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Outreach Strategies in the State Children's Health Insurance Program

What is outreach, and why is it important?

Participation rates in expanded Medicaid programs and state-funded programs for children suggest that states need to do a better job getting the word out to working families that a public health insurance program exists for their children. Expanding eligibility is not enough to ensure coverage. Aggressive outreach efforts are needed as well. Advocates have a vital role to play in urging states to make new children's health insurance programs (CHIPs) and existing Medicaid programs more family-friendly.CHIP defines outreach as activities to inform families of available coverage programs and to assist them in enrolling. Each state submitting a CHIP plan must describe how it will accomplish outreach to eligible families.1 CHIP funds can be used to assist children in enrolling in any public or private health coverage program. This means outreach services reimbursed by CHIP can also benefit undocumented children and other children not eligible for insurance coverage through CHIP.2

Outreach can also refer to activities designed to help enrolled families use available services. For example, the Medicaid program requires states to undertake outreach activities to inform families about available services, the benefits of preventive care, obtaining services under the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program for children.3 CHIP does not specifically require states to provide outreach to help families use available services; however, it does require states to assure quality and appropriateness of care and access to services. These requirements certainly permit states to include plans for this kind of outreach and education to assure that once enrolled, beneficiaries can take advantage of appropriate services. While this paper will only address access to coverage, access to care must be the next step.

Moving from Enrollment to Access

Once a child has a Medicaid or insurance card in hand, that child must have a regular source of high-quality preventive and primary health care. Barriers that prevent children from having such a health home include both personal and system-based issues such as

- lack of transportation,

- clinic hours that conflict with work schedules,
- lack of child care for siblings,
- overcrowded clinics with long delays,
- doctors' unwillingness to see Medicaid or other low-income patients, and
- concern that care is unresponsive to medical needs or interpersonally disrespectful

Successful strategies for overcoming these barriers have included the following:

- financial incentives to enrollees,
- public awareness campaigns regarding the importance of preventive health care and where to get it,
- grassroots outreach through home visiting and community health advisors,
- transportation services,
- improving provider participation and training,
- making clinics, provider sites, and staff more user-friendly,
- care coordination for children, and
- information systems that permit regular review of encounter data.

Mary Brecht Carpenter, and Laura Kavanagh, Outreach to Children: Moving from Enrollment to Ensuring Access, Washington, DC: National Center for Education in Maternal and Child Health, March 1998.

How many eligible children have existing insurance programs been able to reach?

Recent studies suggest that over 4 million of America's 11 million uninsured children are eligible for Medicaid coverage.4 From 1995 to 1996, the number of children covered by Medicaid fell. At the same, time the percentage of children without health insurance grew from 13.8 percent to 14.8 percent.5 Estimates of Medicaid's "participation rate," the percentage of children currently eligible for Medicaid who are actually enrolled in the program, range from 53 percent to 84 percent.6 Participation rates were much lower in Medicaid-only programs compared to cash assistance programs that included automatic Medicaid eligibility. Thus, welfare reform is likely to exacerbate the decline in Medicaid enrollment as families lose cash assistance.State-funded health coverage programs have even lower participation rates than Medicaid. The Alpha Center has estimated the "penetration rate" for 21 state-funded insurance programs for children as ranging between 1 percent and 52 percent of eligible families actually enrolled in the program.7 On average, these 21 programs enrolled just 10 percent of their target population. These low rates are due to many factors—for example, some of the programs evaluated had limited funding and enrollment caps.

Participation in New York's Child Health Plus

New York's Child Health Plus program had enrolled only 37 percent of the eligible population in 1997. Historically, program expenditures have fallen short of available funding each year since the program began in 1991. While children eligible for Medicaid are not eligible for Child Health Plus, as many as 41 percent of Child Health Plus enrollees appear to be income eligible for Medicaid. The State Comptroller recommends additional outreach and marketing efforts and more specific guidance to insurers about screening for Medicaid eligibility.State of New York Office of the State Comptroller, "Department of Health Management of Child Health Plus Program," Report 97-S-10. Available on line at www. osc.state.ny.us.

What are the barriers to enrollment?

- Lack of information
- A difficult application process
- Complex and restrictive eligibility rules
- Premiums and enrollment fees

How can states reduce the barriers to enrollment?

- Spread the word
- Make it easy to apply

--Shorten the form
--Eliminate unnecessary verification
--Distribute forms widely
--Accept applications by mail
--Expand application sites and hours
--Support community-based application assistance

- Simplify the rules
- Eliminate or reduce premiums and enrollment fees

Barriers to enrollment: lack of information

One of the biggest enrollment barriers is that families simply don't know that public insurance programs for their children exist or they don't know how to apply for them. A poll taken several months after passage of CHIP found that only 29 percent of all parents and only 26 percent of parents of children without health insurance had heard anything about the new program.8 In Minnesota, a state-funded insurance program, MinnesotaCare, was established in 1992. A 1995 survey found that one-third of the uninsured were not aware of MinnesotaCare, and of those who had heard of the program, one-third did not know how to find out whether they were eligible or how to enroll.9 Researchers estimated that four-fifths of uninsured children were probably eligible for

MinnesotaCare.In addition to lack of knowledge about the existence of public insurance programs, misinformation is another barrier to enrollment, particularly in the Medicaid program, which many people still (incorrectly) assume limits eligibility to single-parent families receiving cash welfare assistance. As part of a regional outreach initiative in the southern states, the Southern Institute on Children and Families interviewed AFDC and transitional Medicaid recipients, community workers, and others about their knowledge of the Medicaid program.10 The Institute found that a majority of recipients did not know that a child could get Medicaid even if the parents live together and did not know about the availability of transitional Medicaid after a parent gets off welfare because of work. Even among community workers and providers, few knew about the higher Medicaid income limits for children under age six.

