

**STATE EXPERIENCES WITH
ACCESS ISSUES UNDER
CHILDREN'S HEALTH INSURANCE
EXPANSIONS**

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EXECUTIVE SUMMARY

This paper explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services. Based on literature reviews, interviews with nationally recognized experts, and case studies of six states, the study was intended to inform national policy discussion about these publicly financed expansions and to provide early feedback for states as they implement insurance programs for low-income families and individuals.

The study states—California, Colorado, Florida, Massachusetts, New York, and Washington—were selected because they represent a cross-section of public program designs. These include Medicaid expansions, “state only” programs or “stand-alone” CHIP (State Child Health Insurance Program) programs, and combinations of CHIP programs and Medicaid expansions. In each state, interviewers spoke with state legislators, program administrators, advocacy and community group leaders, researchers, physicians, and representatives of health plans and local government agencies.

FINDINGS AND IMPLICATIONS

Federal enactment of Title XXI has sparked widespread enthusiasm among states for expanding coverage to children. States’ efforts to implement their CHIP programs have been generally well received thus far by beneficiaries, state legislatures, and communities. In most states, however, enrollment rates have fallen short of expectations. The national goal—providing coverage for the nearly 5 million uninsured children who are likely eligible under CHIP or Medicaid expansions—remains elusive.

The slow start-up is due to a number of interlinking factors: administratively complex programs and eligibility structures; cost-sharing provisions that may discourage enrollment or provide incentives to leave programs; outreach programs that are not adequately designed to reach target populations; insufficient efforts to ensure that children maintain coverage once enrolled in CHIP or Medicaid; and poor coordination among CHIP, Medicaid, and Temporary Assistance for Needy Families (TANF) programs.

Some state program designs have contributed to administrative complexity and to families’ confusion in attempting to enroll in public expansion programs:

- Many states chose to build new stand-alone CHIP programs with an administration and infrastructure separate from Medicaid and other state insurance programs.

- Administrators developed new eligibility, enrollment, and cost-sharing policies for CHIP that differ from those used for Medicaid and other state insurance programs.
- Stand-alone CHIP programs often contract with a different mix of health plans and physician networks—and also cover different benefits. As a result, there is one set of provider network and health plan choices for CHIP enrollees, and another set for Medicaid enrollees.
- Because policymakers assigned responsibility for children’s coverage to multiple agencies, no single agency is accountable for enrollment levels or for the interface between CHIP and Medicaid.
- CHIP enrollment outreach approaches are not adequately coordinated with related programs. Many parents are confused by new program names and unsure of their child’s eligibility.

Some of these design complications grew out of the way states chose to address complex program goals. Some states wanted to create public insurance expansions that looked more like private insurance, reasoning that such structures would serve as a basis for future expansions aimed at coordinating public insurance systems with employer-provided insurance. They also wanted CHIP to be perceived as distinct from welfare programs—particularly Medicaid, which in many states has a reputation for being ineffective and unresponsive to the public. Program designers felt that low-income working families would be more receptive to an insurance plan that did not carry the stigma of welfare. Finally, states had to balance state-specific political, philosophical, and cultural objectives with the sometimes conflicting requirements of federal CHIP legislation.

Another key factor contributing to lower-than-expected enrollment was that many states did not fully appreciate the constraints that low-income families face in obtaining and maintaining health insurance. These families are often unfamiliar with or reluctant to apply for public programs and thus have difficulty learning about new services. Many do not fully grasp the concept of prepayment for health services for which they do not have an immediate need. Others find it difficult to meet cost-sharing provisions; such families may voluntarily drop coverage when there is not an immediate health need, or they may lose coverage because of nonpayment of premiums or failure to complete recertification forms. These reactions frustrate efforts to cover more children and to sustain coverage.

Failure to maintain health coverage for children once they are enrolled in a program has also been a problem. Increases in CHIP coverage can be easily overshadowed by decreases in Medicaid enrollment (see Table 1, p. 10). In many states, the loss of automatic Medicaid enrollment through welfare programs has caused a sharp decline in Medicaid applications and enrollment. Although Health Care Financing Administration rules require states to provide TANF recipients with Medicaid applications, most states do not ensure that all families keep their Medicaid card when TANF benefits end. States also have not made a regular practice of informing parents of the new higher income levels for CHIP eligibility or alerting applicants who are not eligible for other assistance that they (or their children) may be eligible for Medicaid only. One study by Families USA estimates that in 1997, 420,000 children lost Medicaid coverage and became uninsured as a result of welfare reform. In the case study states, Medicaid enrollment for children has generally been declining.

Based on the experiences of the six study states, we can draw a number of conclusions about the effects of state program design choices on beneficiaries and program administration:

- While creating new stand-alone insurance programs may reduce or eliminate the welfare stigma, doing so makes coordination with existing Medicaid programs difficult. Separate programs create confusion for applicants and beneficiaries, who have trouble navigating the two systems.
- By maintaining separate programs, states run the risk of losing children and families in the transition from one eligibility category to another. Explicit efforts to coordinate applications and assist families in navigating the two systems are essential to maintaining coverage and conducting outreach initiatives.
- States that have complex systems of administration and that delegate authority to numerous agencies seem to face significant challenges in ensuring communication and coordination among program components. These difficulties produce delays in processing applications and determining eligibility, and prevent efficient problem-solving.
- Complex enrollment procedures have a negative impact on program enrollment and enrollees' participation in the program.
- While the cost of program administration was not specifically analyzed in this study, separate administration and operation of CHIP programs and Medicaid can be costly. Most of the study states voiced concerns about being able to stay within the federally mandated 10 percent cap on administrative costs.

- Uncoordinated outreach and enrollment approaches can create confusion among families and uncertainty about eligibility. Designing effective strategies to engage new populations who are unfamiliar with insurance or public programs has been particularly difficult.

The state case studies suggest several conclusions about the ability of outreach efforts to succeed in increasing enrollment. Respondents indicated that these efforts must be locally focused. While working with the media should be part of an overall outreach plan, more personal efforts tailored to individual population subgroups are needed to reach those who have had little contact with public programs. The linguistic and cultural needs of immigrant groups should also be addressed. Finally, outreach campaigns must tackle the root of the problem by educating low-income families and individuals about the value of health insurance and appropriate use of the health care system.

Overall, study findings point to the importance of simplifying both state Medicaid and CHIP programs and emphasizing local outreach approaches. State experience further demonstrates a need for better program coordination and integration, both to achieve optimal efficiency and to sustain families' health coverage when they move from one program to another as income or other eligibility criteria changes. As policymakers consider improvements to CHIP or plan for additional incremental expansions of insurance for low-income families, building links across the range of public programs—and establishing links with private coverage—will become increasingly important.

STATE EXPERIENCES WITH ACCESS ISSUES UNDER CHILDREN'S HEALTH INSURANCE EXPANSIONS

I. INTRODUCTION

Purpose of This Paper

This report explores six states' experiences with eligibility, outreach, and enrollment as they developed their State Child Health Insurance Program (CHIP). CHIP, which focuses on children and a few families, is a national step in incremental health insurance expansions for uninsured people. Successful implementation hinges on policies and procedures that minimize barriers to health insurance coverage for targeted populations. In developing CHIP programs, the six study states made design choices about eligibility, outreach, and enrollment to meet a variety of sometimes conflicting policy objectives. Their choices, in the short term, had positive and negative effects on access to health insurance coverage. Timely, policy-relevant information derived from these states will inform local and national discussions about health insurance policy. Lessons learned from CHIP design and implementation should be applicable to other incremental insurance expansions for poor and near-poor working families as states seek opportunities to close insurance coverage gaps for low-income families and individuals.

Overview of Title XXI

Congress passed CHIP in July 1997 as part of the Balanced Budget Act of 1997. Enacted as Title XXI of the Social Security Act, CHIP appropriates \$24 billion over a five-year period to help states establish or expand health insurance programs for uninsured, low-income children of families with incomes that exceed each state's existing Medicaid eligibility limits. Though plans vary from state to state, the insurance expansion is generally targeted at children living in families with incomes from 150 to 200 percent of the federal poverty level (FPL).

Although the legislation provides general guidelines regarding program structure, CHIP gives participating states significant flexibility in the design and implementation of their insurance expansion programs. States may use their federal allotments to expand Medicaid, to develop a new health insurance program for children or expand an existing one, or to develop a combination of these approaches. CHIP monies are primarily allocated for the expansion of health coverage to uninsured children. The program does allow states to extend coverage to parents as well, as long as they meet certain guidelines and the state obtains a waiver from the Health Care Financing Administration.

Study Methodology

The Lewin Group prepared this paper, and a companion paper on cost-sharing policies under CHIP, with funding from The Commonwealth Fund, a New York City-based private foundation

that supports independent research on health and social issues. The study was accomplished via a multiphase process.

The first phase involved conducting literature reviews of academic studies, papers, and state CHIP plans. The second phase consisted of a series of interviews with nationally recognized experts to gain their views on the current issues facing states as they design CHIP programs, with a focus on access to health insurance coverage and cost-sharing. Next, six states—California, Colorado, Florida, Massachusetts, New York, and Washington—were selected for intensive case studies. Goals for the case studies were to:

- learn from the experience of states that had implemented significant insurance expansions for children and adults, particularly through state-designed programs predating CHIP;
- select a set of states that were geographically representative and included a mix of large urban and rural populations with significant immigrant and minority communities;
- study some states that selected Medicaid expansion as their CHIP approach and some states that chose to build stand-alone CHIP programs.

Washington State did not elect to implement a CHIP program but was included in the study for several reasons. The state had considerable experience with insurance expansion initiatives, experience and data related to enrollee cost-sharing, and experience with a program covering adults, families, and children. We also wanted to explore the reasons behind Washington's decision not to apply for CHIP funds.

