For comparison, Nebraska's is just 218% FPL. To offset the cost of the

state covering individuals at the higher end of the income distribution, the legislature also put

forth many bills that imposed or increased premiums for "higher earning" individuals.

Because Maryland is a Medicaid CHIP state, several bills were focused on all individuals and not

just children. This included bills that called for universal health care for all Marylanders, which

were excluded due to their lack of reference to children. Despite being a Medicaid CHIP state, Maryland still made explicit legislation aimed at increasing the number of children enrolled in public health insurance. The Health and Government Operations repeatedly directed insurance providers to inform employers of Medicaid and CHIP during their enrollment periods. In the 2010s, many bills in the legislature began to focus on Maryland's state cooperation with the Affordable Care Act.

The results from the legislative search mostly align with the responses from my interviews with those in Maryland. Medicaid and CHIP are very much the same in Maryland, though the state does routinely draft legislation aimed at improving outcomes in children's health. Maryland also has a commitment to innovative ways to increase CHIP enrollment among eligible children and increasing eligibility for others. To pay for these increases to the state, the legislature often imposes or increases premiums for upper income families, a mechanism that was brought up by Maryland administrators but not legislators.
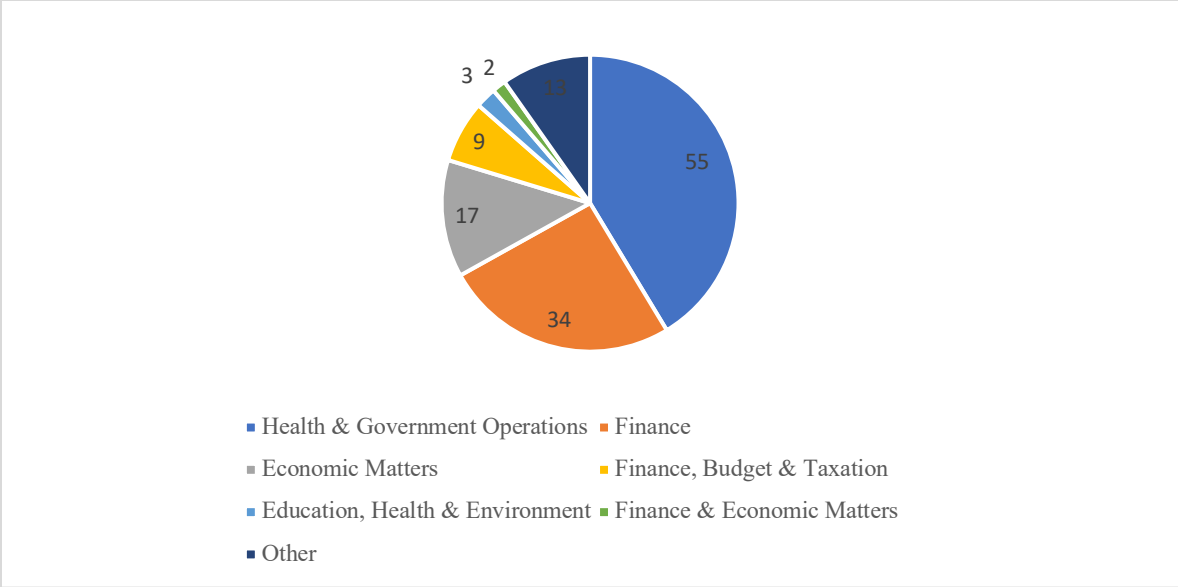
Figure 6: Maryland CHIP Legislation by Committee

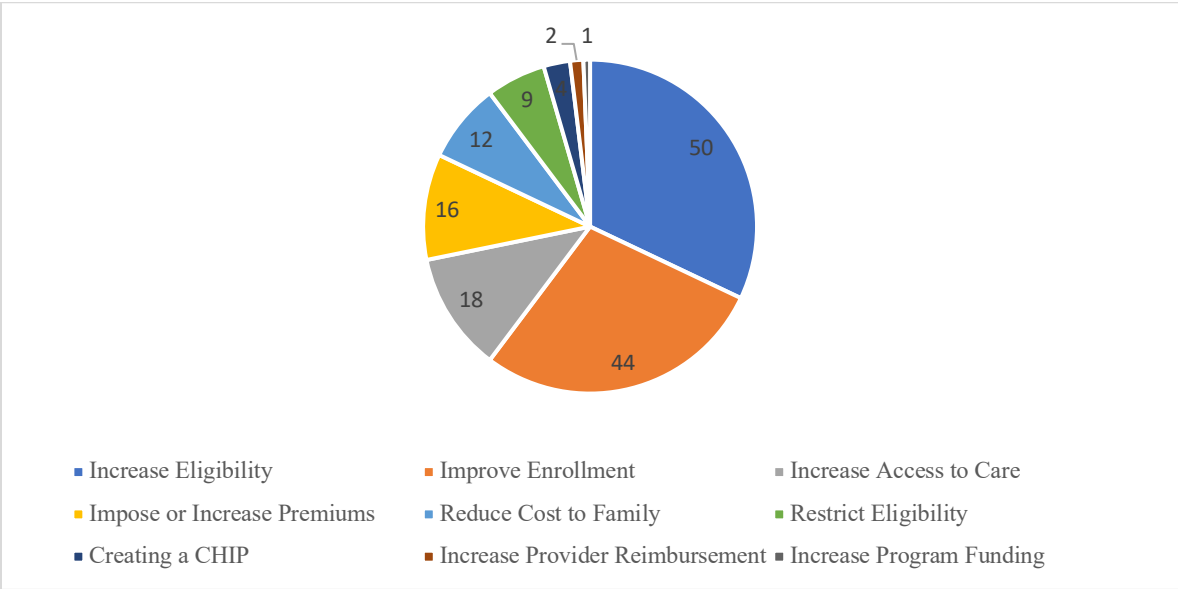Notes: Search total = 500; Relevant legislation analyzed = 133

Figure 7: Maryland CHIP Legislation by Theme

Washington had the largest number of bills related to CHIP ($n = 167$) and most were not

sponsored by a health committee, but rather by the Ways & Means and Appropriations

committees (Figure 8). This is likely because a recurring budget item was to provide children who were ineligible for public insurance (i.e., undocumented children) with charity care through hospitals. This focus on access to care and the state's other focus on improving enrollment outcomes (rather than increasing eligibility) is likely due to the landmark passage of Cover All Kids (SB 5093) in 2007. The bill ensured that all children would have some form of access to health coverage. This means that children in families up to 250% FPL would have state access with no waiting list and no cost, and that others would get subsidized or full cost access to state coverage. This bill changed the trajectory of children's health in the state of Washington and came after a tumultuous few years of budget cuts to children's health and reduced funding during the Great Recession (Office of Financial Management, 2012).

Aside from increasing coverage access for children regardless of citizenship and improving enrollment, Washington legislation has also focused on increasing child access to mental health care and making the paperwork process less burdensome. These bills were often at the recommendation of the state's children's mental health work group. Increasing the number of school nurses, with a particular emphasis on student mental health, was also a common focus of the legislation. This commitment to mental health parity is similar to a theme in legislation from Maryland and points to a common point from interviews, that states can and should do more when it comes to children's mental and behavioral health.

Although Washington has a separate CHIP, it is clear from its legislation over the past twenty-three years that it has a deep commitment to children's health and uses the power of the legislature to ensure it. Cover All Kids was a landmark bill that removed the need for legislation

in Washington to focus on increasing eligibility and made room for the state to instead explore other aspects of children's health (Children's Alliance, n.d.). Even for those who are ineligible for public insurance, the legislature continues to provide access to care at multiple points of service.
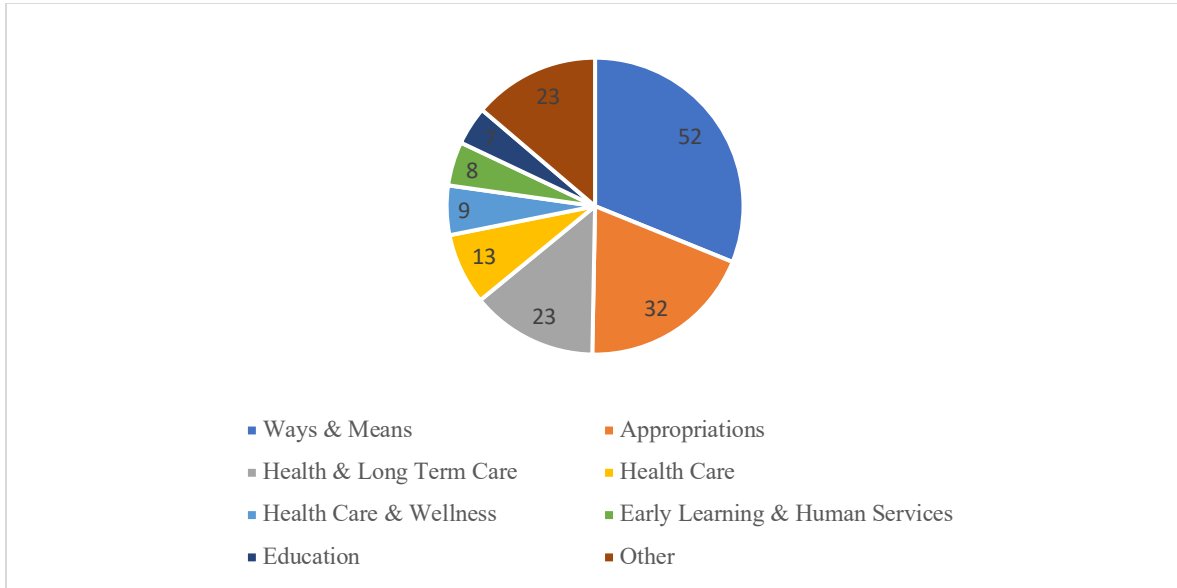