Reducing Barriers to Enrollment: Spreading the Word

Spreading the word: Federal initiativesThe administration has announced a national children's health outreach initiative to enroll uninsured children in Medicaid (or CHIP). It will include a national toll-free number that will connect callers to a toll-free number operated by their state. In addition, several national chain stores and trade organizations have agreed to help publicize the program—for example, by printing the toll-free number on grocery bags and enclosing program information with prescriptions. The President has also directed eight federal agencies with jurisdiction over children's programs—the Social Security Administration, the Departments of Agriculture, Interior, Education, Health and Human Services, Housing and Urban Development, and Labor and the Treasury Department—to develop plans to help enroll children, including distributing information and coordinating the application process with related programs. The report on the multi-agency effort was released as this document went to press.

Spreading the word: State initiatives

Media campaigns. Broad-based efforts to get the word out to the general population typically use such media as radio, television, newspapers, billboards, and posters. The message in a media strategy includes a general description of the program and information about how to apply. Often a toll-free number is advertised, and some states are also supplying an address for a website on the Internet. Every state is including some kind of media campaign in its outreach plan. For example, for its media campaign, Arkansas has run television spots about its children's Medicaid program, ARKids First, and reports that almost half of all applicants identified television as their source of information about the program's availability.Targeting locations and agencies serving children. A targeted strategy will reach out to locations and organizations where parents are likely to be found, such as child health providers, schools, and child care centers as well as businesses and other agencies offering children's services. Such organizations may publicize the program by displaying posters and brochures or including information about the program in newsletters or other materials sent to parents. In addition, the staff

may be trained to make referrals or even to assist parents in obtaining and completing application forms.

Coordinating CHIP and Child Support

[A] logical and cost-effective but frequently ignored agency to involve in these outreach efforts is the state's child support enforcement program. Not only does this agency have records about which children do not have coverage through private insurance or Medicaid, but also it has financial information about parents which would be useful in screening for CHIP [or Medicaid] eligibility. Moreover, the child support agency could assist the state in collecting from non-custodial parents any CHIP premiums the state decides to impose, and could move children to private insurance if and when it becomes available to them through their no-ncustodial parents. This allows the state to keep within its fiscal constraints while making sure that children have continuous access to health insurance.Paula Roberts, Coordination Between the Child Support and Children's Health Insurance Programs in Order to Obtain Health Insurance Coverage for Children, Washington, D.C.: Center for Law and Social Policy, February 1998.Direct mail. A targeted strategy can also include mailing information directly to parents likely to have eligible children. Coordination with other programs serving families with children will enable the state to identify these families more effectively. For example, both Florida and Tennessee plan to send information to families who are receiving food stamps but not Medicaid. Illinois will be sending information to non-cash assistance families who use the state's child support enforcement services. Wisconsin has targeted families terminated from cash welfare assistance. Several states plan to include information about children's health insurance in the materials sent to the parents of school children about the free and reduced-price school meal program.Widespread distribution of application forms. States that have shortened application forms and that accept mail-in applications may choose a strategy of wide distribution of the application form itself. Michigan has combined a short application with its informational brochure. Within a few months of implementation, South Carolina had mailed out over 500,000 copies of its 1-page application with a cover letter from the Governor; it reports over 35,000 new enrollees in the first nine months of the program. Connecticut proposes to mail applications to all families with income under 300 percent of poverty, and Rhode Island plans to send application forms to all children in school.Targeting special population. Hispanic children, in particular, are disproportionately represented among the uninsured. Information should be translated into Spanish as well as other languages represented in the community. California is proposing translations into 10 threshold languages, and Tennessee is preparing a video for Deaf parents.Several state plans, including Colorado and Illinois, promise special efforts to reach homeless and migrant children as well as children living in rural areas. Massachusetts is offering grants to community organizations to find hard-to-reach children, including teens, children of seasonal workers, and young parents. In addition, CHIP requires states to identify how they will enroll American Indian children, and HCFA has urged states to consult with tribal governments.

Demographics of Uninsured Medicaid Eligible Children

Uninsured children who are eligible for Medicaid are more likely to be in working families, Hispanic, and either U.S.-born to foreign-born parents or foreign-born. This suggests that state outreach may effectively target working families and qualified immigrants. States in the West have higher numbers and percentages of Hispanics and immigrants among their Medicaid eligible uninsured children . . . nearly three-quarters of uninsured Medicaid-eligible children live in the West and South.U. S. General Accounting Office, Medicaid: Demographics of Non-enerolled Children Suggest State Outreach Strategies, GAO/HEHS-98-93, March 1998.

Barriers to enrollment: the application process

Once families learn about a public insurance program, they still face barriers in completing the application process.Getting the application form. If it is necessary to go to a particular location to apply, many potential barriers arise. Is an appointment necessary? Is it difficult to get through by telephone to make an appointment? Is the site conveniently located? Does the family have access to transportation? Are the hours of operation convenient, or do they interfere with the parent's work hours? Will the parent have to arrange child care or bring the children to the appointment? How long is the wait for an appointment? Will the family be treated with respect?Understanding and completing the application form. If the parent is not fluent in English, will bilingual workers be available, and will materials be translated into other languages? How long does it take to complete the form? Will the parent's self-declaration be sufficient, or will third-party verification be required of the parent's statements? Who is responsible for getting the verification, the parent or the worker? How many of the parent's statements must be verified? What assistance is available if third parties don't cooperate in supplying information? How much time is the parent given to gather information? What happens if information isn't supplied by the deadline?Nearly half of Medicaid denials are for procedural reasons, not because the applicants didn't meet program eligibility criteria.11 One study of 1996 AFDC applications denied for procedural reasons found that 77 percent of the denied applicants were likely to be financially eligible.12 Medicaid applications processed in state welfare offices are likely to show similar results: lost opportunities to enroll eligible children.