The Lewin Group conducted site visits to the six target states, completing an average of 20 interviews at each site from August 1998 to January 1999. Study respondents included state legislators, program administrators, advocacy and community groups, policy analysts and researchers, health plan representatives, physicians and other health care providers, and representatives of local government agencies. Respondents discussed CHIP implementation, design of enrollment, outreach, eligibility criteria and cost-sharing processes, barriers to enrollment and to health care services, the impact of cost-sharing provisions, and recommendations for improving program implementation and increasing access to coverage and services for CHIP programs.

We then combined information from these interviews with data and documents relevant to the six study states to answer the following research questions:

- How do varying outreach efforts affect enrollment? Which state approaches have been more or less successful?
- What are the relative merits of outreach tactics—for example, media campaigns, outreach workers, and toll-free hotlines—compared with eligibility and enrollment policies aimed at easing entry into programs and making it easier to continue coverage?
- Are states implementing promising new outreach strategies, such as those in community settings and schools, and to what extent do they help reach more potentially eligible groups?
- To what extent do federal and state rules and procedures hinder effective outreach and enrollment?

The information in this report is current as of the time we conducted the interviews.

Overview of Access to Health Insurance Coverage and Health Care Services

Children’s utilization of health care services depends directly on their families’ ability to obtain health insurance, to understand the health care delivery system, and to gain access to services. According to census data, 10.7 million children lack health insurance; of these, approximately 4.7 million are eligible for Medicaid but are not enrolled.^{1, 2} Nearly 70 percent of uninsured children are from families with incomes of less than 200 percent of FPL.³ Evidence suggests that increasing children’s health insurance coverage also increases their use of health care services. After one year of enrollment in BlueCHIP, an insurance program for low-income families in western Pennsylvania, 99 percent of children had a regular source of medical care, and the proportion of families reporting unmet needs for children or delayed care in the past six months decreased from 57 percent to 16 percent.⁴

Families with low incomes face a variety of barriers to obtaining health insurance coverage for their children. These include:

¹ Current Population Survey, 1996.

² Center on Budget and Policy Priorities, *Steps States Can Take to Facilitate Medicaid Enrollment of Children*, Washington, DC, July 23, 1998.

³ Carpenter, M. B. Kavanagh, L. D., *Outreach to Children: Moving from Enrollment to Ensuring Access*. Arlington, VA: National Center for Education in Maternal and Child Health, 1998.

⁴ Lave, J. R., et al. “Impact of a Children’s Health Insurance Program on Newly Enrolled Children,” *Journal of the American Medical Association* 279 (June 1998):1820–1825.

- affordability of health insurance;
- ineligibility for public insurance programs;
- confusing and complex eligibility rules and application and verification procedures for public programs;
- “welfare” stigma often associated with public programs;
- complex organizational and administrative structures;
- lack of culturally appropriate programs and availability of translation services for non-English speaking families; and
- for immigrants, distrust of the health care system and fear of getting in trouble with immigration authorities.

This study explores state experience with addressing these barriers and suggests steps to apply lessons learned.

II. STATE CHOICES FOR CHIP PROGRAM DESIGN AND STRUCTURE

This chapter provides an overview of design options for state CHIP programs, describes the structure of CHIP programs in our six study states, and discusses some of the program's administrative challenges.

Program Design Alternatives

Title XXI of the Balanced Budget Act (CHIP) provides states with financial incentives to expand coverage for children who would not otherwise be eligible for Medicaid by providing states with an enhanced federal match of funds (5 percent more than the match for Medicaid) and by offering states a range of design alternatives. Under Title XXI, states may choose to use federal matching funds to create or expand a state-designed or "stand-alone" program, to expand Medicaid programs, or to do a combination of both.

Stand-Alone Programs

As of April 1999, 14 states had submitted plans to develop or expand a state-designed program. Stand-alone programs offer states increased control over program design, including decisions concerning benefit packages, cost-sharing mechanisms, and methods of service delivery. Of equal significance, states that choose this option are explicitly permitted to institute enrollment limitations. This flexibility allows states to maintain control over program growth and is especially appealing to state governments that are concerned about the adequacy of future funding streams for CHIP programs.

Stand-alone programs also allow states to implement program designs that more closely resemble employer-based coverage. This option is attractive to states that envision CHIP as an opportunity to shift low-income people from public health insurance to employer-sponsored coverage. For these states, stand-alone programs present a means by which low-income populations can be introduced to the mechanisms of private health insurance.

Under federal rules, children covered under such stand-alone CHIP programs should be ineligible for Medicaid. However, the higher federal match for children in the new expansion programs, the structural appeal of the new stand-alone programs, and state enthusiasm for enrolling uninsured children in new programs all create incentives to emphasize free-standing children's programs where these exist.

Medicaid Expansion

As of April 1999, 24 states had elected to use their Title XXI funds to pursue a Medicaid expansion. Because less administrative infrastructure needs to be established, these states avoid the substantial expenses they would have incurred in the development of a separate program. Moreover, states that choose to expand their Medicaid programs are not subject to caps on administrative expenditures. As a result, these states have more money readily available for

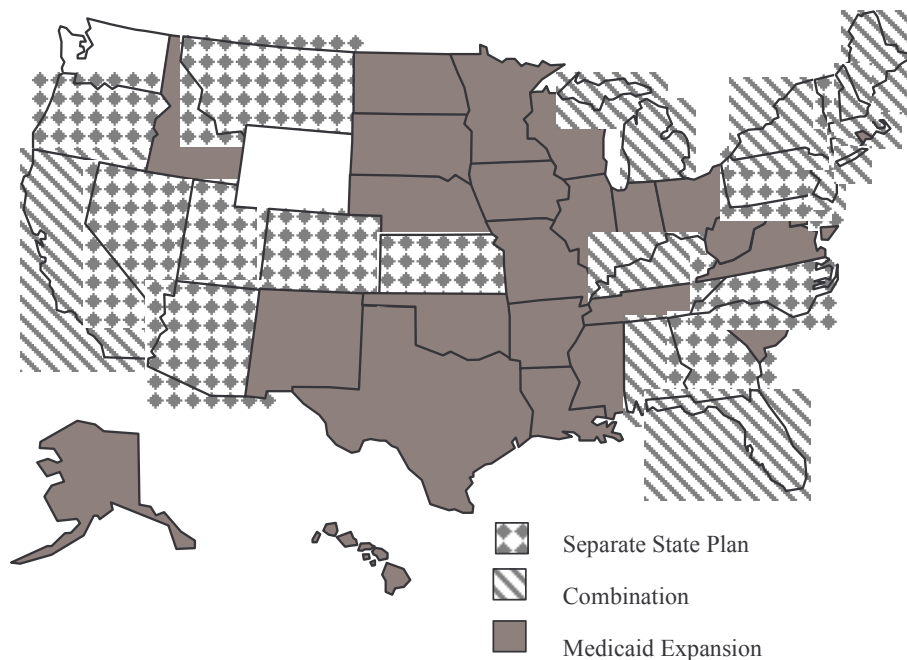
outreach and other enrollment services than do states that elected to set up stand-alone programs. Finally, because the administrative structure is already in place, states that choose to pursue Medicaid expansions are more likely to be able to start their programs quickly.

Child advocates are particularly supportive of Medicaid expansions. Most Medicaid programs offer more generous benefit packages than state stand-alone programs. Typical benefits covered by Medicaid programs that may not be covered by state CHIP stand-alone programs include dental services, mental health services, vision exams and eyeglasses, prescription medicines, and Early Periodic Screening, Diagnostic and Treatment (EPSDT) services. Medicaid expansions also avoid the perception of a two-tiered state-sponsored system of health insurance in which the poorest children receive Medicaid coverage while a new program covers slightly more affluent children. Finally, Medicaid expansions eliminate the need to coordinate enrollment and care among two separate programs. Many states submitted preliminary CHIP plans outlining a Medicaid expansion but hope to establish a separate state program eventually.

Combination

Eleven states decided to expand their Medicaid programs and develop or expand separate stand-alone programs. By incorporating both approaches, these states have the potential to capture the best of both worlds—but they also risk additional administrative burdens and overhead costs.

Figure 1. CHIP Program Options Selected by States



Source: Health Care Financing Administration. Updated February 16, 1999.

Program Structures Selected by Study States

California

California expanded its Medicaid program and designed a stand-alone program. Medi-Cal, the state's Medicaid program, was expanded to cover children ages 14 through 18 from families with incomes up to 100 percent of FPL. Healthy Families, the separate state program, covers children ages 1 through 18 from families with incomes from 100 to 200 percent of FPL. Although Medi-Cal and Healthy Families are administered through separate agencies—the Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) respectively—DHS coordinates outreach efforts for both programs.

Many California child advocates wanted the state to pursue a Medicaid expansion only. They believed this option was advantageous for both the state and enrollees because it would have used Medi-Cal's existing administrative structure and would not have imposed the burden of cost-sharing on beneficiaries. It appears, however, that enrollee response to the new program has been positive thus far. Study respondents said that potential enrollees seem to prefer Healthy Families to Medi-Cal and some misrepresent their incomes in order to qualify for the former, despite the program's cost-sharing requirements. Nevertheless, some respondents felt that multiple programs create a complex system for families to navigate. Having separate agencies to administer the two programs creates some administrative duplication and confusion for families. Coordination among the programs has been a challenge.

Colorado

Colorado implemented a separate state program called Child Health Plan Plus (CHP+). The state is building on the experience and infrastructure of the Colorado Child Health Plan, a program developed in 1992 to cover outpatient health care services to low-income children.

Personal responsibility is a widely accepted credo in Colorado. The state, which embraces the philosophy that people should “pull themselves up by their own bootstraps,” opposed the option to expand Medicaid, an entitlement program. Instead, the legislature expanded the Colorado Child Health Plan, which required beneficiaries to contribute to the cost of care. The intent was to increase health insurance access for low-income families while simultaneously promoting family accountability. Many study respondents believed that the program's cost-sharing requirements prepare enrollees for transition to the private insurance market, impart value to the product, and promotes appropriate member health-seeking behavior.