Figure 8: Washington CHIP Legislation by Committee

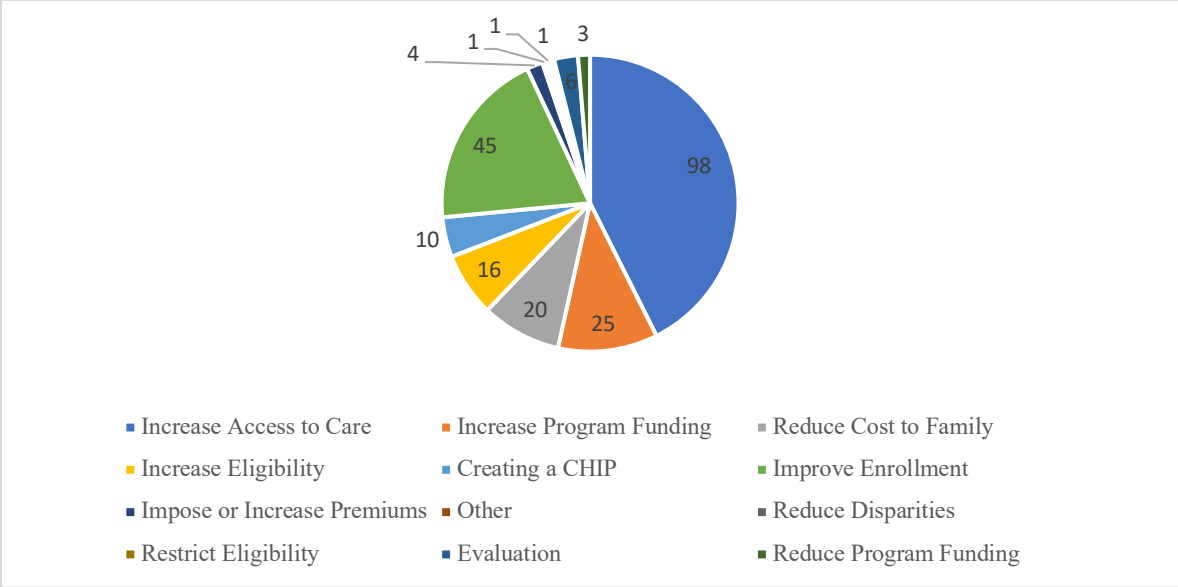Notes: Search total = 892; Relevant legislation analyzed = 167

Figure 9: Washington CHIP Legislation by Theme

Overall, the results of the legislative search largely confirm the statements made by interviewees in each state. Two notable areas of legislation that had few or no bills over the lifespan of CHIP are increasing reimbursement rates and studying or decreasing health disparities in kids. The former may be due to states' likelihood of altering reimbursement rates for providers overall, not just related to children's health—even in Washington, which has a separate CHIP. The latter is disappointing, considering the statements by interviewees that better data is needed to identify and reduce health disparities among children. And yet only one bill in Washington explicitly focused on doing so.

4.3.3 Administration

Nebraska provides annual enrollment data by age group (not by specific age), but not other demographic enrollment data. It has no waiting period to enroll and allows families to apply online or over the phone. Its income cap for eligibility is lower (218% FPL) and it does not include other enrollment features that might assist families in enrolling their child, such as:

Continuous Eligibility, Presumptive Eligibility, or Express Lane Eligibility. Nebraska's CHIP

has no premiums and no cost sharing. The administrative reports available make no mention of

health disparities among children or the state's strategy to reduce them; even basic data on race is

absent. The mixed to weak characteristics present in Nebraska's CHIP administration reflect the

same mixed responses from interviewees: administrators claimed that the state has a generous

benefit package and advocates and some legislators stated that there was room to reach more

children.

Table 16: Nebraska CHIP Administration by Characteristic

Characteristic	Strength
Commitment to increasing enrollment	Weak
Commitment to increasing access to care	Moderate
Commitment to reducing cost to families	Strong
Commitment to reducing disparities	Weak

Note: Includes reports from 2015 - 2019

Maryland does not provide enrollment data on children's health but does provide enrollment data

on Medicaid more broadly. It has no waiting period to enroll and allows families to apply online,

over the phone, via an app, or in person with a navigator/at a health department/at a social

services center. It has a higher income cap for eligibility (322% FPL), but it does not offer other

enrollment features that might assist families in enrolling their child. Maryland's CHIP does

require premiums for some enrollees, but it does not require cost sharing. The administrative

reports available make no mention of health disparities among children or a state's strategy to

reduce them. Like Nebraska, race data is absent. Most of Maryland's administrative reports focus

on detailing access to care in specific areas of health (e.g., outcomes from an autism waiver) and rigorous, standardized measurements to measure progress. The mixed characteristics present in Maryland's CHIP administration mostly align with responses from interviewees. Respondents frequently mentioned increasing access to care. They also confirmed that premiums are applicable to reduce the cost to the state and that health disparities data is difficult to collect.

Table 17: Maryland CHIP Administration by Characteristic

Characteristic	Strength
Commitment to increasing enrollment	Moderate
Commitment to increasing access to care	Strong
Commitment to reducing cost to families	Moderate
Commitment to reducing disparities	Weak

Note: Includes reports from 2014 - 2020

Washington provides enrollment data by age, race, and primary language spoken. Just like Nebraska and Maryland, it has no waiting period to enroll. Families can apply online, in an app, over the phone, by mail, or in person with a navigator. Washington also details coverage options for those who are ineligible for CHIP. Like Maryland, it has a higher income cap for eligibility (317% FPL) and has also implemented Continuous Eligibility. While the state does require premiums of some enrollees—though these are currently waived due to the Covid-19 pandemic––it does not require cost sharing. The state's reports frequently mention access to specific health sectors, such as behavioral health, and whether last year's goal of increasing access was met. Washington is the only state of the three to include data on race, though it is unclear whether health disparities exist or if the state plans to address them. The moderate to strong commitment

to CHIP by Washington's administration is representative of the statements made by interviewees. Ever since Cover All Kids was passed in 2007, the state has had a strong commitment to children's health in both the legislature and the administration.

Table 18: Washington CHIP Administration by Characteristic

Characteristic	Strength
Commitment to increasing enrollment	Strong
Commitment to increasing access to care	Strong
Commitment to reducing cost to families	Moderate
Commitment to reducing disparities	Moderate

4.4 Discussion

The three streams of data used in this study have shed an informative light on how states make decisions when it comes to CHIP. Budget plays an outsized role in the legislative agenda and may represent the most stable part of states' approaches to CHIP. This stability may also help explain why CHIP changes little from year to year in some states, both in outcome and program design. Interviewees often described CHIP—and even sometimes children's health as a whole— as the "forgotten sibling" of state health policy. Debates over Medicaid expansion and whether or not childless adults deserve access to health coverage often take up more of the spotlight. Advocates for children's health described this as both a pro and a con; ask for too little and CHIP will not be expanded, ask for too much and you risk making the program partisan like traditional Medicaid.

Great variation was present across the states. While none of the states were particularly deficient in their approaches to CHIP, each used the policy flexibility available to it to prioritize different aspects of children's health. Nebraska's approach was mostly one of stability; while total program funding increases every year without fail, hardly anything else changed along with it. This may explain the state's high uninsured rate among children. Maryland emphasizes that CHIP and Medicaid are treated the same, which currently makes the program safe politically, as the state has a strong commitment to health access through Medicaid. Although Washington is one of just two states with a separate CHIP, it includes the program in its larger commitment to coverage for every child, a commitment that began with the passage of Cover All Kids and continues to evolve. One area most states are lacking in is in measuring health equity among children in CHIP. Future research should explore how the CHIP experience is affected by race, rurality, and other factors. This will take better data and a commitment by states to gather it. Without this, it is difficult to know if states are reaching all children equally or not.

There are limitations to the generalizability of this study. Although Nebraska, Maryland, and Washington represent three robust examples of how states make decisions in CHIP, they cannot represent every regional and social nuance from state to state. Similarly, the themes that emerged through interviews across the states may have looked different if everyone who was sent an invitation had responded and been interviewed. This is a realistic limitation of survey research. Although my use of triangulation through legislative and administrative analyses helped reduce the bias of only relying on interview data, there are potential limitations to those forms of data as well. The legislative search I conducted, while intentionally broad, still may not have captured all legislation related to CHIP over the years. Additionally, publicly available administrative

documents may not always be representative of everything the administration is doing regarding CHIP.

4.5 Conclusion

The Children's Health Insurance Program is a flexible public insurance option for states and state decision making can look markedly different depending on partisanship, state values, and the structure of the program. While many legislators affirmed their commitment to children's health, ideological splits over the budget for CHIP are similar to those in more contentious political fights. In a way, CHIP is a low conflict issue, if only to a certain degree. This was evident in states like Nebraska, where partisanship may manifest itself more as maintaining the less-than-generous status quo, rather than an active effort to reduce eligibility or benefits, as states may do with adult Medicaid. However, maintaining the status quo does not necessarily equate to a failing program. States that select a Medicaid CHIP, like Maryland, may benefit from including CHIP in their broader health policy approach. Though there are just two separate CHIP states left, Washington is proof that a state's values surrounding a child's right to coverage matter a lot when it comes to reducing the number of uninsured children and that legislators and administrators can work together to make that a reality.

It is clear from my conversations with stakeholders that CHIP receives less attention than other health policies in states. This was referenced as a political benefit in some ways by nonprofit workers; if CHIP does not ruffle any feathers, then it is less likely to be receive budget cuts. However, this lack of attention has consequences. It can also result in less attention to the potential for inequity in CHIP. Nearly everyone I spoke to admitted that the data on equity is severely lacking, and that they could not explain why it was not a greater priority for states.

More work will be needed in the future to collect better data on race, rurality, and other areas of potential inequity in the Children's Health Insurance Program.

Chapter 5 Conclusion

"*We fulfill one of the highest responsibilities we have: to ensure the health and well-being of our nation's children. It is a responsibility that has only grown more urgent as our economic crisis has deepened, health care costs have exploded, and millions of working families are unable to afford health insurance.*"

-President Barack Obama, 2009

Just two weeks after he was inaugurated, President Obama signed into law a reauthorization and expansion of the Children's Health Insurance Program (*CHIPRA | Medicaid*, n.d.). That the legislation had been vetoed twice under President Bush (U.S Senate, n.d.) shows a shift from the strong bipartisan support that existed for CHIP in the late 1990s. The reauthorization allowed states to enroll legal immigrant children and more than doubled the excise tax on cigarettes—policy choices that the Republican party largely opposed. The reauthorization of CHIP was a far cry from the ideological compromise made by senators Hatch and Kennedy just 12 years earlier.