Reducing Barriers to Enrollment: making the application process easier

Under both Medicaid and CHIP, there is a federal obligation to provide benefits only to eligible children. However, the states have broad discretion in establishing both eligibility standards and the process by which eligibility will be determined. The simpler the application process, the lower the risk of denying coverage to eligible children for

procedural reasons. Simplification involves making it easy to get an application form, fill it out and return it and get back a decision. Reforms work best in combination: If complex eligibility rules are eliminated, it will be easier to shorten the application form and eliminate excess verification. If the form is short, excessive verification requirements are eliminated, and mail-in applications are accepted, then the state can better pursue a strategy of wide distribution of the application forms and enlistment of community-based organizations to help enroll eligible children.Making it easy to submit an application formMail-in applications. Nothing in federal law requires a face-to-face interview, and 24 states have already eliminated this step in Medicaid applications for pregnant women and children.13 Mail-in applications avoid the many barriers that may arise in getting to a particular site in order to apply and facilitate information strategies involving wide distribution of application forms to parents, agencies, and community groups. Several states that have eliminated a face-to-face interview still require a telephone interview. Many states are proposing mail-in applications for their CHIP programs.Telephone, fax, and Internet applications. A few states take applications by telephone. For example, Ohio will take applications over the telephone and will mail the application back for the required signature. Colorado's CHIP proposes to take applications over the Internet, which will enable families to apply at any site with Internet access.14

Expanding sites for enrolling children:

Outstationing"Outstationing" means locating eligibility workers in places other than welfare offices to take applications.15 Under the Medicaid program, the state agency must make the final eligibility decision, but outstationed workers not employed by the state agency can engage in the initial processing of applications. Under separate state insurance programs, there are no federal restrictions on who can make eligibility determinations; indeed, states like Florida are hiring third-party administrators to make all eligibility determinations. (Federal matching funds are available for outstationing as an administrative cost, as discussed in more detail in the section below on outreach funding.) Outstationing can be particularly effective if combined with a simplified application form and presumptive eligibility (see below): Community workers can make preliminary eligibility decisions, and help families complete and mail-in the application form.Some states may need to increase their efforts at outstationing in order to comply with existing Medicaid law. Since 1990, federal law has required states to accept Medicaid applications for pregnant women and children at disproportionate share hospitals and federally qualified health centers (FQHC). However, a recent study shows a wide range of state variation on compliance with this requirement.16 Only 57 percent of FQHCs responding to a survey engaged in outstationing, and of these, only 62 percent reported engaging in all the required outstationing activities. The study finds that state support in the form of training, materials, and funding are particularly important to the successful use of outstationing.Many states identify outstationing as an outreach strategy in their CHIP plans. Colorado's CHIP includes grants to satellite eligibility determination sites. South Carolina's Medicaid program has entered into outreach and enrollment assistance contracts with a hospital system in Greenville and with a public housing authority. Georgia's Right from the Start Medicaid program uses outstationed eligibility workers employed by the state Medicaid agency extensively.

Georgia's Right from the Start Medicaid Project (RSM)

Established in 1993 in response to Georgia's high infant mortality rate, RSM hired 195 outreach staff to identify and enroll pregnant women and children in Medicaid. Staff members are housed in community settings and are available during non-traditional hours. Eligibility workers take applications in a variety of different community settings, work with community groups, and make presentations throughout the month. RSM has used creative techniques for getting the word out—sending brochures home with report cards, designing an RSM coloring book, developing audio-tapes that play information while callers are on hold with the state health department, and including flyers in children's shoe boxes.The application process is fast and easy and dispenses with most third-party verification unless the information is questionable. Applicants under 100 percent of poverty need not provide third-party verification of income. Georgia, like all states, does use computer cross-matching to verify income and randomly samples cases for quality-control purposes. The state reports no increase in its "error rate" since eliminating most third-party verification. In its first year of operation, RSM took over 23,000 applications, and by state fiscal year 1997. it took over 63,0000 applications.For more information on Georgia's innovative program, call project director, Becky Shoaf, at 404-657-4086.Making it easy to complete an application: simplifying the formSince 1990, Medicaid has required states to develop a Medicaid application for pregnant women, infants, and children under age 19 that is different from the application for cash assistance. HCFA developed a model 4-page Medicaid application form. Twenty-nine states have streamlined their Medicaid applications to 4 pages or fewer to make it easier for pregnant women, infants, and children to apply.17 In some states, welfare applications are over 20 pages long.Sample short forms. In its January 23, 1998 letter to state officials, HCFA encourages states to simplify their application forms and the application process. It includes copies of Delaware's 2-page application form, Georgia's 1-page form, and South Carolina's 1-page form and 1-page cover letter.Joint CHIP/Medicaid applications. The January 23, 1998 letter also includes a sample joint application for a separate CHIP and the poverty-level-related Medicaid category.18 Joint forms are important in states that are trying to create seamless insurance coverage to permit children to move easily between Medicaid and a separate CHIP as family circumstances change. Both New Jersey and Connecticut will be marketing Medicaid and separate CHIP programs together under new names. New Jersey has developed a joint form for NJKidCare, and Connecticut has developed a joint form for HUSKY. Several more states are working on joint forms.The HCFA instructions state that if the child is ineligible for poverty-level-related Medicaid, the state has an obligation to inform the family about other Medicaid eligibility categories exist, the advantages of Medicaid, and how to apply for other categories. HCFA is not requiring that the joint application include questions needed to address eligibility for all categories of Medicaid. However, families must be informed of other routes to Medicaid coverage as part of the application process. It is important that families know about other routes to Medicaid. For example, a family may be better off incurring a modest spenddown for more comprehensive Medicaid

benefits under the "medically needy" category than signing up for a CHIP program with cost-sharing and a less generous benefits package.