Florida

Florida's preexisting children's health insurance program, Healthy Kids, was one of three state programs grandfathered into the Title XXI legislation. Florida used its federal funds to expand

Medicaid and to build upon the existing stand-alone program, Healthy Kids, to create Florida's KidCare, a program with four distinct components:

- Healthy Kids;
- MediKids, a Medicaid look-alike;
- the Medicaid expansion; and
- the Children's Medical Services Network (CMS).

Currently, five agencies share management responsibility for the program, which has caused some confusion at the administrative level and has led to slow application processing. Florida's KidCare program was designed with specific populations in mind. MediKids, which covers children ages 1 through 5 from families with incomes up to 200 percent of FPL, was developed to address the needs of very young children. CMS uses a direct contracting network to serve children with special health care needs. Healthy Kids covers children ages 5 to 19 from families with incomes up to 200 percent of FPL, includes coverage for undocumented children, and allows families with incomes above 200 percent of FPL to buy into the program.

Massachusetts

Massachusetts' insurance expansion initiatives are complex and, in some instances, cover parents as well as children. The state's CHIP program involved three separate initiatives. First, the state raised the MassHealth Standard eligibility ceiling from 133 percent to 150 percent of FPL for children under age 19. Second, the MassHealth CommonHealth program was expanded to cover disabled children under age 19 from families with incomes from 150 to 200 percent of FPL. Third, the state created a new MassHealth Family Assistance program for children under 19 (and, in some cases, entire families) with gross family incomes from 150 to 200 percent of FPL. This program pays for children's enrollment in qualified employer-sponsored health plans or directly in state coverage, depending on the family's access to employer-sponsored insurance. Parents may gain access to health insurance as a spillover effect, given that children's coverage is not distinguishable from family coverage under employer-sponsored insurance.

The state implemented its Title XXI program very rapidly because much of the legislative and administrative infrastructure was already in place. The MassHealth expansions built upon a preexisting foundation of incrementally implemented safety net programs.

Moreover, the bulk of political wrangling over issues concerning children's health insurance took place before Title XXI was enacted.

New York

New York expanded an existing state-designed program. The state has a history of leadership in child health insurance expansion efforts. New York's Child Health Plus (CHPlus) program, the largest state-subsidized health insurance program in the nation, was one of three programs grandfathered into the Title XXI legislation. It was implemented in 1990 to provide health insurance coverage of primary and preventive outpatient services for children under age 13 who were not eligible for Medicaid. Over the years, the program expanded its coverage to include inpatient services and treatment for substance abuse and mental illness, as well as short-term outpatient therapeutic services. CHPlus now offers a more comprehensive benefit package than Medicaid.

CHPlus is popular among beneficiaries. Numerous respondents reported that potential enrollees consistently expressed a preference for the program over Medicaid, despite the cost-sharing requirements under CHPlus. These respondents believed that enrollees had more confidence in the quality of health care services when they contributed to the cost of their own care.

Washington

Washington State has long been considered a national leader in health insurance expansion efforts. In fact, of the six study states, Washington has made the most progress in attempts to provide health insurance coverage to adults as well as children. In 1987, the state created the Basic Health Plan (BHP), which is a partnership with the private sector to provide access to health insurance for the working poor. The BHP subsidizes individuals, families, and employers in the purchase of managed care plan coverage on a sliding-fee scale. People with incomes greater than or equal to 200 percent of FPL are not eligible for state subsidies, but may buy into the program at full premium rates. Children from families with incomes of less than 200 percent of FPL are eligible for the state's Medicaid program, Healthy Options. However, in an attempt to place all family members with the same insurance carrier, children who are eligible for Healthy Options may be enrolled in the Basic Health Plan Plus (BHP+) instead. Children who are signed up for BHP+ are enrolled in the same plan that their parents are in under BHP—but they receive the full range of benefits and services offered under Healthy Options.

Washington elected not to apply for Title XXI funds. Having already raised Medicaid eligibility levels to 200 percent of the federal poverty level in 1996 for children up to age 19, the

state’s conservative legislature did not want to expand eligibility to 250 percent, as would have been required if the state had applied for the federal funding. Furthermore, only 10,000 more children would have been eligible for coverage under such an expansion, which is lower than the number of uninsured children already eligible but not enrolled in existing state programs. Many believed that it would be wiser to focus state efforts and resources on enrolling the latter group.

Table 1 shows comparative information about Medicaid and CHIP enrollment in the six study sites.

Table 1. Medicaid Eligibles and CHIP Enrollment⁵

	California	Colorado	Florida	Massachusetts	New York	Washington
TOTAL MEDICAID	6,386,720	351,961	2,086,479	810,075	3,229,052	907,542
Children	3,206,566	161,402	1,064,892	352,124	1,556,791	504,161
Adults	1,612,642	72,674	403,565	176,790	594,480	203,503
Aged, blind, and disabled	1,440,935	103,865	597,999	280,971	992,205	181,522
Other or unknown	126,577	14,020	20,023	190	85,576	18,356
Medicaid and cash or other assistance	3,525,086	178,994	1,140,754	445,599	1,966,569	425,345
Children	1,670,246	71,412	508,263	183,235	881,984	197,102
Adults	744,915	35,098	221,464	81,743	396,470	115,553
Aged, blind, and disabled	1,109,925	72,484	411,027	180,621	688,115	112,690
Medicaid only	2,861,634	172,967	945,725	364,476	1,262,483	482,197
Total CHIP (or other programs)						
Adults	—	—	—	489,197	—	127,841
Children	222,351	24,116	154,594	392,895	425,522	80,664

Sources: Medicaid enrollment from Health Care Financing Administration, *HCFA-2082 Report, Fiscal Year 1997*; California, Colorado, and Florida as of 9/99 from HCFA, *The State Children’s Health Insurance Program Annual Enrollment Report, October 1, 1998–September 30, 1999*; New York Department of Health 12/99, www.health.state.ny.us; MassHealth <http://www.state.ma.us/dma/masshealthinfo>; and Washington State Health Care Authority 12/99 www.wa.gov/hca/basic.htm.

As illustrated in Table 1, Medicaid is a critical source of coverage for children in each state. Even a relatively small percentage decline in Medicaid enrollment can overshadow gains in CHIP or state-only children’s expansions.

⁵ “Medicaid eligibles” refers to the number who have actually enrolled in Medicaid not to those who are potentially eligible by income level. “CHIP enrollment” refers to the number of individuals enrolled in a state’s CHIP program or, in the case of Massachusetts and Washington, comparable programs.

Administrative Challenges Related to Each CHIP Program Design Option

The way CHIP programs are structured at the state and local level creates a variety of implementation and administration challenges. Program design decisions affect the complexity of the programs, the infrastructure needed to carry out administrative functions, and the perception of the program by communities, members, and providers. Administrative and management concerns raised by respondents in the six study states include:

Establishing stand-alone initiatives alongside Medicaid increases the complexity of the program for members and managers.

When states choose the separate or stand-alone option for CHIP, they find it difficult to coordinate their CHIP and Medicaid programs. Different program characteristics and procedures cause confusion for participating agencies, members, and providers. Some of the administrative challenges include:

- multiple outreach efforts and program titles;
- duplicative or different application processes; and
- transfer procedures when members no longer qualify for a program and move into a different one because of age or changing income levels.

New York, for example, is experiencing significant difficulties with transferring Medicaid-eligible children enrolled in CHPlus into Medicaid. The state comptroller cited poor coordination between the two programs as the primary cause of the problem.⁶ States have instituted a number of strategies to simplify the application process, piggyback outreach between two programs, and coordinate administration. These are discussed later in this paper.

Recognizing the challenges that enrollees face, states are trying to streamline their programs to facilitate ease of enrollment and use of services. One such approach is to design programs that keep families together in the same plan. California's Healthy Families is taking initial steps to simplify access for families by requiring that all children in the same family be

⁶ In June 1999, New York provided an update on the implementation of its facilitated enrollment model, which it says will ease the transitioning of Medicaid eligible children currently enrolled in Child Health Plus. A request for proposals was issued in March 1999 for facilitated enrollment. Because of the new model, New York now considers its insurance expansion program to be a combination plan, as opposed to a separate state plan.

enrolled in the same plan. The hope is that having one “medical home” for all the children in a family will ease confusion and minimize access challenges for their parents.

Providing one program umbrella is one of the primary goals of Washington’s Basic Health Plan. In Washington, parents and children can apply together for coverage under the Basic Health Plan. The state requires parents to select the same plan for themselves as they do for their children. Moreover, Medicaid-eligible children can remain under the BHP umbrella with their parents by enrolling in BHP+. This unique program provides the children with Medicaid benefits financed with Medicaid funds but managed by the BHP program.

Although delegating administrative authority for CHIP programs across several agencies may help states use the expertise of existing agencies, it increases management complexity.

States have drawn on the expertise of different agencies to take on specific functions for CHIP programs. California, for instance, has delegated responsibility for outreach to DHS, although MRMIB is running the Healthy Families program. Splitting authority among multiple agencies can be tricky, however. Although programs can benefit from the experience of multiple agencies, they can also be hampered by internal conflicts, complexity of coordination, and turf battles. In Florida, a number of issues were raised concerning the division of program responsibilities across five separate entities.

Table 2: Agencies Responsible for Florida KidCare Program

Agency for Health Care Administration	Department of Children and Families	Department of Health	Department of Insurance	Florida Healthy Kids Corporation
Serves as state contact with HCFA, distributes federal funds, calculates program enrollment ceilings, manages FHKC contracts.	Establishes and maintains eligibility determination process directly or by contract (except FHKC).	Conducts KidCare outreach, chairs Florida KidCare Council.	Certifies that health plans meet, exceed, or are actuarially equivalent to FHKC benefits.	Under contract with AHCA, conducts eligibility determination for Kidcare (except Medicaid).
Administers Medicaid, MediKids, and employer-sponsored-dependent coverage (pending HCFA approval).	Continues to perform Medicaid (Title XIX) eligibility determinations.	Administers CMS Network.		Administers Florida Healthy Kids program.