The lack of unity surrounding funding for children's health is also visible in the states. I find that the demographics and partisanship of a given state have a meaningful impact on how inclusive a state's CHIP design is and that some aspects of those design choices impact enrollment rates. State administrators and legislators agree that children should have access to health insurance, though where the responsibility lies for that access is a matter of division. Many states do not

actively block CHIP funding altogether or try to exclude children from inclusion in the program. Rather, they perpetuate the status quo of CHIP as it was in 1997, a CHIP in which design tools to streamline enrollment did not exist and children from outgroups (e.g., immigrant children) did not have access to coverage. A partisan aversion to greatly increasing CHIP's budget plays a large role in maintaining the status quo in states like Nebraska. However, the past twenty-five years have also seen considerable progress in states like Washington, where administrators and legislators alike have made a commitment to covering all children, regardless of background. States like Maryland tie the political fate of Medicaid and CHIP together, which can be beneficial in states where Medicaid is popular and well supported.

Where the Children's Health Insurance Program goes from here, as political and societal challenges to children's health arise, is unclear. In early 2020, the novel coronavirus discovered in Wuhan, China spread rapidly, creating a worldwide pandemic that has killed nearly one million people in the United States alone (CDC, 2022). The impact of an economic emergency in which millions of Americans lost their jobs on health insurance coverage is not yet clear. Prior to the pandemic, many children did not need CHIP access because they were covered as dependents through plans from their parents' employers. However, that situation likely shifted considerably over the past two years, making countless children CHIP eligible. Future research should explore whether states met the task of making sure they were continuously enrolled.

In many interviews with individuals who work on children's health, a known failing repeatedly came up: the data on disparities in the Children's Health Insurance Program is severely lacking. Because race related data is usually optional on enrollment forms, it simply never gets collected.

While nearly everyone I spoke to acknowledged this as a problem, almost no one was doing anything about it. Without better data on race, rurality, and other potential health disparities in CHIP enrollment data, we have no way of knowing if the program's success has been equitable. Finding a way to obtain this data will be challenging, but vital to better understanding whether policy flexibility in CHIP should continue to be granted to the states.

The Children's Health Insurance Program occupies a peculiar place in health policy in the United States. Like Medicaid and Medicare, it represents one of the more ambitious advancements in socialized medicine in a country that is largely dominated by private insurance (CDC, 2021). And yet, the difference in political attention to CHIP is vast. CHIP can most aptly be described as a low salience, low conflict health policy. It remains in place in states and a vital fixture, but its stability can prevent the program from adapting enough to meet changing needs. This policy drift (Hacker et al., 2015) may be the price of CHIP's political safety, compared to constant attempts to repeal policies like the Affordable Care Act.

Despite this lack of attention, CHIP remains a vital component of children's access to coverage in the US. Failing to reauthorize CHIP when its funding expires in two years (Bipartisan Budget Act of 2018, 2018), changing the eligibility structure of the program, or altering the tools available to states all have the potential to undo the decades of progress in reducing the number of children who are uninsured in America. Conversely, maintaining the status quo and failing to make sure that all children have equal access to coverage means that the program will continue to not live up to its promise.

Appendices

Appendix A: Discussion of fsQCA Method

Although fsQCA has been in use for two decades—and its parent method, QCA, has been in practice for more than three—it is still unfamiliar to many quantitively trained social scientists (CDC, 2021). Its "fuzzy" nature makes the method less traditional than a typical regression, but not any less valuable. Studies with large datasets that aim to determine the precise causal effect of individual variables are well suited to traditional regressions as there is less concern regarding underpowered data or questions about robustness in determining causality. When a researcher is examining just one example of a thing, or a few, a standard cases analysis will usually suffice. However, studies with small to medium sample sizes that seek to know the impact of a particular causal pathway on an outcome and want some level of generalizability are often stuck between the two aforementioned methods.

Unlike crisp set QCA (csQCA), fsQCA allows researchers to include both binary conditions (i.e., variables) and "fuzzy" conditions (i.e., on a scale from 0 to 1). A researcher inputs each condition for each case and the software then assesses whether the case belongs to a set (i.e., a set of conditions that leads to a given outcome). Membership in a set is not binary; researchers have the ability to set a threshold for membership and each solution option shows a different set with a different list of conditions (Pappas & Woodside, 2021). For example, if the outcome we are interested in is a good economy at the country level, several conditions may contribute, such

as: unemployment, inflation, Covid-19 cases, and median age of population. One set may include: unemployment and inflation, with the complex solution (i.e., the solution that includes all conditions) including low unemployment and low inflation. This is not to say that Covid-19 cases and median age of population do not affect the economy, this result just means that they are less predictive of our selected outcome, among the cases included in our analysis. The parsimonious solution (i.e., the solution that is the most predictive of the outcome) may include only low unemployment.

As described in the methods sections of Paper One and Paper Two of this work, the coverage and consistency figures are the most important numbers in the fsQCA output. Coverage is the proportion of cases that are explained by the set and ranges from 0 to 1. Consistency represents the extent to which a causal pathway leads to a selected outcome and ranges from 0 to 1 (Ragin, 2017). The consistency value is the closest comparable figure to a coefficient in a traditional regression, but it should *not* be interpreted in the same, precise way.

As with traditional regression, fsQCA has its limitations. The requirement for considerable contextual knowledge is likely the biggest limitation to fsQCA as a method. Because a researcher decides which cases are included, which conditions are included, and various thresholds for assessing relationships between conditions and outcomes, approaching this method with a solid theoretical understanding of the subject matter is essential. When conditions are not obviously binary and the "fuzziness" is more at the researcher's discretion, the need for institutional and contextual knowledge becomes even more necessary. Given this requirement, conditions should always be directly related to the cases and research question at hand. The goal

of fsQCA is not to obtain a precise number related to causality, but rather a causal pathway that explains a selected outcome (which should also be selected with the cases and research question in mind) (Schneider & Wagemann, 2010).

Indeed, the significant adaptability available to the researcher has opened up the method to critiques of robustness:

> fsQCA—like many conventional methods—also demands the assumption of correct model specification…But the robustness of fsQCA is potentially limited by the fact that it may be more likely than not to accept the sufficiency of causal configurations that include variables knowingly unrelated to the outcome (Krogslund et al., 2015).

Even when relevant conditions are selected by the researcher, incorrect calibration of the method or overextrapolation of the results can lead to overgeneralizations about what they represent.

Despite these shortcomings—which, of course, all methods in some way have—fsQCA is still incredibly valuable and well suited to studies with smaller sample sizes and social science inquiries that are interested in pathways rather than precise predictions. As Willison writes in her use of the method for her work on homelessness policy, "Identifying this variation is important, because it demonstrates that…governments may arrive at the same outcome as a result of different factors and processes" (2019). In my own work, I am purposefully aware of the potentials for misuse of fsQCA and utilize the calibration of former research in order to avoid it, which I will outline below.

First, I do not use fsQCA alone in my pursuit of state variation in CHIP design. In Papers 1 and 2, I use traditional regression as a robustness check. The pairing of fsQCA with a complementary method is recommended to achieve triangulation (Schneider & Wagemann, 2010). Of course, my regression results are largely non-significant (which is expected, given my small n), but many of the results share the same directionality as my fsQCA results and two are significant. Second, I use the results of my fsQCA for one of the method's greatest strengths: case selection for qualitative follow up (Kraus et al., 2018) in Paper Three. Third, the construction of my cases and conditions is deeply rooted in the literature and CHIP universe. Rather than excluding cases, I include all fifty states and D.C. to create a comprehensive database of cases. Excluding states would introduce doubt as to whether the results are generalizable across the United States. In both papers, the program design variables are the choices that states have control over and are directly related to enrollment. In Paper 1, the state demographics I use as conditions that affect design have been shown to impact state decision making in past health policies (i.e., they are chosen based on theory, and not randomly). Fourth, the conditions I select do not require the researcher to decide the exact value for each case. For example, a state either has Express Lane Eligibility or it does not.

Finally, I make parametric choices while using fsQCA based on previous work in the field. I utilize a frequency threshold of 2, which is appropriate for a medium sample size (Pappas & Woodside, 2021). I set my consistency threshold at 0.7, which is standard among past research and high enough to make the results meaningful (Schneider & Wagemann, 2010). Still, there is no figure in fsQCA that is equivalent to a p-value in traditional regression, which automatically tells a reader whether the results are significant or not. With that in mind, I attempt to give

sufficient discussion of the implications of my fsQCA results on their own, as well as in

comparison to my regression results. Paper Three also provides space to further analyze the full

meaning of those results as quantitative results can only explain so much.

Appendix B: Discussion of Annual Trends in IVs/DVs

In Paper One, I select the year 2018 for both my independent variables (state demographics and partisanship) and dependent variable (program design). Because I am interested in several CHIP design variables, I rely on annual state reports from CMS to obtain a comprehensive picture of CHIP in each state. Unfortunately, CMS only publicly provides these annual reports for the previous fiscal year (CMS, n.d.-e). If I were interested in CHIP program design changes by state over time, this would present a problem. However, a significant, robust literature surrounding early CHIP decisions by states exists and I do not intend to replicate it. Additionally, I am interested in some design elements (e.g., Express Lane Eligibility) that only became available to states following the passage of the Children's Health Insurance Program Reauthorization Act in 2009 and in allowing sufficient time for states to implement these new design options. Primarily, I am interested in CHIP in 2018, not 1998 or 2008. Therefore, I selected the most recent available year, as of this writing, for my dependent variable for both pragmatic and theoretical reasons.