Screen and enroll

If a separate program calculates income differently than Medicaid does, it must inquire about allowable Medicaid income deductions and disregards in order to screen for Medicaid eligibility. The law specifically requires that children found through both intake and follow-up screening to be eligible for Medicaid be enrolled in Medicaid, 2102(b)(3)(B). HCFA's letter to state officials dated January 23, 1998 clarified that screening for gross income eligibility is not enough. States must compare net income to Medicaid income eligibility levels. In addition, HCFA has asked states to describe in their CHIP plans "how the State will ensure that children who are determined to be Medicaid eligible will be enrolled in the Medicaid program (rather than simply referred to the Department of Social Services)." (Letter from Richard Fenton, HCFA to Michael Starkowski, Connecticut Department of Social Services, dated March 18, 1998). Joint CHIP/Medicaid application forms are a good way to satisfy this requirement.Short forms, trade-offs. There is a trade-off between the goals of facilitating enrollment by shortening the application form and maximizing the availability of all benefits for which a family may be eligible. To the extent different programs provide different benefits and/or have different rules, a joint application will probably have to be longer than an application for just one program. However, if different programs use the same eligibility rules, coordination and simplification can work together. States that opt for a short children's health insurance application should at least provide information describing other benefits available through a separate application process for food stamps, child support enforcement services, and subsidized day care, for example.Short forms also sacrifice valuable information that could be used to evaluate and improve the program. For example, states concerned about "crowd out" may want to ask about prior insurance status. Questions about race and ethnicity and other family characteristics can help a state target its outreach efforts. Getting this information through surveys of enrollees will be more difficult than by adding a question to the application form.What information must be included in an application for CHIP benefits?At a minimum, the application form must ask enough information to determine whether a child is eligible. This requires compliance with the CHIP law, certain other federal laws, and for CHIP Medicaid expansions, the Medicaid law. See Table 1.Information required by the CHIP law

- The CHIP definition of targeted low-income children refers to the child's age and family income and the child's insurance status. A determination of family income requires a determination of who is in the family and information about any allowable deductions or disregards from income, such as child care expenses.
- Excluded from the definition of targeted low-income children for purpose of a separate CHIP are inmates of public institutions, patients in Institutions of Mental Disease, and children of employees of a public agency with access to coverage.

These exclusions in the CHIP law do not apply to Medicaid, but Medicaid law also excludes inmates of public institutions.

- In a separate CHIP, the state has the option of adding a variety of other eligibility standards including periods without insurance, or access to insurance, financial assets, and residence. In Medicaid, too, the state can impose an asset test and limit benefits to state residents (as defined by the Medicaid program).

Information required by other federal laws

- Other federal laws also impose eligibility requirements that affect CHIP. The 1996 welfare reform law limits Medicaid and "federal public benefits" like a separate CHIP to children who are citizens or qualified aliens.
- Federal law requires certain public benefit programs, including Medicaid (but not a separate CHIP), to obtain social security numbers from applicants for or recipients of benefits and to verify income through computer cross-matches with data maintained by the state unemployment agency, the Social Security Administration, and the Internal Revenue Service.19 Applicants must be notified at the time of application that information available through the system will be used and that the information must be independently verified before it can be used to deny benefits. If only a child is applying for Medicaid, only the child's social security number is required. (HCFA's joint application asks for the social security number of other household members, but federal law does not mandate this.)

Information required by the Medicaid Law

- Medicaid applications must be in writing and signed under penalty of perjury. Medicaid also requires that as a condition of eligibility, applicants with "legal capacity" to do so assign rights to medical support and third-party payment and cooperate in establishing paternity and obtaining medical support and third-party liability.20 However, because children under the age of 18 do not have "legal capacity" to assign their rights, these are not conditions of eligibility for children and are not included in HCFA's sample joint form. Nonetheless, states are required to seek medical support from the parents at some time during the application process. HCFA may be releasing guidance on this issue in the future.
- Questions about pregnancy are typically included in the Medicaid application for purposes of referrals to the WIC program, and because the Medicaid eligibility category for pregnant women often has a higher income threshold than children's categories—e.g., 185 percent of poverty based on pregnancy vs. 133 percent of poverty based on age.
- Medicaid also requires that applicants be informed of certain rights and responsibilities. For example, the application must disclose how the social security number will be used. Because Medicaid provides three month retroactive

eligibility, the application usually inquires about bills incurred in the past three months as well.

Information required	Medicaid	Separate CHIP	Third-party verification required
Child's age	☑	☑	
Family composition	☑	☑	
Family income (including deductions and disregards)	☑	☑	
Family income as defined by Medicaid (if different)		☑	
Family assets	Optional	Optional	
Current insurance coverage	☑ (only for enhanced CHIP match)	☑	
Patient in Institution for Mental Disease	☑	☑	
Inmate of public institution	☑	☑	
Family of public employee with access to insurance		☑	
Social Security Number of applicant	☑		☑ (cross-match by agency required)
Citizenship or immigration status of the child	☑	☑	☑ (only for non-citizen status)
State residence	Optional	Optional	
Pregnancy	☑ (only if		

	higher income level than children)		
Notice of rights and responsibilities	☑		
Other optional eligibility criteria— e.g., geographic area, disability status, period uninsured or access to insurance		☑	
Signature under penalty of perjury	☑		

Making it easy to complete an application: minimizing third-party verificationUnder Medicaid, states are required to have a Medicaid eligibility quality control system (MEQC) that verifies eligibility decisions in a random selection of cases.23 States with error rates over a specified percentage face financial penalties. States sometimes attribute the need for third-party verification to the error rate. However, states like Georgia that do not require income verification for families with income under 100 percent of poverty report no increase in their error rate. In its January 23, 1998 letter to state officials, HCFA stated: "While it is important to maintain program integrity by verifying income, excessive requirements can deter families from completing the application process." Advocates have urged HCFA to go further and take whatever action is needed to assure states that they need not fear error rates in children's Medicaid eligibility. What HCFA will do remains to be seen.The CHIP law, unlike the Medicaid law, does not specify an eligibility quality control system. The technical guidance regarding financial provisions of CHIP that HCFA has released to date does not suggest that HCFA will be imposing quality control requirements on separate CHIPs.What verification does federal law require?HCFA's January 23 letter to state officials includes a sample joint CHIP/Medicaid application form. In its instruction to the sample joint application form, HCFA explains that there are only two verification requirements for children's poverty-level-related groups under Medicaid: immigration status of no-ncitizens and the state agency's use of the applicant's social security number, described above. Separate CHIPs are also subject to the verification requirements for noncitizen children but are not required to ask for social security numbers.With regard to citizenship status, the state must require a written declaration under penalty of perjury whether the eligible individual is a citizen of the United States, and if not, that the individual's immigration status qualifies them for benefits. If the individual is not a citizen, documentation of immigration status is required. Verification of immigration status will also be necessary for separate insurance programs.22 Eligibility of a citizen child may be established on the