Many informants in the state expressed their frustration that because so many agencies are responsible for pieces of the program, not one is specifically held accountable for its success. Because these agencies have not worked together in this capacity in the past, coordination takes some time to accomplish. It is taking far longer than projected for enrollment forms to get through all the agencies required to determine eligibility for all children in a family. (These issues are discussed in greater depth in the section “Getting Children Covered by CHIP Programs.”) Slow enrollment processes may cause applicants to become frustrated with the program and lose interest in enrolling.

States are concerned about the federal 10 percent cap on administrative expenses and are trying to reduce program expenses by dovetailing administrative systems needed for Medicaid and stand-alone programs.

CHIP regulations restrict states from spending more than 10 percent of federal funds on administrative functions, including outreach and enrollment efforts. Many states consider this cap to be too restrictive, particularly for stand-alone program start-up expenses. The costs of developing a new administrative infrastructure are substantial. Necessary expenses range from staff salaries to the establishment of program billing and data collecting mechanisms. In addition, states also must use this allocation to pay for marketing, education, outreach, enrollment activities, and procurement. CHIP programs require outreach campaigns that are substantially different from earlier outreach efforts. The characteristics of the CHIP target population, the diversity of potential enrollees, and the desire to make the program look more like private insurance require new and varied outreach methods. These must be intense if they are to reach enrollment targets. Up-front costs are less likely to be distributed across other programs (e.g., welfare programs), which has been a historical advantage for traditional Medicaid program outreach.

Even states that built on preexisting separate programs express concern about the 10 percent cap. Respondents in Colorado, for example, suspected that the state had already exceeded the 10 percent allotment. In New York, respondents reported that the limited availability of administrative funds has constrained critical outreach campaigns. It is not yet clear whether the 10 percent administrative cap will remain a problem once programs are more mature and stable. Administrative costs in large group plans in the private sector and Medicaid typically average around 8 percent and 5 percent, respectively.

As states develop Title XXI administrative capacity and devise plan outreach strategies, they may find ways to share costs across other programs including Medicaid and family support

programs such as Women, Infants and Children (WIC) and food stamps. In Colorado, Medicaid and the state's CHP+ program are using the same billing systems, while Washington fields joint quality "investigative teams." Massachusetts and Washington each linked their contracting processes so that plans only have one contracting process, even if rates and benefits differ. Some states are moving some administrative costs into contracts with managed care plans, thus accounting for the costs on the health care side of the ledger rather than the administrative side. Interestingly, numerous respondents suggested that if the federal government had interpreted the rule to allow the 10 percent cap to be spread over the course of the first five years, most states could be much further along with administrative functions like outreach.

States are recognizing the need to promote both separate stand-alone and Medicaid programs, while addressing the stigma associated with public programs.

Under federal regulations, Medicaid-eligible children must enroll in Medicaid and not in separate state programs. But Medicaid carries a stigma of "welfare" for many families, often making it a less attractive option than new state-designed programs. So while efforts to enroll children in new state insurance programs will also identify children eligible for Medicaid, families may not want to enroll in Medicaid if they perceive it to be of less value. Policymakers are concerned that states will be unable to meet insurance coverage goals for children unless problems with the infrastructure, management, and reputation of Medicaid programs are addressed. Nationwide, approximately 4.7 million uninsured children are eligible for, but not enrolled in, Medicaid.

A number of respondents pointed out that CHIP has drawn attention to methods to improve outreach, eligibility, and enrollment processes. Process improvement efforts focused on stand-alone CHIP programs generate ideas that can be adopted by Medicaid. Perhaps more importantly, CHIP has stimulated new enthusiasm for addressing the Medicaid stigma and bureaucracy. Connecticut, for example, calls its stand-alone and Medicaid programs by the same name in an effort to capitalize on the enhanced reputation of the new program. In a number of states, Medicaid insurance cards have been designed to resemble the cards issued to enrollees of private insurance programs. Massachusetts and Washington have launched a variety of efforts to improve their Medicaid programs over the last decade, resulting in greater beneficiary trust and a lessening of the welfare stigma. Observers believe that such ideas present a potential for positive change in states like California and New York, where Medicaid does not yet appear to have experienced the same degree of redesign and where Medicaid stigma remains a concern.

Some respondents recommend an alternative approach to enrollment that makes the distinctions between Medicaid and CHIP less visible to families when they enroll. Applicants are

allowed to choose where to enroll irrespective of the administrative funding source. From an accounting standpoint, states still need to designate some children as “Medicaid” children and others as “CHIP” children and to guarantee all Medicaid children the full Medicaid benefit package, but that can be handled internally. This approach embraces a consumerist view of public insurance coverage and might spark positive changes in management through friendly competition among the programs. Washington has pursued this model to some extent with the establishment of BHP+. Medicaid-eligible children whose parents are in BHP are enrolled in BHP+, which has an identical benefit structure to Medicaid, and the Medicaid program pays to cover them.

Variation in reimbursement rates across programs can create issues for plans and providers, which states try to address by combining contracting processes for Medicaid and stand-alone programs.

Reimbursement rates offered under Medicaid expansions and stand-alone programs vary within states. Plans and providers are more reluctant to participate in the program with lower rates. To ensure the availability of providers for all programs, some states (e.g., Colorado, Washington, and Massachusetts) require that managed care plans participate in both the Medicaid and stand-alone programs or in Medicaid and the state employee program. Although New York has not gone as far as Washington and Massachusetts, it looks “favorably” upon those plans that apply for both programs. Washington has not enforced its linked contracting rule for fear of spiraling plan withdrawals. In light of recent plan withdrawals from Medicaid, it is likely that other states will follow suit and will not vigorously enforce these rules.

III. GETTING CHILDREN COVERED BY CHIP PROGRAMS

For the purposes of this paper, we define “access” broadly as a process that begins with eligibility, outreach, and enrollment and ends with a covered population using services effectively. Our case study research has identified the initial phase of this process—eligibility, outreach, and enrollment—as the one most states are currently confronting as they establish the basic systems to identify and enroll eligible beneficiaries. This section discusses each aspect of that phase.

Eligibility

Simplification of eligibility standards is sometimes at odds with other coverage goals and is difficult to achieve using an incremental expansion approach.

As a block grant, Title XXI allows states considerable flexibility to tailor program eligibility to state needs. States set eligibility levels based on the state’s philosophic slant, existing Medicaid eligibility, other health insurance programs for children, and the demographics of uninsured groups in the state.

Table 3, below, shows that our study states have used their CHIP programs to (1) even out eligibility across age groups by extending coverage to children caught between the eligibility requirements of Medicaid and state-designed programs, and (2) to make program eligibility more straightforward. California and Massachusetts, for instance, used Title XXI funding to increase coverage for all children under age 18 to 200 percent of FPL.

Having instituted coverage expansions over time in an incremental stair-step fashion, all six study states, except Colorado, now cover children of families with incomes of less than 200 percent of FPL. The states have reached this point by piecing together coverage under multiple programs and over many phases of implementation. This approach, however, has increased the complexity of the programs for families, physicians, and health plans: with each new step, they have to learn about a “new” initiative with its unique benefits and coverage. Even though there has been a leveling of eligibility status by income level, programs still differ in enrollment procedures, benefit packages, provider networks, and administrative processes.

Determining eligibility can still be complicated in cases where all children in a family are not covered by one program. Such families have to follow different enrollment procedures and redetermination schedules for each program child. Once children are enrolled, families must learn about different benefit packages and provider networks for each program. In Florida, for

Figure 2: Eligibility Levels for Florida KidCare

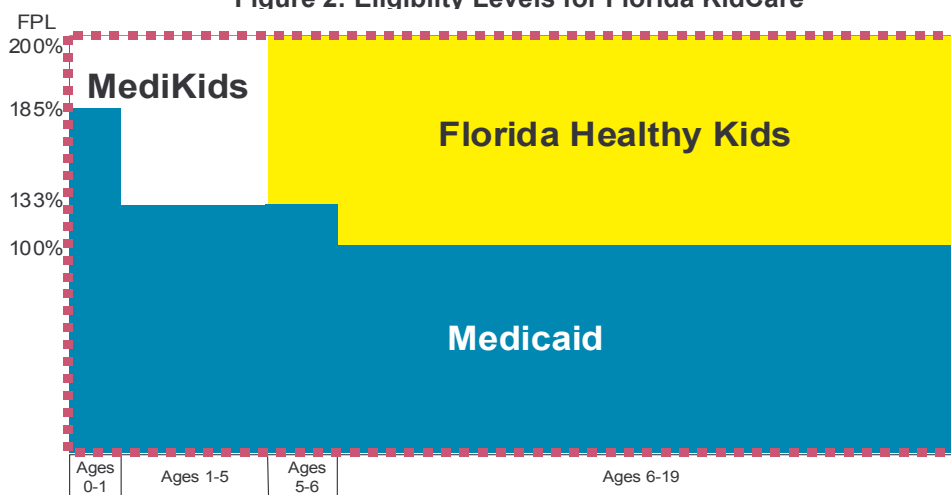


Table 3. Eligibility for Medicaid and CHIP for Six Study Sites by Percentage of the Federal Poverty Level

	California				Colorado				Florida				Massachusetts				New York				Washington*			
	Age Ranges				Age Ranges				Age Ranges				Age Ranges				Age Ranges				Age Ranges			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
200–250%	■																■	■	■	■				
185–200%	■	■	■	■					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
133–185%	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
100–133%	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
To 100%	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Program Key		Age Key	
■	Baseline Medicaid	1	Infant
■	CHIP Medicaid Expansion	2	Young Child
■	CHIP Stand-Alone	3	Older Child
■	Other State Program	4	Adolescent

* Washington also offers coverage to adults with incomes of less than 200 percent of FPL on a sliding-fee scale (see Appendix B). Families with incomes above 200 percent of FPL can buy into BHP at the full premium.

example, children up to age 5 from a family at less than 200 percent of poverty are covered by MediKids, while children ages 5 to 19 in the same family are covered by Healthy Kids. Conceivably, a Florida family with an income from 133 percent to 185 percent of FPL and with three children—an infant, a grade school-age child, and an adolescent—would have to deal with a Medicaid-only program, a state-funded program, and a CHIP stand-alone program. In addition, program eligibility for different children in the family may change as family income changes, causing confusion and disruption for the family.