I also select 2018 as the year for state demographics and partisanship (i.e., my independent variables in Paper One). As can be seen below in a series of graphs for state demographics, the selection of 2018 for these variables is unlikely to negatively impact my ability to assess the impact of the relationship between state demographics and state program design. The proportion

of Black Americans is relatively stable over the past five years (Appendix Figure 1 – Appendix Figure 10) (Bureau, n.d.-c). The proportion of poor Americans does show some decline from 2013 to 2018 (Appendix Figure 11) (Bureau, n.d.-b). However, this is expected given the gradual recovery from the 2008 recession (World Bank, n.d.). While there is some growth in the proportion of Americans who are foreign-born form 2013 – 2018, the trend becomes relatively stable when examining the data in the context of the overall increase in immigration since 1960 (Appendix Figure 12) (Budiman et al., 2020). The final variable where there may be concern for the impact of looking at a 2018 independent variable's impact on a 2018 dependent variable is state partisan control. Indeed, there is considerable change from 2014 to 2018 (Appendix Figure 13 – Appendix Figure 15). However, 2018 partisan control data actually represents the legislative and governor control of each state in January of 2018, meaning that the data reflects governors in control since at least 2016 (National Conference of State Legislatures, 2021). Thus, the snapshot of CHIP by state in 2018 *is* reflective of those that had control over altering the state's program design, not of newly elected leaders who may be completely inexperienced regarding CHIP.
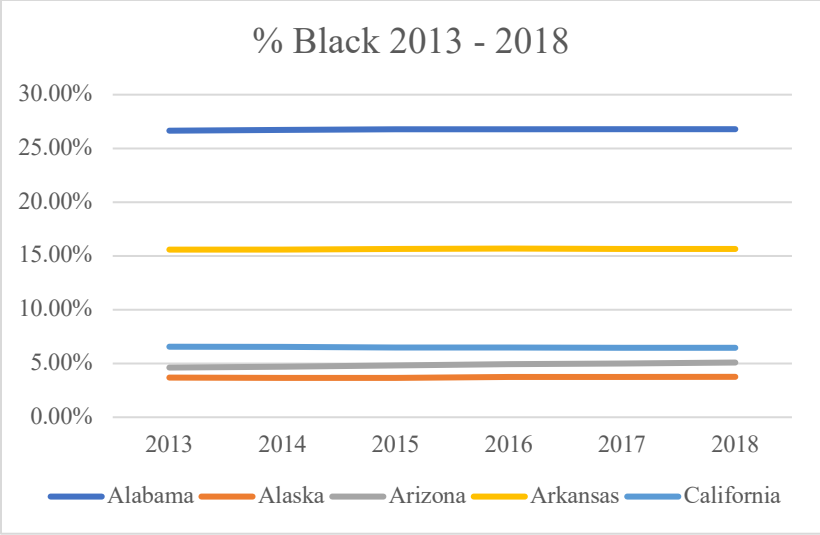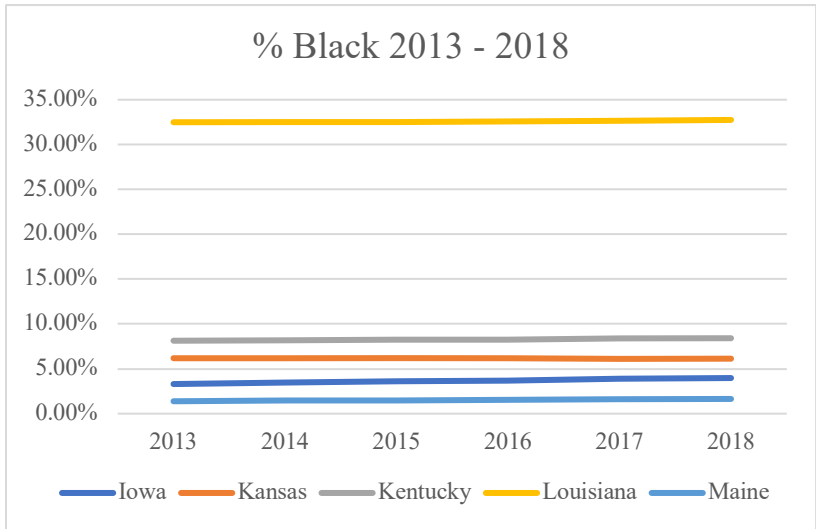
Appendix Figure 1: Change in Percent Black: AL, AK, AZ, AR, CA (2013 – 2018)
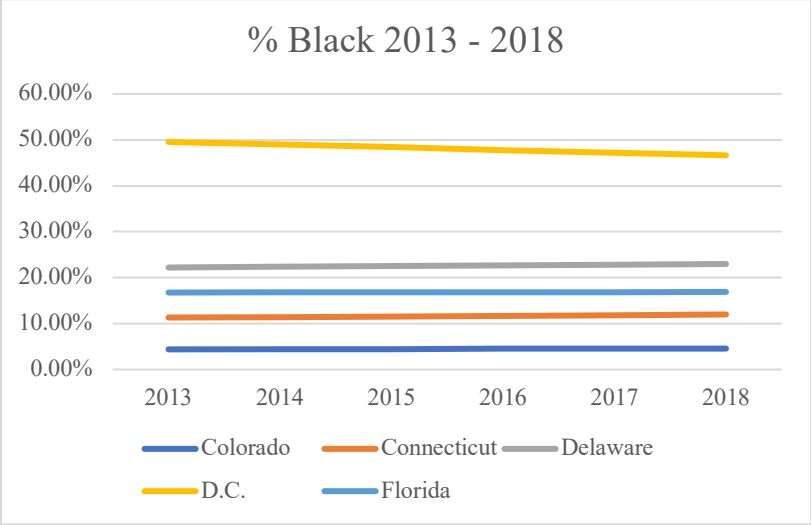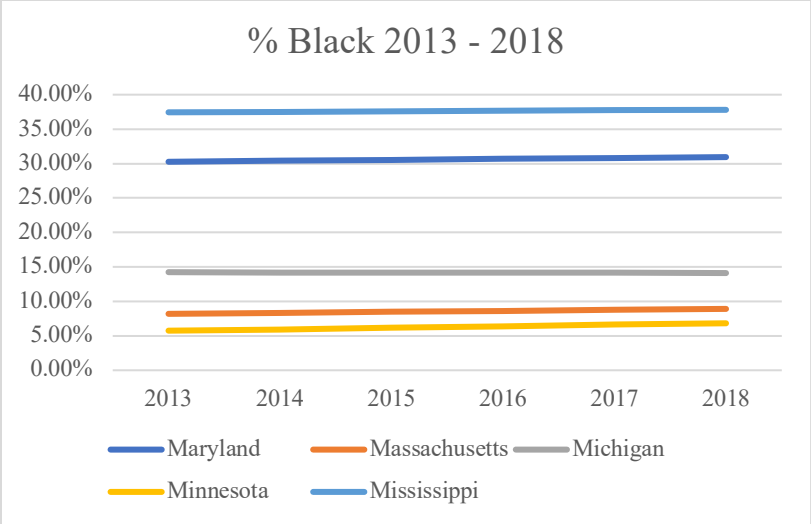

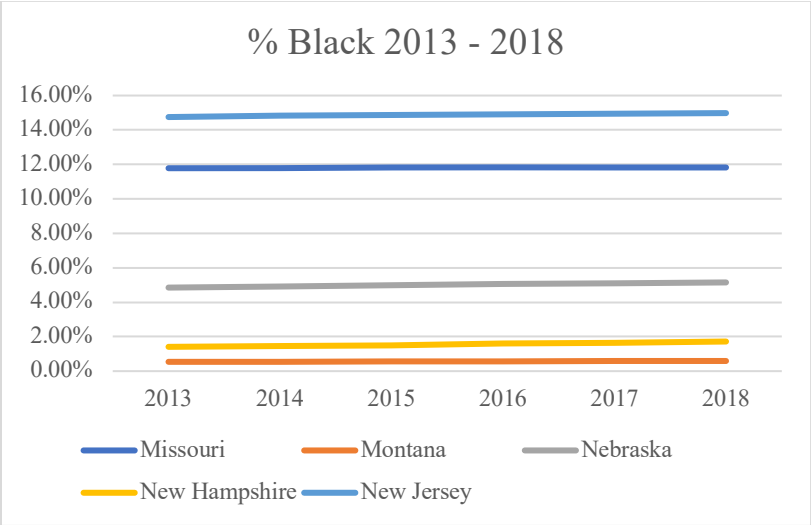Appendix Figure 2: Change in Percent Black: CO, CT, DE, D.C., FL (2013 – 2018)

95
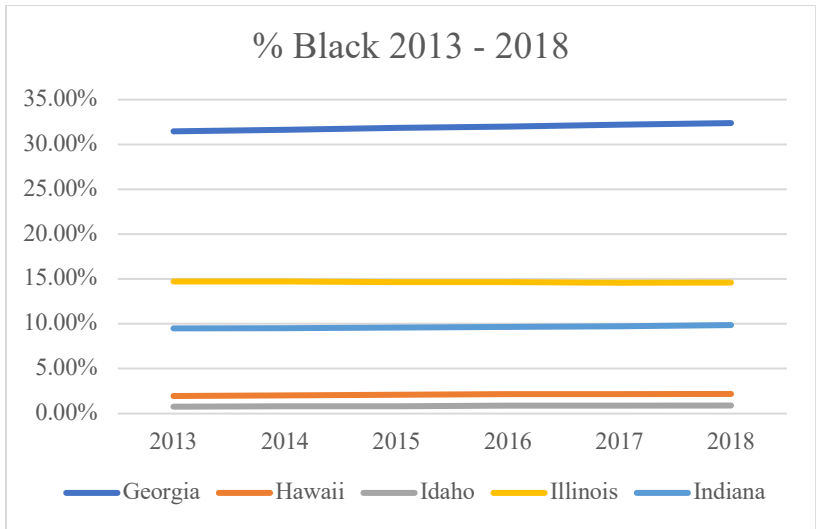
Appendix Figure 3: Change in Percent Black: GA, HI, ID, IL, IN (2013 – 2018)
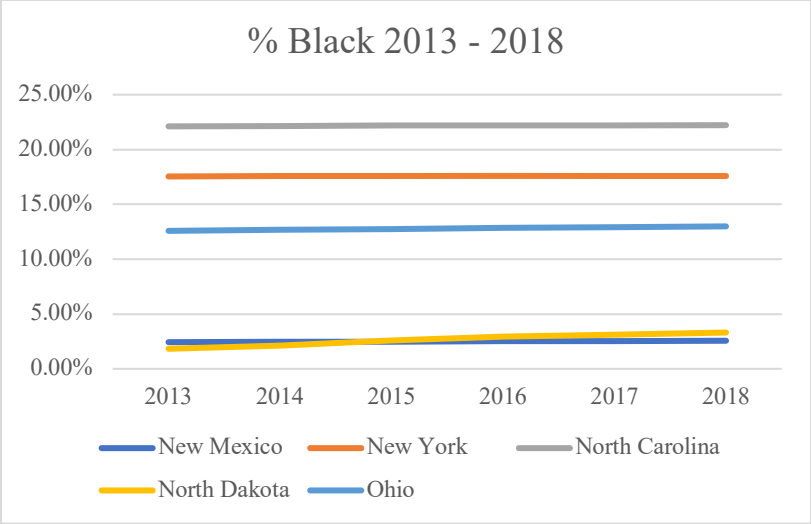