basis of the parent's declaration alone; federal law permits but does not require third-party verification that a child is a citizen.Application assistance programs.Complicated forms can overwhelm families who cannot read well or who have trouble obtaining verification documents from employers, utility companies, or absent parents. Limited or complicated information can confuse families about which programs to apply for. Many states—among them, California, Connecticut, Colorado, Florida, Michigan, Missouri New Jersey, New York, Ohio, and Pennsylvania—are proposing to enlist community-based organizations to identify eligible families and help them to apply.Several models of application assistance programs exist. The Philadelphia Citizens for Children and Youth (PCCY) Child Health Watch offers families one-on-one counseling to help with insurance access problems. PCCY also offers families easy-to-read written materials. Colorful charts clearly describe the income-eligibility criteria for Philadelphia's four major programs for uninsured and Medicaid-eligible children and give local phone numbers to call for more information. A simple checklist helps families organize the documents that they need. Based on its hands-on experience providing application assistance, PCCY can also advocate more effectively for systemic changes needed to make the process easier for families to navigate.

Wisconsin's KIDS CARE: Preventive Health Screening and Family Health Benefits Counseling

Traditional outreach information campaigns may not be enough to ensure enrollment. KIDS CARE, a Wisconsin program funded by the Maternal and Child Health Block Grant, offers an annual physical and diagnostic services through participating county health departments and providers in rural areas. It does not cover treatment costs. This is where benefits counselors fit into the picture. Family Health Benefits Counseling offers peer-to-peer contact and advocacy on behalf of families to help them connect to appropriate health care financing programs—not just Medicaid but private insurance and other programs too. ABC for Health, a public interest law firm, is available to provide legal back-up to the benefit counselors.Several counties in which KIDS CARE is operating show a significantly higher rate of enrollment in children's Medicaid. The success of counselors has now spread to the private sector. A medical center working with ABC for Health set up its own health benefits counseling program for clinic patients. The clinics report a $10 recovery of third-party payments for every dollar spent on health benefits counseling.For more information: Robert "Bobby" Peterson, Executive Director, ABC for Health, Inc., Madison, WI (608) 261-6939

Barriers to enrollment: complex and restrictive eligibility rules

Eligibility requirements create barriers to coverage in several ways. Obviously, eligibility rules exclude those who don't meet the requirements. In addition, the existence of

complex rules makes it harder to explain the program and harder to use a short and simple application form. This is particularly true if the state requires third-party verification of the parent's statements.Optional eligibility criteria. Under the separate state program, states have the option of adding eligibility criteria. Several states are considering additional criteria related to insurance status, either requiring that a child be uninsured for a specified period of time or that children have no access to insurance. These rules will complicate the eligibility determination process. Several states that had imposed such requirements in their state-funded insurance program later eliminated them because of their administrative complexity. For example, Florida's Healthy Kids Corporation originally restricted eligibility to children who were uninsured for the prior six months. However, Florida found verification of prior insurance status so cumbersome to administer that it discontinued the requirement.23Citizenship and immigration status. Federal law limits eligibility to insurance benefits under Medicaid or CHIP to citizens, qualified aliens who entered the country before August 22, 1996, and refugees and certain other immigrants entering later.24 This not only excludes undocumented children and late entrants but may deter undocumented parents from applying on behalf of citizen children. Undocumented parents may fear that the application process will require disclosure of their unlawful status to immigration officials and lead to deportation. They may also fear that their ability to reenter the country or readjust their immigration status will be jeopardized if the Immigration and Naturalization Service (INS) finds they are likely to become a "public charge" because Medicaid or CHIP insures their children.25

Reducing barriers to enrollment: simplify eligibility rules

Income: Raising income levels for all children in the same family is likely to increase participation. Obviously, raising income limits will make more children eligible, but income eligibility affects the likelihood of enrollment in other ways. Currently, Medicaid has three different income-eligibility levels, depending on the age of the child. Raising Medicaid income levels so that all children are eligible at the higher income level will make the program easier to explain and make more sense to parents. A recent study found that the Medicaid participation rate for children increased when more family members were covered by Medicaid.26Income: Defining income the same way will make it easier to coordinate Medicaid and a separate insurance program. Using the same income methodology in Medicaid and a separate state program will make it easier to avoid children's falling between the cracks. Medicaid generally uses the income deductions and disregards required under the former AFDC program. However, states have the option of using more liberal income methodologies in Medicaid. Similarly, under a separate insurance program, states are free to define income as they choose. Thus, there is no legal impediment to defining income the same way in both Medicaid and a separate program.Assets: Eliminating asset rules will simplify the process.Asset rules, which require an inquiry into the items of personal property a family owns and the value of the items, are particularly burdensome for both families and eligibility workers. States are not

required to impose asset tests for children's health insurance under either Medicaid or a separate state program. In addition to the general authority of states to use more liberal income and resource methodologies in children's Medicaid, Medicaid for poverty level children expressly makes an asset test optional. Only 12 states still use asset rules for some or all children eligible for Medicaid as a poverty-level-related group.27 Outreach strategies that rely on a short, easy-to-complete application forms will benefit from elimination of the asset test. Several states report that elimination of the asset test alone enabled them to shorten the application form significantly.Those states that eliminate the asset test after March 31, 1998 can qualify for enhanced CHIP funding for those children newly eligible by reason of the elimination of the asset test. Unfortunately, in order to identify these children, states may still have to ask about assets. California eliminated its asset test for Medicaid. It originally proposed to use sampling to estimate the number of children who became eligible due to elimination of the asset test. Instead, the state will continue to question applicants about asset ownership. The old application form required 35 questions for this purpose, the new form asks two questions related to assets.Citizenship and immigration status. The eligibility rules on immigration status are federally imposed and require federal initiatives to change. The administration has proposed changing the law to give states the option of covering qualified alien children who entered after August 1996. Meanwhile, given the current federal requirements, states can take steps to encourage citizen children and qualified alien children to apply:

- use application forms that do not ask about the parent's citizenship status directly or indirectly by asking for the parent's social security number;
- use flexible guidelines for verifying income for undocumented parents who may not have pay stubs available;
- contract with community-based organizations trusted by the immigrant community to take application forms, whether through outstationing, presumptive eligibility, or contracts for outreach and enrollment assistance;
- translate application information into languages spoken by the immigrant community;
- protect essential community providers who now serve the immigrant community by including them in provider networks or by seeking direct services waivers for community networks under CHIP;
- use state-only funds to provide health services to otherwise ineligible immigrant children and CHIP funds to pay for outreach to such programs.

Citizen children in immigrant families

A recent study found that 15 percent of families with income under 200 percent of federal poverty levels consist of at least one citizen child and one no-ncitizen parent. In some states, the percentage of such families was much higher. In California, over 45 percent of lower-income families included a citizen child and noncitizen parent.28Sheri A. Brady, One in Ten: Protecting Children's Access to Federal Public Benefits under the New Welfare and Immigration Laws (Washington, DC: National Association of Child

Advocates, 1998).Piggyback eligibility. One good way of simplifying eligibility rules in order to facilitate enrollment is to provide for expedited eligibility if a family has already been determined eligible for a public benefit program with the same eligibility rules as the CHIP program. For example, in Colorado, families eligible for any one of six other programs, including the Free and Reduced Price School Meals Program, WIC, or Colorado's Indigent Care Program, can use a special color-coded short application form with income verification obtained directly from the other program. Free and Reduced Price School Meals are available to families with incomes under 185 percent of poverty; therefore, many states may be able to piggyback at least the income component of CHIP eligibility with the School Meal program.Avoid periods of uninsurance.
Several states are imposing optional eligibility criteria requiring that a child be uninsured for some period of time, typically three to six months, prior to enrollment. These criteria are generally seen as a way to discourage families from dropping private coverage in favor of coverage under CHIP. Unfortunately, the families who are turned away may not return. If a state is set on a waiting period, it may want to consider enrolling children when they apply but delaying coverage until the waiting period expires.Waiting periods are not required. HCFA has approved CHIP plans in New York and Florida that do not require periods of uninsurance. Each of these states will be conducting a survey of enrollees regarding prior insurance status to determine whether substitution of coverage is a significant problem. Only if substitution is identified as a serious problem will states take measures such as imposing waiting periods. For more information on ways to avoid substitution for private coverage without restricting eligibility to uninsured children, see Families USA, What Is Crowd-Out and Why Should Children's Health Advocates Care? December 1997.12-month continuous eligibility. In states that adopt this new option, children can receive 12 months of continuous Medicaid coverage even if a family's income or circumstances change during the year. This is particularly important for the working poor whose income is likely to fluctuate considerably from month to month. States that adopt the 12-month continuous Medicaid eligibility option help assure that children get care on a regular basis without burdensome reporting requirements, frequent eligibility re-determinations, and "churning" off and on the program.Discontinuity of careA recent study found that of children enrolling in Medicaid between 1991 and 1993, only 20 percent of children under 16 were still enrolled 28 months after initial enrollment. After losing Medicaid, 54 percent of persons of all ages had no insurance in the following month, and 39 percent were still uninsured at four months. Of those who were insured at four months, 26 percent had reenrolled in Medicaid.O. Carrasquillo, "Can Medicaid Managed Care Provide Continuity of Care to New Medicaid Enrollees?" American Journal of Public Health 88, 3 (March 1998): 464-466.Twelve-month continuous eligibility is especially important in states with managed care programs because going off and on a managed care plan every time eligibility is lost and regained can jeopardize preventive care and stack up significant administrative costs. It is also important in states that recalculate eligibility every month. In these states, when a month happens to have five Fridays, the extra paycheck in a "five-Friday month" can mean the family loses its insurance even though its annual income and financial circumstances have not changed at all. Further, with the state's investment in outreach, it only makes sense to keep children enrolled long enough to benefit from preventive care.State can adopt 12-month continuous eligibility under both Medicaid and CHIP. In states with separate CHIPs,

some, like Connecticut, have adopted 12-month continuous eligibility in both the separate CHIP and Medicaid. Other states, like Colorado, have only adopted continuous eligibility for the separate CHIP program.

Barriers to enrollment: premiums

Premiums or other enrollment fees that are imposed as a precondition to coverage will be a barrier to enrollment for many low-income families. Based on a study of premiums charged low-income families in three states, the Urban Institute found that when families were charged a monthly premium of 1 percent of income, participation dropped to 57 percent of uninsured families. With premiums set at 3 percent of income, only 35 percent of uninsured families participated; and at 5 percent of income, only 18 percent enrolled.29 A survey of Washington State residents who inquired about but did not enroll in Washington's Basic Health Plan, which covers families earning up to 200 percent of federal poverty levels, found that 78 percent did not enroll because monthly premium costs were too expensive.30 Indeed, the likely reason that the number of Americans without insurance is increasing is the increased share of costs families must assume to obtain coverage.31 CHIP permits total aggregate cost-sharing of up to 5 percent of family income; if states impose such high levels of cost-sharing, participation will be low, regardless of how short the application form or how easy the process.