Paradoxically, the desire to cover more children is a potent driver of complexity in eligibility standards and program design. Some states want to provide rich benefit packages for children in certain age groups and income brackets or to ensure an entitlement through Medicaid to some, but not all, children. These goals lead to the development of two or more separate programs, each with their own eligibility standards, policies, and procedures.

Determining eligibility levels for CHIP programs can be a divisive process for state policymakers.

Debates about eligibility often center on whether programs should be a part of a larger scheme to provide health insurance for all families who cannot afford it, or should serve only to provide a safety net for families during difficult times. These philosophic policy differences are apparent in the establishment of strikingly different eligibility standards from state to state. Minnesota, for example, provides coverage to children up to age 18 from families with incomes up to 275 percent of the federal poverty level, whereas Mississippi provides coverage for children ages 6 through 14 from families with incomes up to 100 percent of FPL.

The experiences of our six study states demonstrate the importance of state and local politics in the determination of eligibility levels and program design for CHIP programs. Florida's experience, in particular, highlights the importance of state and local politics in the design process. It also demonstrates how the natural and well-intentioned "give and take" of politics and advocacy can result in the development of a program that is complicated and hard for enrollees to understand.

Florida's state-designed program, Florida Healthy Kids, was grandfathered into Title XXI. The Governor had pushed for a Medicaid expansion for CHIP, while the legislature favored a private stand-alone program. Advocates, meanwhile, had concerns about coverage for children with disabilities and very young children. A series of compromises created the system that is now in place, which includes a Medicaid expansion, a state-designed program, a Medicaid look-

alike program for young children, and a carve-out for children with special health care needs. Consequently, the complexity of eligibility criteria for the many programs is matched by an equally complicated division of responsibility among agencies for program management.

Experiences in Massachusetts and Washington illustrate the varying influences of public will and politics on public insurance programs. Both Massachusetts and Washington have, over time, demonstrated a strong commitment to insurance expansions for children. However, the way in which the two states approached the new CHIP opportunity differed greatly. Massachusetts had a previously designed framework for public insurance expansions. This framework, which built upon employer-based coverage, was widely debated and accepted before the enactment of Title XXI. In fact, the concept had been submitted to the Health Care Financing Administration as part of the state's Section 1115 Medicaid waiver application. In addition, Massachusetts was philosophically committed to providing either public or private coverage to all children. Throughout our interviews, providers, plans, advocates, and purchasers repeated the statement that "there is insurance for every child" in the commonwealth.

Given Massachusetts's public support for children's coverage and broad-based, bipartisan agreement on the goals and principles of insurance expansion efforts, there was very little debate about how to use the Title XXI funds. Massachusetts quickly pursued the federal resources because the funds provided additional financing to implement the previously conceived plans. Title XXI dollars were used to bring coverage for all children up to the 200 percent FPL income limit.

The Massachusetts plan works on paper, insofar as all children of families with incomes under 200 percent of FPL can be covered by some sort of insurance. In reality, however, a family with children of varying ages is divided into "slices" and must contend with three different programs. Washington's plan is simpler. One program covers all children of families with incomes up to 200 percent of FPL. The complexity of the Washington program results from efforts to integrate adult and child coverage for families. This type of complexity will become more of an issue in the future as states begin to move toward family coverage.

Washington's political experience provides an interesting counterpoint to that of Massachusetts. Despite widespread support in Washington for universal insurance coverage for children—echoing the "every child can be covered" theme commonly heard in Massachusetts—there was no consensus on what role the state should play in achieving expanded coverage goals through a new CHIP program. Washington had raised extended Medicaid eligibility to 200 percent of FPL for children up to age 19 in 1996. When CHIP was enacted, political backing was inadequate to expand children's coverage to 250 percent of FPL. Many state legislators felt that

families with annual incomes from 200 to 250 percent of FPL fall into the middle-income group and thus should not be eligible for government-sponsored coverage. In addition, the state felt it was being penalized for having already expanded coverage to 200 percent of FPL.

Recent changes in the political makeup of Washington state government have led to questions about the role of government in health care reform. With less support for activist policy, the state has dismantled much of the comprehensive health care reform plan passed in 1993. At the same time, the state experienced a budget crunch and difficulty balancing the public account that covers both the state Medicaid program and the Basic Health Plan. The state passed Initiative 601 in 1994, which limited the growth rate of the state budget to the rate of population growth and inflation combined—effectively capping state spending for Medicaid and the Basic Health Plan. Legislators were concerned that eligibility expansions under CHIP would exacerbate budget problems.

Washington’s experience raises the question of whether there is a natural stopping point for these programs. Alternatively, does the expansion of programs that extend coverage into middle-income ranges require the creation of a new structure that might depart from historic program design?

Differences in income-determination rules among programs are particularly confusing for enrollees and also cause problems for administrators and eligibility workers.

States have the option of defining family income as gross income, net income, or as the value of assets. Many states have different income standards for Medicaid and state-designed programs. These differences are confusing to enrollees and hamper the development of linked enrollment processes. States with separate programs appear to use more lenient income standards for the Medicaid program than for the state-designed program, creating an “overlap” population that appears eligible for both programs. The differences in income determination methods caused consternation in California, where Medicaid uses net income to determine eligibility and the separate Healthy Families Program uses gross income. Advocates felt that the gross income test was applied in a way that reduced the number of people potentially eligible for the new Healthy Families Program. In response to these concerns, California is now planning on adopting net income standards for both programs.

Outreach

Eligibility alone does not ensure that individuals and families will enroll in public health insurance programs. Approximately 32 percent of the children eligible for Medicaid are not

enrolled in the program.⁷ By many accounts, the de-linking of cash assistance (i.e., welfare programs) and Medicaid has increased the percentage of eligible children who are not enrolled in the program. In fact, evidence shows that families of children with access to expanded Medicaid eligibility often do not enroll unless they are also applying for cash assistance.⁸

States have developed a variety of innovative outreach strategies in response to this challenge. Outreach strategies are designed to advertise and promote publicly funded insurance programs, to identify individuals and families that may be eligible, and to encourage them to apply for coverage.

Some states did not focus on outreach initially. In some cases, program managers were busy establishing the fundamentals of the programs—contracts with plans, monitoring mechanisms, and enrollment processes. In other instances, states seemed concerned that aggressive outreach would result in growth too rapid for the capacity of their programs. However, as programs have matured, states have become concerned about low enrollment levels. Only \$260 million of Congress's \$4.2 billion CHIP allocation was used in 1998, an indication that CHIP enrollment may currently fall far short of Congress's original coverage goals.⁹ This concern has led to a new focus on outreach, and a new interest in what is working and what is not in different environments.

Community-based outreach is considered most critical, but there is no single strategy that works for every community. Each must design a strategy that addresses its particular needs.

Forty-eight states are using community-based organizations to assist with outreach efforts.¹⁰ Partnerships among plans, providers, and community organizations seem to be particularly effective in spreading the word and enrolling families in new programs. Missouri, for example, had high enrollment numbers a few months after CHIP implementation. The state attributed its high participation levels to the grassroots efforts of churches, schools, and community centers.¹¹ Similarly, South Carolina was very successful with its enrollment efforts: in addition to using

⁷ Sheils, J. F., and Haught, R. A., *The Insurance Status of Medicaid Eligible Persons Not Participating in the Program: Estimates for Children and Other Eligibility Groups*. Fairfax, VA: The Lewin Group, December 1997.

⁸ Summer, L., Parrott, S., Mann, C., *Millions of Uninsured and Underinsured Children Are Eligible for Medicaid*. Washington, DC: Center for Budget and Policy Priorities, April 1997.

⁹ Pear, R., "Many States Slow to Use Child Health Plan," *The New York Times* (online), May 9, 1999. Available at: <http://www.nytimes.com>.

¹⁰ National Governor's Association, *Annual Report: State Children's Health Insurance Program*. Washington, DC: National Governor's Association, 1998.

¹¹ "CHIP Enrollment Level Exceeds Projection, Lawmakers to Consider Additional Funding," *BNA's Health Care Policy Report* 7 (January 18, 1999):109.

several local agencies that make home visits to families to spread the word, the state also distributed applications at schools for children to bring home to their parents.¹²

States and communities found that developing effective outreach strategies was not so much a matter of adopting specific approaches that worked in other communities, but rather a process of understanding a local community's character and culture and devising strategies that worked for that specific setting. Developing effective community outreach necessitates addressing a series of questions. Who are the people that are eligible for this program? Where do they live and congregate? What makes the state program appealing to this group? Who are the "real" community leaders and how can they be engaged? What are the "access points" where these people might be approached or encouraged to apply? What might discourage people from applying? Title XXI programs are trying to reach new groups of people who may not have participated in a public program before and need to be approached in new ways. The groups are diverse—and there is no "one size fits all" outreach strategy that will work everywhere.

Media campaigns are seen as disconnected from local communities and their needs.

Media campaigns include radio and television advertising, and the use of billboards, posters, and flyers. Forty-five states are using such media to raise awareness about their programs, and 44 states operate toll-free telephone hotlines for applicants and enrollees for questions about available programs.¹³ States believe that these methods will enable them to reach the largest number of eligible families. While media campaigns may help to raise general awareness about health insurance, they do not work well alone and states differ in their assessments of the campaigns' success. Views are mixed as to whether the expense of such a campaign is worth the results, given the difficulty in targeting the messages effectively.