Appendix Figure 4: Change in Percent Black: IA, KS, KY, LA, ME (2013 – 2018)
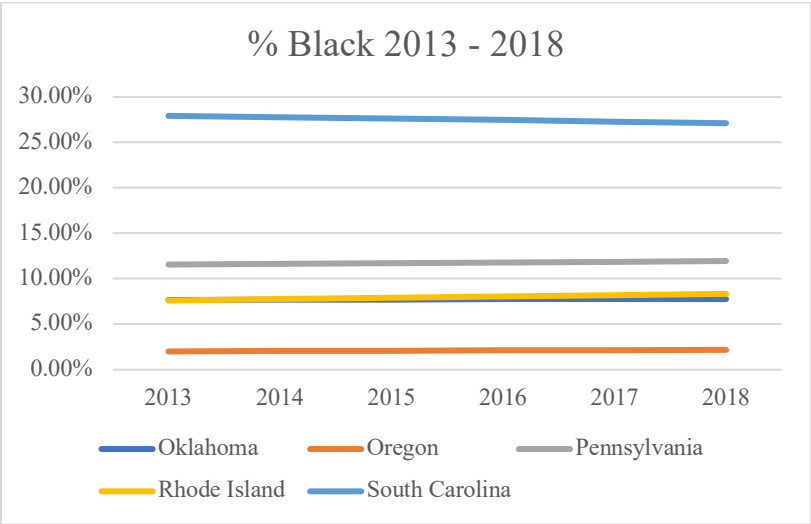
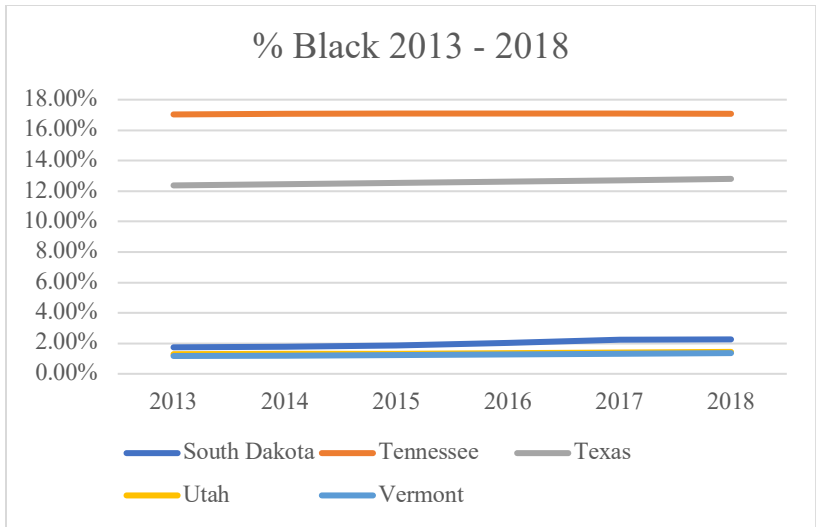Appendix Figure 5: Change in Percent Black: MD, MA, MI, MN, MS (2013 – 2018)

Appendix Figure 6: Change in Percent Black: MO, MT, NE, NH, NJ (2013 – 2018)

Appendix Figure 7: Change in Percent Black: NM, NY, NC, ND, OH (2013 – 2018)

Appendix Figure 8: Change in Percent Black: OK, OR, PA, RI, SC (2013 – 2018)

Appendix Figure 9: Change in Percent Black: SD, TN, TX, UT, VT (2013 – 2018)
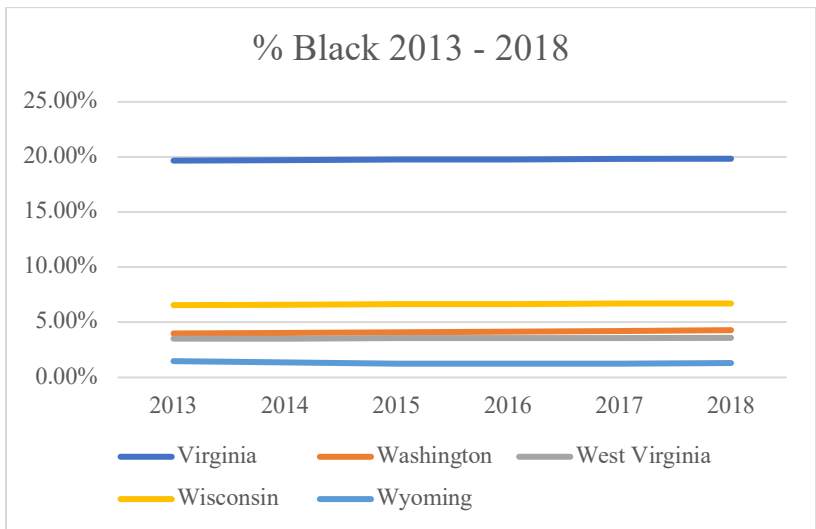

Appendix Figure 10: Change in Percent Black: VA, WA, WV, WI, WY (2013 – 2018)
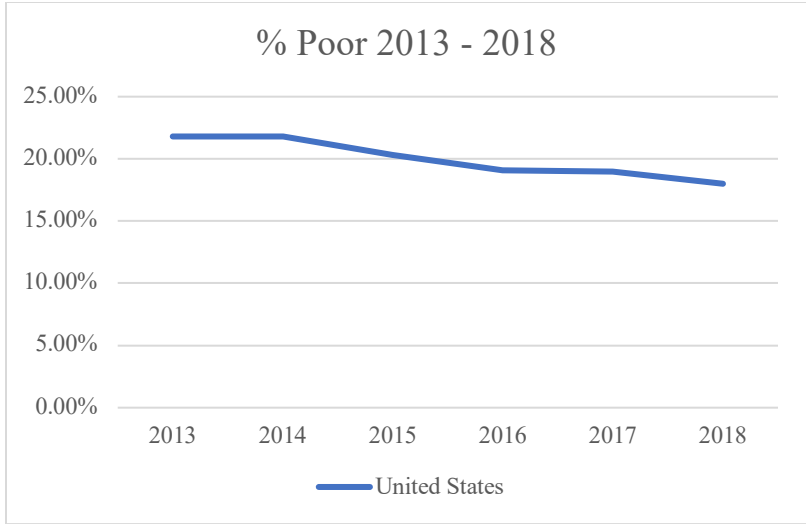
Appendix Figure 11: Change in Percent Poor: United States (2013-2018)
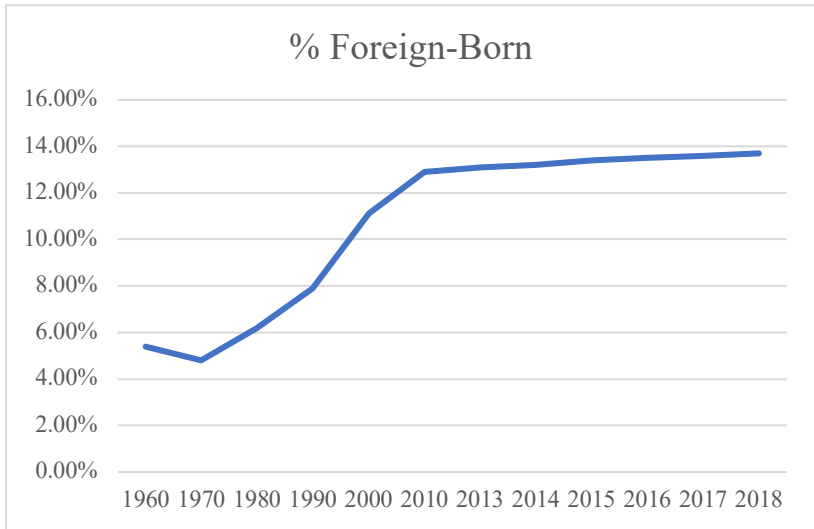
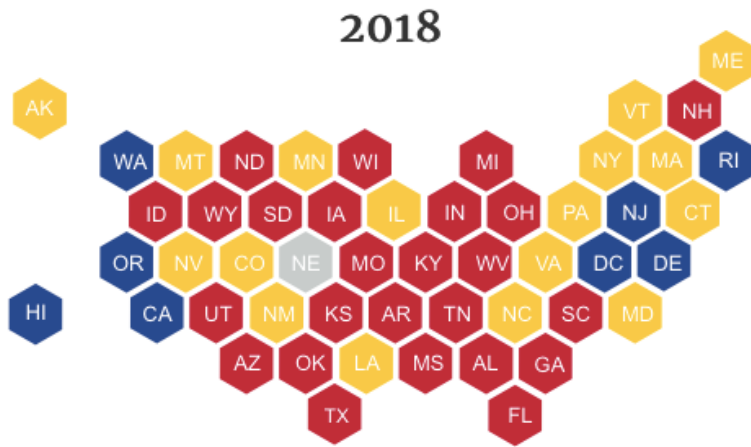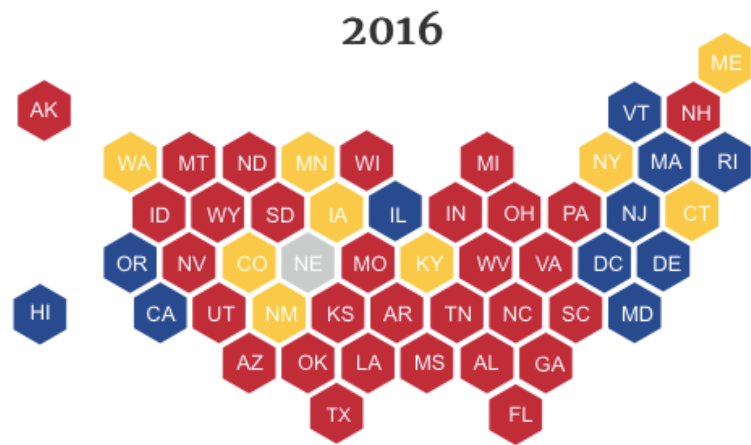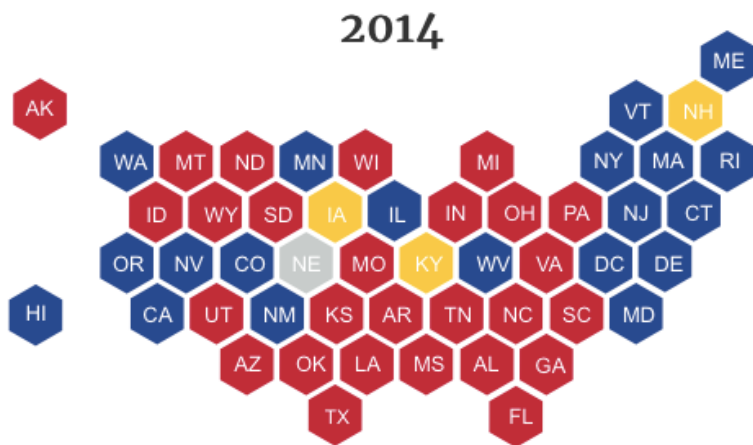Appendix Figure 12: Change in Percent Foreign-Born: United States (2013-2018)