Reducing barriers to enrollment: affordable coverage

Keeping premiums affordable is probably the single most important thing that a state can do to increase participation. Ninety percent of uninsured children are in working families. Presumably, their parents cannot afford the cost of private coverage. It serves little purpose if public insurance programs are similarly unaffordable. The great majority of state plans creating separate CHIPs or expanding Medicaid waivers that permit cost sharing are not imposing costs on families at income levels of 150 percent of poverty or below. Connecticut does not charge premiums until family income is over 235 percent of poverty; Pennsylvania and Rhode Island charge no premiums until family income is over 185 percent of poverty; Oregon charges no premiums, but its upper income limit is 170 percent of poverty; and New York charges nothing until family income is over 160 percent of poverty.If a state is set on charging something, states may want to consider a modest one-time enrollment fee that gives parents an investment in the program but is not a financial barrier to coverage and does not require the complicated administrative structure needed to collect monthly premiums. North Carolina, for example, will be charging an annual enrollment fee of $50 per child up to $100 per family for children in families between 150 and 185 percent of poverty. It is also important that the process for collecting premiums and disenrolling families for nonpayment includes reasonable consumer protections such as grace periods for late payment.

Outreach funding

General Medicaid administrative funding. The Medicaid program provides a 50 percent federal matching rate for general administrative expenses, including outreach. There is no cap on the amount of reimbursable administrative expenses under Medicaid. A state expanding children's insurance under Medicaid can bill outreach expenses to the general Medicaid program or to CHIP. Eligible administrative expenditures include the costs of contracting with non-state employees to engage in initial processing at outstationed locations.Enhanced Medicaid outreach funding related to welfare reform. An enhanced federal matching rate from a specially designated $500 million fund is available for Medicaid outreach during FFY 1997-2000. 32 The fund can be used for allowable activities required as a result of the "delinking" of Medicaid and AFDC cash welfare in the 1996 welfare reform law. Some outreach activities can be reimbursed at a 75 percent match rate, including hiring new eligibility staff to handle redeterminations, designing new forms such as a joint application for Temporary Assistance for Needy Families (TANF) and Medicaid, and identifying TANF recipients at risk of losing Medicaid. Other activities can be reimbursed at a 90 percent match rate including the costs of training and outstationing eligibility staff and assisting beneficiaries with redeterminations. Wisconsin is drawing on the fund to send notices to all families terminated from cash assistance over the past year who do not have current Medicaid enrollment. So far few states have taken advantage of this source of outreach funding. The Administration has proposed legislation to expand the eligible uses of the fund and extend it beyond the year 2000. The amount of each state's allocation is attached to this report.CHIP funding. CHIP funding at the enhanced matching rate determined for each state is also available for outreach expenditures. However, no more than 10 percent of expenditures for health insurance can be used for purposes other than administration, outreach, and other child health initiatives. Eligible outreach expenditures can include application assistance programs. For example, HCFA has approved California's plan to pay a $25 fee to insurance brokers and others certified to assist families in filling out the application form for Healthy Families, California's CHIP plan.Private funding. Several private foundations, including the Robert Wood Johnson Foundation, are also supporting outreach and enrollment initiatives at the state level. In addition, hospitals and other providers have a direct financial incentive in getting their uninsured patients enrolled in insurance programs and have been willing to contribute time, space, and funding to facilitate enrollment efforts.Public-Private PartnershipsThe Robert Wood Johnson Foundation is conducting a $13 million initiative to identify and enroll uninsured children in Medicaid and other health insurance programs. The goals of the initiative are to design and conduct outreach programs that identify and enroll eligible children in Medicaid or other health coverage programs, simplify enrollment processes, and coordinate existing coverage programs for low-income children. For more information, see the RWJ website

Managed Care Organizations, Marketing, and Outreach

For states delivering services through managed care, families face two levels of enrollment: enrollment in the program generally and enrollment with a particular managed care plan. Plans have generally engaged in outreach as part of marketing a particular managed care product, and the competition for enrollees has often led to abusive marketing and enrollment practices in the Medicaid managed care context. Because of this experience, the Balanced Budget Act of 1997 (BBA) now mandates certain basic consumer protections in Medicaid managed care. For example, fraudulent and misleading information about covered benefits are prohibited, and all marketing materials used by a plan must be approved by the state. All materials must be easy to read and include basic information. For more information on this topic, see Families USA, A Guide to Marketing and Enrollment in Medicaid Managed Care, Washington, DC, June 1997.States administering separate state programs that take heed of the lessons of Medicaid managed care will want to adopt the marketing and enrollment standards of the BBA; however, they are not required to do so. For example, the BBA requires enrollment brokers to be completely independent of any plan, but California proposed to hire one of its participating plans as an enrollment broker, and HCFA has approved this practice so long as sufficient "firewalls" are in place. Pennsylvania's CHIP program, which does not offer a choice of plans, relied on plans to do outreach and required participating plans to allocate 2.5 percent of plan payments to outreach. However, in this case, HCFA has determined no federal match is available for these funds because they run afoul of the restrictions on provider taxes and donations.

Timely processing of applications by eligibility workers

Enrollment occurs only after eligibility workers process the applications. Having an adequate number of trained eligibility workers is indispensable. Medicaid requires applications to be acted upon within 45 days; separate programs have no federally imposed time limit. With application streamlining, the turnaround time for applications should be much shorter. California's plan provides that its eligibility contractor has 10 days from receipt of an application to return it as incomplete or enroll the child in a health plan. If states anticipate longer turnaround times, presumptive eligibility, discussed below, can help a family receive needed services while the application is being processed.