California developed relatively sophisticated mass media strategies. The state uses a well-known publicity and media firm and has placed its outreach emphasis on mass media campaigns. While the state committed more money and resources to mass media efforts than many other states, community reactions to these initiatives were not very positive. There was a widespread perception that the campaigns were not conducted well. Respondents felt that the messages used to sell the program did not appeal to immigrant and minority groups, and that the advertising did not connect people to local organizations through which they might learn about the program.¹⁴ New York respondents voiced similar concerns about their state's mass media campaign.

¹² "Aggressive Outreach Efforts Help State Exceed Its CHIP Enrollment Goal," *BNA's Health Care Policy Report* 7 (January 4, 1999):13.

¹³ National Governor's Association, 1998.

¹⁴ However, in the early months of the media campaign, it was the primary source of phone calls to the program's toll-free line.

Florida's outreach activities include a statewide media campaign and a toll-free hotline. As in California and New York, response to the outreach measures has been mixed. While a number of state-level informants felt that the outreach has been adequate, local health care providers saw no evidence that program advertising has been successful. One physician in Miami believed that enrollees find out about the program mostly by word-of-mouth.

Successful outreach strategies target people where they congregate, using mechanisms already trusted by families.

Communities that are cited as having effective community outreach typically have a strong and vibrant network of safety net providers, such as community health centers and public hospitals. These organizations already have many of the resources and skills necessary for informing families and individuals about health care issues. They often have outreach workers as well as translation and transportation services. Moreover, such organizations are located in communities where many eligible people live and work, and they have an enduring interest in helping them sign up for health insurance. Linking people to available services is often a major part of their organizational missions. Public hospitals, clinics, and other safety net providers also have an economic incentive to enroll uninsured clients in health insurance plans so as to reduce the financial burden of uncompensated care.

The success of community outreach efforts based on safety net providers is inherently limited to their current users. Not all eligible families have contact with these providers—some may not be connected to a medical home of any sort. Communities and states are now confronting the issue of how to reach out to those families not linked to the systems that historically served the uninsured and Medicaid populations. Our site visits revealed a number of interesting initiatives:

- Using a state mini-grant, one Massachusetts group conducted a successful outreach campaign at a town dump, where heads of household (mostly fathers) go to drop off garbage every week. Those who filled out a MassHealth application were given a raffle ticket to win a chainsaw.
- Another group in Massachusetts increased applications by placing fliers about MassHealth into coupon “ValPacs” mailed to families.
- A community organization in Washington published clip-out coupons in the local newspaper that could be mailed in for additional information about available programs.

- California approved the use of tax preparers to assist with filling out applications. Many low-income families use low-cost tax preparers and are thus accustomed to sharing financial information with them. In fact, over 50 percent of people receiving an earned income tax credit use a tax preparer. For their part, tax preparers are accustomed to helping people fill out forms and welcome the additional income from assistor fees.
- A number of communities in Massachusetts, Florida, and California established outreach campaigns through schools. In California, a program organized by the National Health Foundation asked schools to help identify eligible families and then link them with volunteer outreach workers from local hospitals.

State policies can support the development of local outreach capacity.

Recognizing the need to develop sustainable local outreach capacity, two of our study states instituted mini-grants to assist community-based organizations in identifying and reaching out to eligible people in the community. This strategy has a number of advantages. First, it directs the state's outreach resources to the organizations that best understand local needs. Second, it creates a sort of idea incubator, allowing local organizations to experiment with different strategies, which can then be adopted or modified by other communities.

Massachusetts is providing \$650,000 worth of mini-grants to 52 organizations statewide to assist them in their outreach efforts. Mini-grant recipients meet regularly to discuss best practices and to share information as policies change and new ideas are developed. California recently established a similar program that will award \$1 million to help local organizations develop outreach programs. In fiscal year 1999–2000, the state will make an additional \$6 million available for grants. Many states, including California and Washington, used the one-time federal government outreach resources available in connection with welfare reform to make grants to local governments to increase Medicaid outreach. California also directly supports the development of local staff capacity by paying trained application assistants to help families fill out forms.

In Washington, Massachusetts and New York, state policies unrelated to CHIP programs have provided unexpected support for the development of outreach capacity:

- The state of Washington continues to reimburse federally qualified community health centers on a cost basis. This enhanced reimbursement stream allows health centers to pay for outreach workers, translators, and other services. These services in turn allow community health centers to have a much more proactive and engaged relationship with their communities.

- Massachusetts recently began enforcing a requirement that providers must screen for Medicaid eligibility before services will be covered by the state’s free-care pool. According to respondents, hospitals and health clinics have hired many outreach and eligibility workers as a result.
- In New York, the WIC program encourages Medicaid and CHIP enrollment through its network of stores that accept WIC vouchers. These stores are often located in neighborhoods where target populations reside. The local stores distribute program flyers as well.

Outreach efforts are hampered by the low demand for insurance.

Some outreach efforts are not successful because they presume that insurance coverage is in high demand among individuals and families. Respondents in all of the study states cited low demand for insurance as a major barrier to increased enrollment in CHIP programs. For the most part, states have not geared outreach and advertising efforts to address this issue.

A number of respondents indicated that CHIP outreach initiatives should use more social marketing and business concepts. Many uninsured families are used to paying for health care services as they need them and seek services only when they are sick. Enrollees are not accustomed to prepaying into an insurance pool to cover services that they may or may not use. Some informants report that it is not unusual for an enrollee to request a premium refund at the end of a month if no health services were used. Moreover, many low-income persons are accustomed to “cash only” lifestyles and do not have checking accounts. As a result, what would be assumed to be a simple issue—paying a premium—is in fact complex. Some states have developed payment sites where members can make cash payments to address this unanticipated problem. States are now debating various ways to work with the populations newly eligible for publicly funded health insurance to:

- educate potentially eligible families about the purpose and value of health insurance;
- help members use the health care systems more effectively and understand the value of preventive health care; and
- enable members to conveniently pay premiums and copayments through methods adapted to their lifestyles.

Colorado, for example, is working with various business groups to develop a program to help educate enrollees about the values of a medical home, preventive health care, and the concept of insurance. California allows beneficiaries to pay their premiums in cash at Rite Aid stores.

Medicaid stigma is another reason that demand for public insurance programs is low.

The stigma connected to public assistance programs is a factor that lowers demand for Medicaid and CHIP. Concern about Medicaid stigma led some states to develop separate state-designed CHIP programs instead of Medicaid expansions. In the study states that have both a state-designed children's health insurance program as well as a Medicaid expansion—California, Florida, and Massachusetts—there was a general sense that applicants preferred the state-designed program. In fact, in Florida and California, respondents indicated that some applicants inflate their reported income in order to qualify for the stand-alone programs, even though these programs require a premium contribution.

Even in states where Medicaid stigma is not prevalent, enrollment in Medicaid often involves extra steps and barriers that make state-designed CHIP programs preferable from an enrollee perspective. This is the case in New York, where families favor Child Health Plus over Medicaid because the application process does not require a face-to-face interview, while Medicaid does. In recent focus groups conducted in New York City by Peter Feld for The Commonwealth Fund, participants reported that the application process for Medicaid is “degrading” and that it requires a great deal of persistence and resilience to complete. As one respondent stated “[you] have to go through all this trouble . . . to try to get Medicaid. . . . There is too much time and running back downtown.”

Massachusetts respondents reported that many families are reluctant to enroll in Medicaid and to leave the Children's Medical Security Program (CMSP) because Medicaid is considered to be welfare and therefore undesirable. State officials hope to address this problem with a comprehensive outreach campaign.

Advocates in New York suggested officially changing the name of Medicaid for children to “Child Health Plus.” In this fashion, both programs would have the same name while maintaining separate funding streams. They argued that this strategy would eliminate any stigma association with Medicaid, streamline marketing efforts, and increase enrollment. A number of states have already renamed their Medicaid programs to reduce stigma (e.g., Vermont's Dr. Dinosaur program and Rhode Island's RIte Start).¹⁵

¹⁵ Carpenter, M. B., and Kavanagh, L. D., *Outreach to Children: Moving from Enrollment to Ensuring Access*. Arlington, VA: National Center for Education in Maternal and Child Health, 1998.

Immigrants and undocumented residents have special outreach needs.

Some state officials, plans, and providers are pursuing the children of immigrants who are eligible for CHIP and want to establish a regular source of care for them. Other states are still clarifying their positions towards immigrants and children of immigrants and are waiting for guidance from the U.S. Immigration and Naturalization Service (INS). As a result, many illegal immigrants consider enrolling eligible children to be a risky endeavor. These immigrants fear that the INS will use application information to identify and deport them. A number of respondents told stories of applications routinely being passed from local enrollment offices to the INS. Applications written in Spanish in California contain warnings about information being available to the INS. Even legal immigrants are often reluctant to enroll their children. Many are under the mistaken perception that this form of public assistance will jeopardize their applications for citizenship under the new immigration laws.

Initially, the INS has failed to issue clarifying statements to allay these fears. As a result, in California—where, according to some estimates, 62 percent of eligible families are Latino—immigration attorneys were advising clients not to enroll in MediCal and Healthy Families until the INS makes a statement about the security of immigrants’ status if they enroll their children in a public assistance program.¹⁶ On a more positive note, the regional INS office for New England has issued a statement indicating that the Department of Medical Assistance (DMA) is not required to report routinely to the INS, although the DMA may have to provide information upon request. In addition, Massachusetts requested and received a written statement from the INS establishing that state residents who receive services through the state’s uncompensated-care pool are not considered public charges. Meanwhile, some states, including Florida, Massachusetts, and Washington are insuring noneligible immigrant children in CHIP or other state programs using state-only dollars.