Appendix Figure 13: Partisan Control by State (2018)

Appendix Figure 14: Partisan Control by State (2016)

Appendix Figure 15: Partisan Control by State (2014)

Appendix C: Interactions in Chapter 3

Appendix Table 1: Interactions in Comprehensive Design Model (Linear Regression).

Enrollment	Coef.	Std. Error	P>|t|
Combination	.0929678	.796902	0.251
Separate	-.0364418	.1471045	0.806
Presumptive	.1155445	.1056031	0.281
Eligibility*Express	-.0874033	.0697071	0.218
Lane Eligibility (0/1;	.2323433	.1392454	0.104
1/0; 1/1)			
Continuous	-.1480076	.1033132	0.161
Eligibility*Waiting	-.0883633	.0632571	0.171
Period (0/90; 1/0;	-.1091725	.1351085	0.424
1/30; 1/60; 1/90)	.0241981	.1833766	0.896
	.0329289	.0843313	0.698
Buy-in	-.0974116	.0596828	0.111
Option*Noncitizens	.0794341	.1193812	0.510
(0/1; 1/1)			
Premiums	-.1157219	.0564949	0.048*
Constant	.5319949	.0751418	0.000

Notes: $F_{(13, 36)} = 1.71$; Prob > F = 0.1009; $R^2 = 0.3819$; *interaction term or $p \leq .05$; interactions were included between similar program variables but were not included in the main analysis due to a lack of significance

Appendix D: Interview Protocol

<u>Interview Subjects:</u> There will be three groups of interview subjects. The first will be comprised of public officials in three states who will discuss their duties as state administrators and their state's rationale for choosing a specific program design. The second will include legislators in each of these states from relevant committees. The third will include individuals at related organizations in each state.

<u>Recruitment:</u>

State administrators will be recruited based on job expertise in each state. From there, a snowball sample method will be used until data saturation is reached. A similar approach will be used for legislators and other individuals.

<u>Interviewee Preparation:</u> I will send interviewees the interview protocol before the interview to ensure that they are comfortable with the questions I will be asking. I will provide the interviewee with an opportunity to ask me questions about the project. By explaining the goals of the project to the subjects, I hope to gain trust and extract more truthful responses. I will use the template provided by the IRB HSBS for Informed Consent Information prior to beginning the interview.

Data Storage: I will record the interviews on Zoom and store this data on an encrypted external hard drive which only I will have access to. If interviewees do not feel comfortable with recording, I will take detailed notes. I will be the only one conducting the interviews and transcription. I will use doctoral research funds to cover the use of a transcription service. After the transcription and data analysis are completed, all recordings and notes will be destroyed. I will commit to sending the interviewees a transcript of the interview and share project publications (should they so wish) to ensure they are comfortable with any quotations that may be utilized.

Identifying Information: No identifying information will be documented during the interview, its analysis, or the final dissertation. Analysis will be conducted via Dedoosewithout identifying information.

Appendix E: Sample Interview Questions

Group One: State Administrators

1) What is your relationship to CHIP as an administrator?

2) How do you interact with the state legislature, citizens, insurance companies, and/or

nonprofits on CHIP?

3) What you think is going well/what can be improved with CHIP in X state?

4) How do you measure success in CHIP/children's health? Enrollment is X% (X the national

average) but the uninsured kids rate is X% (X the national average).

5) How do you decide what to change from year to year in CHIP?

6) How does X state treat CHIP v. Medicaid?

7) How did you decide to X?

8) Any final thoughts? Who else should I talk to?

Group Two: State Legislators

1) What is your relationship to CHIP as a legislator?

2) How do you interact with state administration, constituents, and/or nonprofits on CHIP?

3) What you think is going well/what can be improved with CHIP in X state?

4) How do you measure success in CHIP/children's health? Enrollment is X% (X national average) but the uninsured kids rate is X% (X the national average).

5) What is the relationship between your party and CHIP?

6) What are your thoughts on CHIP in the broader health policy landscape in X state?

7) How has CHIP and its politics evolved throughout your tenure?

8) Why do you think many state legislators aren't knowledgeable about CHIP?

9) Any final thoughts? Who else should I talk to?

1) What is your relationship to CHIP as a nonprofit?

2) How do you interact with state legislature, CHIP parents, or the administration?

3) What you think is going well/what can be improved with CHIP in X state?

4) How do you measure success in CHIP/children's health? Enrollment is X% (X the national average) but the uninsured kids rate is X% (X the national average).

5) What advocacy for CHIP is successful? What would you change?

6) What are your thoughts on CHIP in the broader health policy landscape in X state? Does it matter that CHIP is X?

7) What about specific health groups or demographic groups? Is there any data on this?

8) Why do you think many state legislators aren't knowledgeable about CHIP?

9) How much can CHIP really do versus social determinants of health?

10) Any final thoughts? Who else should I talk to?

Bibliography

Abdus, S., Hudson, J., Hill, S. C., & Selden, T. M. (2014). Children's health insurance program premiums adversely affect enrollment, especially among lower-income children. *Health Affairs (Project Hope)*, *33*(8), 1353–1360. https://doi.org/10.1377/hlthaff.2014.0182

admin. (2021, May 19). *Developmental disability waiver proposal stalls*. Unicameral Update. http://update.legislature.ne.gov/?p=30397

Alker, J., & Corcoran, A. (2020). *Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade*. Georgetown University Health Policy Institute. https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf

Bansak, C., & Raphael, S. (2007). The Effects of State Policy Design Features on Take-Up and Crowd-Out Rates for the State Children's Health Insurance Program. *Journal of Policy Analysis and Management*, *26*(1), 149–175. JSTOR.

Barrilleaux, C., & Rainey, C. (2014). The Politics of Need: Examining Governors' Decisions to Oppose the "Obamacare" Medicaid Expansion. *State Politics & Policy Quarterly*, *14*(4), 437–460. https://doi.org/10.1177/1532440014561644

Bennefield, R. L. (1998). *Health Insurance: 1997* (No. P60-202). U.S. Census Bureau. https://www.census.gov/library/publications/1998/demo/p60-202.html

Berchick, E. R., Barnett, J. C., & Upton, R. D. (2019). *Health Insurance Coverage in the United States: 2018* (No. P60-267 (RV)). U.S. Census Bureau. https://www.census.gov/library/publications/2019/demo/p60-267.html

Beyer, D. (2021). *Immigrants Are Vital to the U.S. Economy*. Congress.

    https://www.jec.senate.gov/public/index.cfm/democrats/2021/4/chc-jec-release-new-

    report-on-why-immigrants-are-vital-to-u-s-economy

Blavin, F., Kenney, G. M., & Huntress, M. (2014). The effects of express lane eligibility on

    Medicaid and CHIP enrollment among children. *Health Services Research*, *49*(4), 1268–

    1289. https://doi.org/10.1111/1475-6773.12157

Budiman, A., Tamir, C., Mora, L., & Noe-Bustamante, L. (2020, August 20). Immigrants in

    America: Trend Data and Demographics, 1960-2018. *Pew Research Center's Hispanic*

    Trends Project. https://www.pewresearch.org/hispanic/2020/08/20/facts-on-u-s-

    immigrants-trend-data/

Bureau, U. C. (n.d.-a). *American Community Survey (ACS)*. Census.Gov. Retrieved December

    15, 2021, from https://www.census.gov/programs-surveys/acs

Bureau, U. C. (n.d.-b). *POV-01. Age and Sex of All People, Family Members and Unrelated*

    Individuals. Census.Gov. Retrieved December 16, 2021, from

    https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-

    01.html

Bureau, U. C. (n.d.-c). *State Population by Characteristics: 2010-2019*. Census.Gov. Retrieved

    December 16, 2021, from https://www.census.gov/data/tables/time-

    series/demo/popest/2010s-state-detail.html

Bureau, U. C. (n.d.-d). *State Population Totals and Components of Change: 2010-2019*.

    Census.Gov. Retrieved January 25, 2022, from https://www.census.gov/data/tables/time-

    series/demo/popest/2010s-state-total.html

Burnham, L. (2007). Racism in United States Welfare Policy. *Race, Poverty & the Environment*, *14*(1), 47–50.