Presumptive eligibility: an outreach and coordination strategy

Medicaid. The Balanced Budget Act of 1997 (BBA) created a presumptive eligibility option for children. If a state chooses, qualified Medicaid providers and eligibility workers in Head Start, WIC, and Child Care and Development Block Grant programs can enroll children in Medicaid temporarily if preliminary information about family income suggests that the children are Medicaid-eligible. States that adopt this option make it possible for children to receive the full range of Medicaid services right away while their applications are under review.Prior to the BBA, presumptive eligibility was only an

option for pregnant women. As of February 1996, 30 states used presumptive Medicaid eligibility so that pregnant women could receive prenatal care right away. A GAO report found that states that both adopted presumptive eligibility and dropped the assets test experienced the most rapid growth in enrollment of pregnant women.33Presumptive eligibility lasts for however many days are left in the month in which the children are found presumptively eligible, plus the next full month. During this time, a formal Medicaid application for the children must be filed. Once it is filed, the children may stay enrolled in Medicaid until the state makes its decision. If presumptive eligibility is coupled with a simplified application process, the same workers making the presumptive eligibility determination can assist the family to complete and mail in the application form. Connecticut is one state electing this option for its children's Medicaid program, HUSKY Part A (HUSKY Part B is a separate state program). Massachusetts is electing presumptive eligibility for both its Medicaid program (MassHealth Standard) and its separate CHIP (MassHealth Family Assistance).If the state finds that the children are not eligible, the family does not have to pay for coverage received during the presumptive eligibility period; the costs of coverage will be taken out of the state's CHIP allotment. Payment to the "qualified entities" making the preliminary determination will be considered administrative costs of the program. See the section above on outreach funding.Presumptive eligibility can serve as an effective coordination strategy between Medicaid and a separate state program. If Medicaid providers and others qualified to make presumptive eligibility determinations under Medicaid are also able to make presumptive eligibility decisions under CHIP, there is little danger of children falling between the cracks.Separate state programs. Presumptive eligibility is a Medicaid option; however, HCFA has determined it is also available in separate state programs. In Michigan, for example, participating health plans can temporarily enroll children into the plan and then forward the application form to the administrative contractor for a final eligibility determination.The role of essential community providers. Presumptive eligibility protects essential community providers. These providers are assured that they will be reimbursed for care given to children prior to a formal eligibility determination that in many states means enrollment in a managed care plan and a change of providers.Federal initiatives. The administration is proposing two changes to federal law to make presumptive eligibility easier for states to use. One change will expand the sites and people states can qualify to make presumptive eligibility decisions to include schools, child care resource and referral centers, child support enforcement agencies, and CHIP eligibility workers. The second proposal is to eliminate the current requirement that the costs of coverage for a family later determined ineligible be deducted from the state's CHIP allotment.Additional Resources

- Start Healthy, Stay Healthy is a national outreach campaign conducted by the Center on Budget and Policy Priorities (CBPP) in Washington, D.C. in collaboration with early childhood programs across the country. In 1997, CBPP staff worked with community organizations in 15 states and the District of Columbia to expand Medicaid outreach to uninsured children. It will be releasing an Outreach Campaign Kit later this summer. For more information about the many useful materials produced by the Start Healthy, Stay Healthy project, see www.cbpp.org or call the project director, Donna Cohen Ross at 202-408-1080.

- The Southern Institute on Children and Families has worked extensively on outreach issues, including a regional outreach initiative in the southern states in 1997. It is now project director for a major program of the Robert Wood Johnson Foundation: Covering Kids: A National Health Access Initiative for Low-Income Uninsured Children. For more information on the valuable resources produced by the Institute, see www.kidsouth.org, or call its director Sarah Shuptrine at 803-779-2607.

Conclusion

The purpose of CHIP is to reduce the number of uninsured children. The success or failure of this new health care initiative is likely to rest on the numbers of children states are able to enroll. It is clear that this will require a concerted outreach effort to identify uninsured children already eligible for Medicaid as well as children newly eligible for CHIP. Low participation rates in Medicaid-only programs and even lower participation rates in state-funded programs suggest that enrolling significant numbers of children will require much more than opening the door to eligibility. However, the federal government, the states, private foundations, providers, research institutions, and advocacy groups are rising to the challenge. Ideally, the experimentation now going on at the state level will yield valuable information about the most effective ways to enroll different populations of children. With these lessons in hand, the program can turn to its next challenge—ensuring enrolled children access to care.For More Information, Contact kids@familiesusa.org.

Endnotes

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8 Harvard University, Robert Wood Johnson Foundation, University of Maryland, National Survey of Americans' View on Children's Health Care, December 9, 1997, unpublished.
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13 Center on Budget and Policy Priorities, States That Have Simplified the Medicaid Application Process (Washington, DC: Center on Budget and Policy Priorities, August 1997)
14 Colorado's system includes detailed security measures necessary to comply with the Federal Privacy Act.
15 §1902(a)(55); 59 Federal Register 48805 (September 23, 1994).
16 Sara Rosenbaum, Kathleen A. Maloy, Jennifer Stuber, and Julie Darnell, Initial Findings from a National Study of Outstationed Medicaid Enrollment Programs at Federally Qualified Health Centers: Implications for Low-Income Children Under Welfare Reform (Washington DC: George Washington University, February 1998).
17 Center on Budget and Policy Priorities.
1 There are different Medicaid "categories" with different eligibility criteria for each category. The poverty-level-related category covers children under age 6 in families with income up to 133 percent of the federal poverty level and from ages 6-14 with family income under 100 percent of poverty. At state option, this category can also include children at higher income levels and older children.
19 42 USC 1320b-7
20 §1912 of the Social Security Act; 42 CFR 435.610
21 §1903(u) of the Social Security Act.
22 The Department of Justice has issued interim guidance on verification of citizenship and qualified alien status for federal public benefit programs like CHIP. 62 Federal Register 61344-61416, November 17, 1997.
23 Families USA, What Is Crowd Out and Why Should Children's Health Advocates Care? (Washington, DC: Families USA, December 1997).
24 Entrants after that date are subject to a five-year bar except for refugees and certain other groups. 8 USC 1601 et seq.
25 For more information on the public charge issue, contact the National Health Law Program at 202-289-7661 and the National Immigration Law Center at 202-216-0261.
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