The cultural diversity of eligible populations creates challenges for outreach.

Informants in many states say their state’s outreach efforts have not done enough to include culturally diverse populations. Some families are hesitant to enroll because of cultural and language barriers. Those who cannot easily read the applications are frequently deterred from applying.¹⁷ Moreover, advocates for both English- and Spanish-speaking populations say that reading the applications and brochures requires a high level of literacy.

¹⁶ Since the field work was completed, the INS has issued federal guidance on the “public charge” issue. According to recent California reports, Latino enrollment in California has since increased.

¹⁷ U.S. General Accounting Office, GAO/HEHS-98-93, p. 15.

There are also translation issues. In Colorado, respondents reported that many potential enrollees, particularly Hispanics, find that materials and marketing messages are unclear. Translations from English to Spanish are reportedly done in a strictly literal, word-for-word fashion, rendering many of them inadequate.

These sentiments were echoed in New York, where study respondents did not consider outreach efforts to have been very effective. Outreach materials are available in Spanish and English; Child Health Plus managed care plans may provide plan-specific marketing materials in languages such as Russian and Chinese, depending on need. Respondents felt that messages were not delivered in culturally sensitive ways and that understanding the brochures and application required a high level of literacy. Likewise, in Massachusetts, application and member booklets are available only in English and Spanish, despite the state's increasingly diverse immigrant community.

In a number of states, respondents felt that marketing messages that focused on CHIP programs as “insurance coverage for the poor” do not function as a “hook” for immigrant and ethnic groups. In California and Colorado, respondents suggested that marketing messages for Latino families should emphasize providing health insurance coverage as a basic family obligation. In Seattle, one respondent stated that many immigrant families who are eligible for public programs think of themselves as middle class and so would not think to apply for programs that are marketed to the “poor.”

Enrollment

The largest access issue that respondents in a number of our study states identified was getting children enrolled and keeping them in programs for which they are eligible. One of the most promising outcomes of CHIP program implementation is that states are critically examining their enrollment processes and changing them accordingly. States have simplified enrollment forms, removed cumbersome steps from the enrollment process, shortened the turnaround time for enrollment, and introduced presumptive eligibility—all to better serve potential enrollees. This new attention to enrollment processes has also infused a new energy and enthusiasm into the development of system improvements for Medicaid and other state programs.

A number of themes emerged from our discussions with informants about these issues:

- States that want to maximize program enrollment need short and simple applications that request only essential information.

- Even with simplified forms, many families require one-on-one assistance in filling out applications.
- Enrollment processes are still complex, in part because of the multiplicity of programs.

Simple application processes enable families to enroll more easily and open up the number of and types of places where applications can be distributed and accepted.

States are simplifying the application process by:

- shortening the application forms;
- reducing the amount of required information;
- eliminating asset tests;
- streamlining the process for verifying information such as residence and income;
- developing joint Medicaid and CHIP applications; and
- changing requirements for accepting applications (e.g., allowing mail-in applications and eliminating the need for face-to-face interviews).

Thirty-two states are planning or are now using a simplified application or eligibility process.¹⁸ Five of the states we visited are using joint applications for Medicaid and their separate programs, reducing the amount of paperwork needed to enroll. In addition, 40 states eliminated the asset test as of November 1998.¹⁹ Typically, an asset test counts the value of a family's assets—cars, bank accounts, stocks, bonds, homes—in considering eligibility for the program. Eliminating the test allows applicants to mail in applications instead of spending time in a Medicaid office, and reduces the administrative costs of processing the applications and the complexity of applying for public health insurance programs. Massachusetts, for example, increased enrollment by eliminating the asset test, shrinking the application length from 12 pages to four, and streamlining the income verification process. New York has a joint application, but

¹⁸ Riley, P., and Pernice, C., *How Are States Implementing Children's Health Insurance Plans? An Analysis and Summary of State Plans Submitted to the Health Care Financing Administration*, 2d ed. Portland, ME: September 1998.

¹⁹ Center on Budget and Policy Priorities, *Steps States Can Take to Facilitate Medicaid Enrollment of Children*, November 1, 1998. Available at: www.cbpp.org/11-1-98med.htm.

families who are eligible for Medicaid still must have a face-to-face interview with Medicaid workers.

Joint applications for Medicaid and CHIP do not necessarily lead to simplified enrollment. For example, California developed a joint application process, but the application was still long (27 pages) and complicated. According to informants, this form represented a compromise document, balancing the need for simplicity and ease of understanding with the need to inform applicants about all their entitlements and to screen people for Medi-Cal, the state's Medicaid program. Some in the advocacy community had wanted the state to leave in four pages that detailed the applicant's rights and responsibilities. Data elements included for public health research made the application even longer. As a result, the application form became cumbersome and difficult to navigate. Many respondents believed that the form intimidated potential applicants and contributed to slower-than-expected growth in enrollment. On April 1, 1999, the state released a new four-page joint application and also altered the actual enrollment process. This revised version introduced single points of entry, so that applicants would not have to decide whether to submit an application to Medi-Cal or to the separate state program.

Some states are making the application process less burdensome not only by reducing the information requested on the forms but by simplifying the process for verifying that information. Medicaid programs traditionally required applicants to bring in proof of residence (e.g., a letter from their landlord), verify date of birth with a copy of the child's birth certificate, and verify income with tax statements or several months of pay stubs—requirements that Title XXI programs are trying to reduce. Sometimes requests for such information deters families from applying. Families may be unwilling to seek proof of residence from their landlords, and immigrant families in particular may be fearful of providing such information as social security numbers. Colorado's application, for example, asks for parents' social security numbers. According to program administrators, the information is not necessary for eligibility determination but is used to track applications. Based on this request, some noncitizens assume either that their children must not be eligible for the program or become concerned that the information will be used by the INS.

Presumptive eligibility can get children linked to services more quickly.

The Balanced Budget Act gives states the option of allowing certain health care providers and community-based organizations to “presumptively” enroll children in Medicaid if they appear to be eligible based on their age and family income. Presumptive eligibility permits providers and other entities to be reimbursed for covered services they provide from the time the application is initiated until the final enrollment decision is made. In addition to traditional Medicaid providers,

WIC agencies, Head Start programs, and agencies that determine eligibility for subsidized childcare can make presumptive eligibility determinations.²⁰ These organizations often schedule their hours of operation to accommodate working parents.²¹ Presumptive eligibility facilitates the enrollment process for families and allows children to get necessary medical care as soon as possible. A U.S. Government Accounting Office study found that states that simultaneously implemented presumptive eligibility and dropped the asset test used in determining Medicaid eligibility experienced the most rapid growth in program enrollment.²²

States are also using presumptive eligibility to ensure that enrollees have access to the best coverage during the transition between programs. In Colorado, where Medicaid offers a richer benefit package than CHP+, children who switch from CHP+ to Medicaid during the contract year must be treated immediately as Medicaid patients by their CHP+ providers. Similarly, in New York, where CHPlus provides a more comprehensive benefit package to enrollees than Medicaid does, children making the transition from Medicaid to CHPlus before the end of a contract year must be immediately treated as CHPlus enrollees.

Not all states have pursued the presumptive eligibility option, however. In Florida, former Governor Lawton Chiles originally included presumptive eligibility in the program, but the measure was rejected by the state legislature. Legislators wished to design the state’s children’s health insurance program to resemble private insurance, and felt that presumptive eligibility did not fit this model.

Table 4: Eligibility Simplification Strategies

	California	Colorado	Florida	Massachusetts	New York	Washington
Presumptive Eligibility		✓		✓	✓	
No Assets Test	✓	✓	✓	✓	✓	✓

Many families need personalized assistance filling out application forms.

Under the Balanced Budget Act of 1997, states have the option of placing Medicaid eligibility workers at community locations, such as family support centers and school-linked centers.

²⁰ Center on Budget and Policy Priorities, 1998.

²¹ Ross, D. C., *Presumptive Eligibility for Children: A Promising New Strategy for Enrolling Uninsured Children in Medicaid*, Center on Budget and Policy Priorities, October 17, 1997.

²² U.S. General Accounting Office, *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions*, February 1991.

Eligibility workers at such sites answer applicants' questions and ensure that the application process goes smoothly. However, many states have not expanded their complement of eligibility workers because of budget constraints.

States are trying other innovative ways to increase assistance for families in filling out the application. The CHP+ plan in Colorado has developed 26 Community Enrollment Projects that provide outreach to eligible families and give one-on-one assistance with CHP+ applications. California pays "application assistants" on a per-application basis to help families fill out the application form. In acknowledgment of the extensive time and effort needed to help applicants fill out the form—some community respondents estimated that it took an hour to complete each application—payments to assistants were increased in late 1998 from \$25 to \$50 for each completed application.

While there have been concerns about the adequacy of the training provided to assistants in California, this program addresses an underlying issue faced by many community agencies: how to organize and pay for the assistance that families continue to need in filling out even simple application forms. In Washington, a state that has made substantial strides in simplifying its application forms, community health center respondents report that almost all families need one-on-one assistance to fill out application forms for Medicaid and the Basic Health Plan. Across our study states, community members and providers feel the state has asked them to shoulder the burden of conducting enrollment activities without providing the technical and financial support necessary for their success.

There has been considerable debate over what type of employees should provide the hands-on assistance families need in filling out application forms. Some respondents feel that sending state Medicaid workers to community sites is not the ideal solution. In Colorado, where applicants must come to county welfare offices to complete applications, enrollees report unfavorable experiences with eligibility workers. In Washington, a community health clinic indicated that outside eligibility workers do not provide much assistance to the clinic because they often only speak English. While most respondents believe that community-based providers play a critical role in helping families enroll, a minority of respondents also believe that this option is not ideal. These respondents suspect that enrollees are uncomfortable about sharing confidential financial information with their health care providers. The idea of using tax preparers to perform the enrollment assistance function—currently being piloted in California—is an intriguing approach to this issue.