Legislative Bill 376, no. LB376, Nebraska Legislature (2021).

https://www.nebraskalegislature.gov/FloorDocs/107/PDF/Intro/LB376.pdf

CDC. (2021, October 21). *Health Insurance Coverage*. https://www.cdc.gov/nchs/fastats/health-insurance.htm

CDC. (2022, January 28). *COVID Data Tracker Weekly Review*. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

Chapter 58 of the Acts of 2006, (2006).

https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58

Children's Alliance. (n.d.). *Washington's Cover All Kids Law: Summary | Children's Alliance*. Retrieved January 26, 2022, from https://childrensalliance.org/resource/washingtons-cover-all-kids-law-summary

CHIPRA | Medicaid. (n.d.). Retrieved January 30, 2022, from

https://www.medicaid.gov/chip/chipra/index.html

CMS. (n.d.-a). *CHIP Cost Sharing | Medicaid*. Retrieved December 15, 2021, from

https://www.medicaid.gov/chip/chip-cost-sharing/index.html

CMS. (n.d.-b). *CHIP State Program Information | Medicaid.gov*. Retrieved December 15, 2021, from https://www.medicaid.gov/chip/state-program-information/index.html

CMS. (n.d.-c). *Eligibility | Medicaid*. Retrieved March 22, 2022, from

https://www.medicaid.gov/chip/eligibility/index.html

CMS. (n.d.-d). *Medicaid & CHIP Enrollment Data | Medicaid*. Retrieved December 15, 2021,

> from https://www.medicaid.gov/medicaid/national-medicaid-chip-program-

> information/medicaid-chip-enrollment-data/index.html

CMS. (n.d.-e). *Reports & Evaluations | Medicaid*. Retrieved December 15, 2021, from

> https://www.medicaid.gov/chip/reports-evaluations/index.html

CMS. (n.d.-f). *Waiting Periods in CHIP | Medicaid*. Retrieved December 15, 2021, from

> https://www.medicaid.gov/chip/eligibility-standards/waiting-periods-chip/index.html

CMS. (2021a, July 9). *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant

> Women | Medicaid*. https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-

> and-chip-coverage-lawfully-residing-children-pregnant-women

CMS. (2021b, August 6). *Express Lane Eligibility for Medicaid and CHIP Coverage | Medicaid*.

> https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-

> medicaid-and-chip-coverage/index.html

CMS. (2021c, August 31). *Presumptive Eligibility | Medicaid*.

> https://www.medicaid.gov/medicaid/enrollment-strategies/presumptive-

> eligibility/index.html

CMS. (2021d, September 9). *Continuous Eligibility for Medicaid and CHIP Coverage |

> Medicaid*. https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-

> eligibility-medicaid-and-chip-coverage/index.html

CMS. (2021e, December 1). *Emergency Medical Treatment & Labor Act (EMTALA) | CMS*.

> https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA

Colby, M., & Natzke, B. (2015). Health Care Utilization among Children Enrolled in Medicaid

    and CHIP via Express Lane Eligibility. *Health Services Research*, *50*(3), 642–662.

    https://doi.org/10.1111/1475-6773.12241

Bipartisan Budget Act of 2018, Pub. L. No. 115–123 (2018).

    https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf

Fording, R. C., & Schram, S. F. (2020). *Hard White: The Mainstreaming of Racism in American*

    Politics. Oxford University Press. https://doi.org/10.1093/oso/9780197500484.001.0001

Fox, A. M., Stazyk, E. C., & Feng, W. (2020). Administrative Easing: Rule Reduction and

    Medicaid Enrollment. *Public Administration Review*, *80*(1), 104–117.

    https://doi.org/10.1111/puar.13131

Georgetown University Health Policy Institute, C. for C. & F. (2009). *Addressing Crowd Out*.

    https://ccf.georgetown.edu/wp-content/uploads/2012/03/Addressing-Crowd-Out.pdf

Goggin, M. L. (1999). The Use of Administrative Discretion in Implementing the State

    Children's Health Insurance Program. *Publius*, *29*(2), 35–51.

    https://doi.org/10.2307/3330890

Goodnough, A. (2015, July 17). Over Objections of Legislature, Alaska's Governor Says He

    Will Expand Medicaid. *The New York Times*.

    https://www.nytimes.com/2015/07/17/us/over-objections-of-legislature-alaska-governor-

    bill-walker-says-he-will-expand-medicaid.html

Gramlich, J. (2017, May 27). Few Americans support cuts to most government programs. *Pew*

    Research Center. https://www.pewresearch.org/fact-tank/2017/05/26/few-americans-

    support-cuts-to-most-government-programs-including-medicaid/

Gresenz, C. R., Edgington, S. E., Laugesen, M. J., & Escarce, J. J. (2013). Income eligibility

   thresholds, premium contributions, and children's coverage outcomes: A study of CHIP

   expansions. *Health Services Research*, *48*(2 Pt 2), 884–904. https://doi.org/10.1111/1475-

   6773.12039

Gresenz, C. R., Laugesen, M. J., Yesus, A., & Escarce, J. J. (2011). Relative Affordability of

   Health Insurance Premiums under CHIP Expansion Programs and the ACA. *Journal of*

   Health Politics, Policy and Law, *36*(5), 859–877. https://doi.org/10.1215/03616878-

   1407658

Hacker, J. S., Pierson, P., & Thelen, K. (2015). Drift and conversion: Hidden faces of

   institutional change. In J. Mahoney & K. Thelen (Eds.), *Advances in Comparative-*

   Historical Analysis (pp. 180–208). Cambridge University Press.

   https://doi.org/10.1017/CBO9781316273104.008

Hawes, D. P., & McCrea, A. M. (2018). Give Us Your Tired, Your Poor and We Might Buy

   Them Dinner: Social Capital, Immigration, and Welfare Generosity in the American

   States. *Political Research Quarterly*, *71*(2), 347–360.

Health Insurance Coverage of Children 0-18. (2020, October 23). *KFF*.

   https://www.kff.org/other/state-indicator/children-0-18/

Hendryx, M., Onizuka, R., Wilson, V., & Ahern, M. (2012). Effects of a Cost-Sharing Policy on

   Disenrollment from a State Health Insurance Program. *Social Work in Public Health*,

   27(7), 671–686. https://doi.org/10.1080/19371910903269653

Herndon, J. B., Vogel, W. B., Bucciarelli, R. L., & Shenkman, E. A. (2008). The effect of

   premium changes on SCHIP enrollment duration. *Health Services Research*, *43*(2), 458–

   478.

Hirschi, M., Walter, A. W., Wilson, K., Jankovsky, K., Dworetzky, B., Comeau, M., &

    Bachman, S. S. (2019). Access to care among children with disabilities enrolled in the

    MassHealth CommonHealth Buy-In program. *Journal of Child Health Care*, *23*(1), 6–19.

    https://doi.org/10.1177/1367493518777310

Hoag, S., Harrington, M., Orfield, C., Peebles, V., Smith, K., Swinburn, A., Hodges, M.,

    Finegold, K., Orzol, S., & Robinson, W. (2011). *Children's Health Insurance Program:*

    An Evaluation (1997-2010) (Interim Report to Congress 06873.130). Mathematica.

Jerome-D'Emilia, B., & Suplee, P. D. (2012). POLICY & POLITICS: The ACA and the

    Undocumented. *The American Journal of Nursing*, *112*(4), 21–27.

Kaiser Family Foundation. (2021a, February 18). Enhanced Federal Medical Assistance

    Percentage (FMAP) for CHIP. *KFF*. https://www.kff.org/other/state-indicator/enhanced-

    federal-matching-rate-chip/

Kaiser Family Foundation. (2021b, November 19). Status of State Medicaid Expansion

    Decisions: Interactive Map. *KFF*. https://www.kff.org/medicaid/issue-brief/status-of-

    state-medicaid-expansion-decisions-interactive-map/

Kanak, M., Rutman, L., Pirrotta, E., Elizabeth, A., Giammona, M., Bermudez, M., & Wang, N.

    E. (2015). Emergency Department-Based Health Insurance Enrollment for Children:

    Does Linkage Lead to Insurance Retention and Utilization? *Pediatric Emergency Care*,

    31(3), 169–172. https://doi.org/10.1097/PEC.0000000000000340

Balanced Budget Act of 1997, no. H.R. 2015, Congress (1997).

Kaushal, N., & Kaestner, R. (2005). Welfare Reform and Health Insurance of Immigrants.

    Health Services Research, *40*(3), 697–722. https://doi.org/10.1111/j.1475-

    6773.2005.00381.x

Keigher, S. M. (1997). America's most cruel xenophobia. *Health and Social Work*, *22*(3), 232–238.

Kenney, G. (2007). The Impacts of the State Children's Health Insurance Program on Children Who Enroll: Findings from Ten States. *Health Services Research*, *42*(4), 1520–1543.

Kinder, D. R., & Kam, C. D. (2009). *Us Against Them: Ethnocentric Foundations of American Opinion*. University of Chicago Press. http://proxy.lib.umich.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=318372&site=ehost-live&scope=site

Klein, R. (2003). Presumptive Eligibility. *The Future of Children*, *13*(1), 230–237. https://doi.org/10.2307/1602653

Kraus, S., Ribeiro-Soriano, D., & Schüssler, M. (2018). Fuzzy-set qualitative comparative analysis (fsQCA) in entrepreneurship and innovation research – the rise of a method. *International Entrepreneurship and Management Journal*, *14*(1), 15–33. https://doi.org/10.1007/s11365-017-0461-8

Krogslund, C., Choi, D. D., & Poertner, M. (2015). Fuzzy Sets on Shaky Ground: Parameter Sensitivity and Confirmation Bias in fsQCA. *Political Analysis*, *23*(1), 21–41.

Lanford, D., & Quadagno, J. (2016). Implementing ObamaCare: The Politics of Medicaid Expansion under the Affordable Care Act of 2010. *Sociological Perspectives*, *59*(3), 619–639.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An Array of Qualitative Data Analysis Tools: A Call for Data Analysis Triangulation. *School Psychology Quarterly*, *22*(4), 557–584. https://doi.org/10.1037/1045-3830.22.4.557

Leininger, L. J., Friedsam, D., Dague, L., Mok, S., Hynes, E., Bergum, A., Aksamitauskas, M.,

    Oliver, T., & DeLeire, T. (2011). Wisconsin's BadgerCare Plus Reform: Impact on Low-

    Income Families' Enrollment and Retention in Public Coverage. *Health Services*

    Research, *46*(1p2), 336–347. https://doi.org/10.1111/j.1475-6773.2010.01215.x

Lo Sasso, A. T., & Buchmueller, T. C. (2004). The effect of the state children's health insurance

    program on health insurance coverage. *Journal of Health Economics*, *23*(5), 1059–1082.

    https://doi.org/10.1016/j.jhealeco.2004.03.006

Lurie, I. Z. (2008). Welfare reform and the decline in the health-insurance coverage of children

    of non-permanent residents. *Journal of Health Economics*, *27*(3), 786–793.

    https://doi.org/10.1016/j.jhealeco.2007.10.009

MACPAC. (n.d.-a). CHIP eligibility. *MACPAC*. Retrieved December 15, 2021, from

    https://www.macpac.gov/subtopic/eligibility-2/

MACPAC. (n.d.-b). EXHIBIT 35. Medicaid and CHIP Income Eligibility Levels as a Percentage

    of the FPL for Children and Pregnant Women by State. *MACPAC*. Retrieved December

    15, 2021, from https://www.macpac.gov/publication/medicaid-and-chip-income-

    eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-

    women-by-state/

MACPAC. (2020). *Medicaid Buy-In: Program Options and Considerations* (p. 13) [Report to

    Congress]. MACPAC. https://www.macpac.gov/wp-content/uploads/2020/04/Medicaid-

    Buy-In-Program-Options-and-Considerations.pdf

Marton, J. (2007). The Impact of the Introduction of Premiums into a SCHIP Program. *Journal*

    of Policy Analysis and Management, *26*(2), 237–255.

Mcgrath, R. J. (2009). Implementation Theory Revisited . . . Again: Lessons from the State

    Children's Health Insurance Program. *Politics & Policy*, *37*(2), 309–336.

    https://doi.org/10.1111/j.1747-1346.2009.00174.x

Meyer-Gutbrod, J. (2020). Between National Polarization and Local Ideology: The Impact of

    Partisan Competition on State Medicaid Expansion Decisions. *Publius: The Journal of*

    Federalism, *50*(2), 237–255. https://doi.org/10.1093/publius/pjz028

Mink, G. (1994). Welfare Reform in Historical Perspective. *Social Justice*, *21*(1 (55)), 114–131.

Mitchell, A. (2020). *Medicaid's Federal Medical Assistance Percentage (FMAP)* (No. R43847;

    p. 23). Congressional Research Service. https://sgp.fas.org/crs/misc/R43847.pdf

Moffitt, R. A. (2015). The Deserving Poor, the Family, and the U.S. Welfare System.

    Demography, *52*(3), 729–749.

Mott, D. W., & Dunst, C. J. (2006). Use of Presumptive Eligibility for Enrolling Children in Part

    C Early Intervention. *Journal of Early Intervention*, *29*(1), 22–31.

    https://doi.org/10.1177/105381510602900102

Moynihan, D. P., & Herd, P. (2018). *Administrative Burden: Policymaking by Other Means*.

    Russell Sage Foundation. http://muse.jhu.edu/book/62771

National Conference of State Legislatures. (2021, September 14). *State Partisan Composition*.

    https://www.ncsl.org/research/about-state-legislatures/partisan-composition.aspx

Nebraska Legislature. (n.d.). *Nebraska Legislature—Unicam Focus*. Retrieved December 15,

    2021, from https://nebraskalegislature.gov/education/lesson3.php

Nelson, D., & Rushakoff, J. (2019). *Massachusetts' remaining uninsured*. Harvard Kennedy

    School of Government.

https://www.hks.harvard.edu/sites/default/files/degree%20programs/MPP/files/PAE%20

Final%20-%20Nelson%20Rushakoff%20NO%20LOGO%20NO%20NAME.pdf

Nikolova, S., & Stearns, S. (2014). The impact of CHIP premium increases on insurance

outcomes among CHIP eligible children. *BMC Health Services Research*, *14*(1), 101.

https://doi.org/10.1186/1472-6963-14-101

Office of Financial Management. (2012). *Guiding Washington Through the Great Recesssion*.

https://ofm.wa.gov/sites/default/files/public/legacy/reports/Guiding_Washington_through

_the_Great_Recession_final.pdf

Ozaki, A. (2021, May 20). *Senator calls colleagues "disgraceful" for killing funding bill for*

developmentally disabled children. KETV. https://www.ketv.com/article/senator-calls-

colleagues-disgraceful-for-killing-funding-bill-for-developmentally-disabled-

children/36480951

Children's Health Insurance Program Reauthorization Act of 2009, no. H.R.2, Congress (2009).

Pappas, I. O., & Woodside, A. G. (2021). Fuzzy-set Qualitative Comparative Analysis (fsQCA):

Guidelines for research practice in Information Systems and marketing. *International*

Journal of Information Management, *58*, 102310.

https://doi.org/10.1016/j.ijinfomgt.2021.102310

Pear, R. (1997, March 14). Hatch Joins Kennedy to Back a Health Program. *The New York*

Times. https://www.nytimes.com/1997/03/14/us/hatch-joins-kennedy-to-back-a-health-

program.html

Quadagno, J. (1994). *The Color of Welfare: How Racism Undermined the War on Poverty*.

Oxford University Press USA - OSO.

http://ebookcentral.proquest.com/lib/umichigan/detail.action?docID=716691

Ragin, C. C. (1989). *The comparative method: Moving beyond qualitative and quantitative strategies*. University of California Press.

Ragin, C. C. (2017). *Fuzzy-Set/ Qualitative Comparative Analysis* (fsQCA 3.0) [Computer software]. http://www.socsci.uci.edu/~cragin/fsQCA/download/fsQCAManual.pdf

The Patient Protection and Affordable Care Act, no. H.R. 3590, Congress (2010).

Reinberg, S. (2020, November 9). *Nearly 74 Million Essential Workers at High Risk for COVID in U.S.* U.S. News. https://www.usnews.com/news/health-news/articles/2020-11-09/nearly-74-million-essential-workers-at-high-risk-for-covid-in-us

Rocco, P., Keller, A. C., & Kelly, A. S. (2020). State Politics And The Uneven Fate Of Medicaid Expansion. *Health Affairs*, *39*(3), 494–501. https://doi.org/10.1377/hlthaff.2019.01414

Ross, D. C., & Hill, I. T. (2003). Enrolling Eligible Children and Keeping Them Enrolled. *The Future of Children*, *13*(1), 81–97. https://doi.org/10.2307/1602640

Saloner, B., Hochhalter, S., & Sabik, L. (2016). Medicaid and CHIP Premiums and Access to Care: A Systematic Review. *Pediatrics*, *137*(3), e20152440. https://doi.org/10.1542/peds.2015-2440

Schiff, J. E., Jaclyn. (2010, September 17). A Timeline of Kennedy's Health Care Achievements And Disappointments. *Kaiser Health News*. https://khn.org/news/kennedy-health-care-timeline/

Schneider, C. Q., & Wagemann, C. (2010). Standards of Good Practice in Qualitative Comparative Analysis (QCA) and Fuzzy-Sets. *Comparative Sociology*, *9*(3), 397–418. https://doi.org/10.1163/156913210X12493538729793

National Federation of Independent Business et al. V. Sebelius, Secretary of Health and Human Service, et al., No. 11-393 (June 28, 2012).

Shaefer, H. L., Grogan, C. M., & Pollack, H. A. (2011). Who Transitions from Private to Public

Health Insurance? Lessons from Expansions of the State Children's Health Insurance

Program. *Journal of Health Care for the Poor and Underserved*, *22*, 359–370.

Slifkin, R. T., Freeman, V. A., & Silberman, P. (2002). Effect of the North Carolina State

Children's Health Insurance Program on Beneficiary Access to Care. *Archives of

Pediatrics & Adolescent Medicine*, *156*(12), 1223–1229.

https://doi.org/10.1001/archpedi.156.12.1223

State Health Access Data Assistance Center. (2013, February 6). *Medicaid "Early Opt-In"

States*. SHADAC. https://www.shadac.org/news/medicaid-%E2%80%9Cearly-opt-

in%E2%80%9D-states

The National Academy for State Health Policy. (n.d.). *CHIP*. Retrieved December 15, 2021,

from https://www.nashp.org/policy/health-coverage-and-access/chip-4/

Tope, D., & Hickman, L. N. (2012). The Politics of Children's Health Insurance Policy.

Sociological Perspectives, *55*(1), 43–66. https://doi.org/10.1525/sop.2012.55.1.43

U.S. Department of Health & Human Services. (n.d.). *State Children's Health Insurance

Program*. Benefits.Gov. Retrieved December 15, 2021, from

https://www.benefits.gov/benefit/607

U.S Senate. (n.d.). *Vetoes by President George W. Bush*. Retrieved February 17, 2022, from

https://www.senate.gov/legislative/vetoes/BushGW.htm

Vermont State Profile. (2019, August 22). *Georgetown CCF Data*.

https://kidshealthcarereport.ccf.georgetown.edu/states/vermont/

Volden, C. (2006). States as Policy Laboratories: Emulating Success in the Children's Health

Insurance Program. *American Journal of Political Science*, *50*(2), 294–312. JSTOR.

Ward, D. E. (2005). *The White Welfare State: The Racialization of U.S. Welfare Policy*.

University of Michigan Press. https://doi.org/10.3998/mpub.22210

Will, J. A. (1993). The Dimensions of Poverty: Public Perceptions of the Deserving Poor. *Social*

Science Research, *22*(3), 312–332. https://doi.org/10.1006/ssre.1993.1016

Willison, C. (2019). *Ungoverned and Out of Sight: Urban Politics and America's Homeless*

Crisis [University of Michigan].

https://www.proquest.com/docview/2387281307?parentSessionId=bAuluNg%2B%2BC

GmmExLGiq85OZTyaCDgw%2FMzUZwwMdO6Ww%3D&pq-

origsite=primo&accountid=14667

Woolridge, J., Kenney, G., & Trenholm, C. (2005). *Congressionally Mandated Evaluation of the*

State Children's Health Insurance Program (HHS-100-01-0002). Mathematica.

https://www.mathematica.org/-/media/publications/pdfs/schipcongress.pdf

World Bank. (n.d.). *GDP (current US$)—United States | Data*. Retrieved December 16, 2021,

from

https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?end=2020&locations=US&star

t=2008&view=chart

Zimmer, D. M. (2011). The Effects of the State Children's Health Insurance Program on

Insurance Status and Health Care Utilization of Children. *Journal of Family and*

Economic Issues, *32*, 373–383. https://doi.org/10.1007/s10834-010-9235-y