The enrollment process in **New York** requires four distinct steps:

1. Applicant calls a 24-hour toll-free hotline number staffed by eligibility workers, who list the plans that are available in the applicant's county and ask that he or she make a selection.
2. The chosen health plan sends an application to the applicant.
3. The applicant completes the form and mails it to the plan with supporting documentation. The member is enrolled presumptively upon submission of the completed application.
4. The plan follows up with the applicant if it has not received all the necessary documentation within 60 days.

The complexity of programs and the number of different options make the enrollment process more difficult for administrators and applicants.

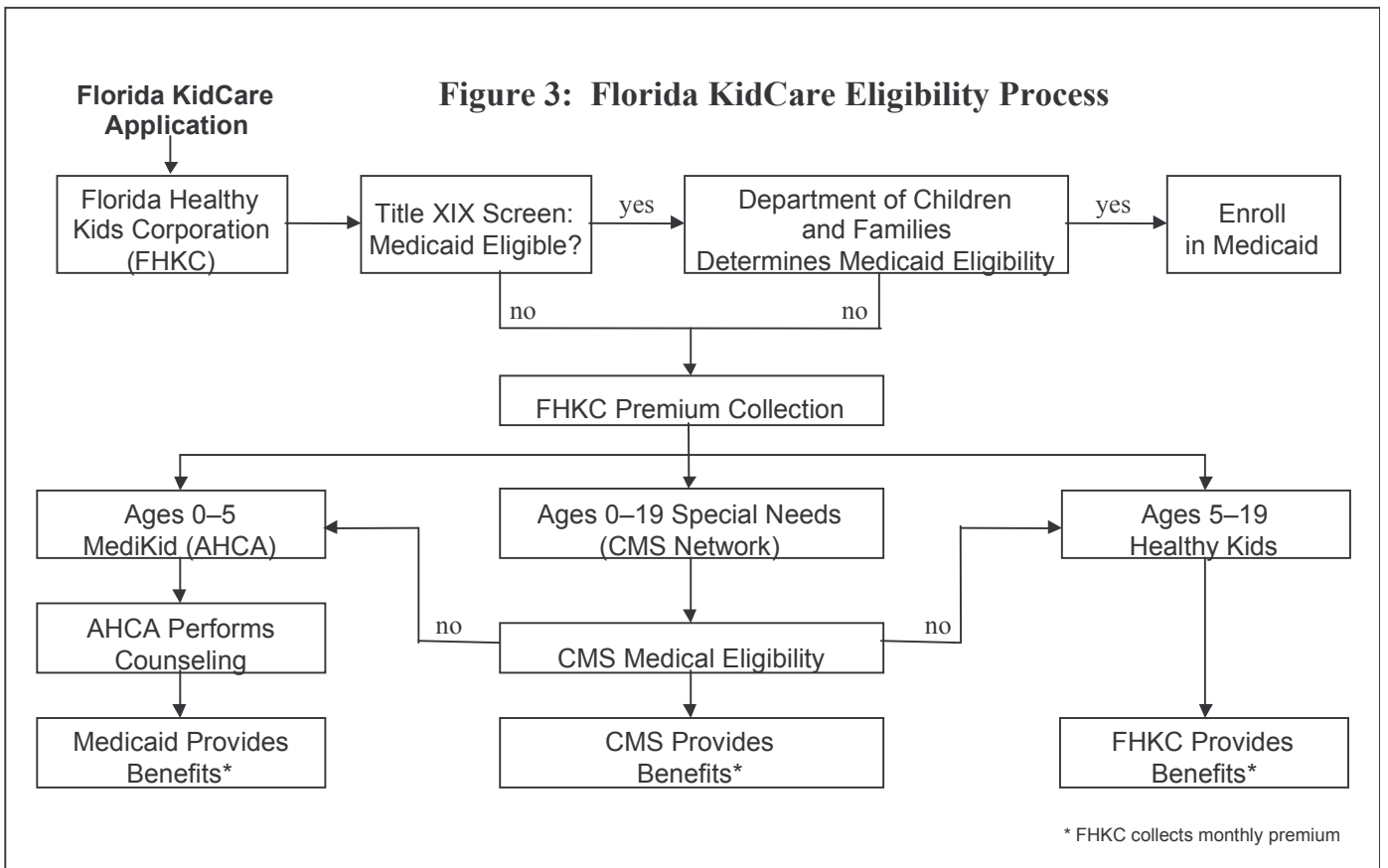
Even in states that have simplified forms and paid enrollment workers, there may be complicated enrollment processes and administrative problems with linking the relevant agencies. These issues seem particularly acute in states with two or more linked programs and where administrative responsibility has been divided among many agencies. Problems in coordinating efforts among agencies contribute to slow turnaround time for determining eligibility and enrolling children.

In Florida, applications must pass through multiple agencies to determine eligibility if children in one family qualify for different programs. Program enrollment so far has been lower than projected; these low numbers are generally blamed on the time it takes for applications to be processed. The state would like to present the program to the public as a unified, seamless system. Its administration, however, makes this a challenge. The enrollment process is as follows:

- Applications are sent to the Florida Healthy Kids Corporation (FHKC), the private entity that runs the Healthy Kids program, which makes an initial eligibility screen.
- If one child on the application (one application is filled out per family) *appears* to be Medicaid eligible, the entire application is sent to the Department of Children and Families (DCF).
- DCF does a full-scale Medicaid eligibility screen of all children in that family. Many informants in Florida mentioned DCF's inability to process these applications quickly, as

the volume of applications is much higher than anyone anticipated. Additionally, DCF does not have information systems capable of tracking applications.

- Once Medicaid eligibility is determined, the application is returned to FHKC if some children in the family were not deemed Medicaid-eligible but appear eligible for Healthy Kids.
- FHKC makes the eligibility determination for children not eligible for Medicaid.



This process is lengthy, and families wait for long periods before learning whether their children are eligible. Because the state does not have presumptive eligibility, the application processing lag can create access-to-care issues for children. The process in New York is similarly cumbersome.

State officials in Massachusetts are struggling with how to make their complicated and multifaceted program more accessible to the public. They have tried to organize the program so

that most of the burden of the complexity falls on the state. However, even state outreach workers have difficulty understanding the system and process, which affects their ability to provide effective guidance to families. The concurrent “redetermination” process compounds the confusion that results from the number and complexity of programs for MassHealth. In fall 1998, all persons enrolled in MassHealth prior to July 1997 were required to submit updated personal information for eligibility redeterminations. Those who did not were disenrolled.

Washington tried to make programs easier to use by enabling families to choose a common plan for children covered by Medicaid and parents covered by the state’s Basic Health Plan. Such families can enroll children in BHP+, a special program that offers Medicaid benefits to Medicaid-eligible children whose parents are enrolled in BHP. Most respondents in the state believe this structure has been beneficial because it allows families to be covered under one plan and allows for continuity of coverage. However, people are still concerned about differences in coverage. Some state respondents were not sure whether or not the BHP+ program offered Medicaid benefits or a more limited benefit package, and whether or not it required premiums.

In an effort to simplify the application process for its two programs, California in April 1999 created a single point of entry for all children’s applications.

States with preexisting state child health insurance programs are facilitating transfer of state-covered children to the new CHIP program.

As states have expanded coverage through CHIP, they have had to transfer children who were enrolled in other state programs into the new CHIP initiatives. States are making this transition in order to take advantage of dollars available under Title XXI and to comply with federal regulations that require states to move Medicaid-eligible children who are already enrolled in state stand-alone programs into Medicaid. Accomplishing this process has been difficult and demanding.

In California, the majority of children who were formerly covered by California Kids, a private program that covers primary and preventive care, are now eligible for Healthy Families. Likewise, most of the children covered by Massachusetts’ Children’s Medical Security Plan (CMSP) are now eligible for expanded Medicaid or subsidized employer-based coverage. The state’s health department, which ran CMSP, sent multiple letters to CMSP enrollees. The return rate was only 45 percent, which raised the possibility that 55 percent of CMSP enrollees were being disenrolled. Massachusetts ultimately hired outreach workers to follow up with every eligible family to ensure they were transferred to MassHealth Family Assistance. This effort paid

off: at the end of 1998, most of the children eligible to be transferred had been switched to Medicaid coverage.

Similarly, New York needed to transfer 41 percent of the 260,000 children enrolled in CHPlus to Medicaid in 1997. The state explained that this transition was administratively challenging and time-consuming. However, New York reduced the risk that these children would lose coverage during the transition process by providing presumptive eligibility.

Maintenance of Enrollment

The issue of keeping children enrolled in public programs is as significant as signing them up in the first place. In some states, increases in CHIP enrollment have been overshadowed by steady decreases in Medicaid enrollment. These decreases may be attributed in part to positive changes, notably the booming economy and resulting increases in employer-based coverage. However, respondents also point to a number of challenges states face in keeping children enrolled. These include the issue of families who drop coverage because of cost-sharing and confusion surrounding welfare reform.

Cost-sharing places financial as well as administrative demands on families.

The financial and administrative demands of cost-sharing can be a barrier to initial coverage and may keep families from staying enrolled in programs. This issue is discussed at length in our companion paper on the use of cost-sharing in CHIP.

How states choose to collect premium payments has a surprisingly significant impact on enrollment. Many low-income enrollees do not have checking accounts. Fifty percent of the premiums received from New York City enrollees in CHPlus were in the form of money orders. Therefore, requirements that premium payments be submitted in the form of a check or money order can be both costly and time-consuming for enrollees. In response to these concerns, some states are setting up alternative payment options. In California, for example, enrollees can now pay by cash at Rite Aid pharmacies throughout the state. Fifteen percent of all payments are made this way. Wisconsin has instituted payroll deductions to pay for program premiums.

Requiring monthly payments is also an issue for low-income families. While monthly payments lower the amount of individual payments, many respondents indicate that frequent payments actually increase the barriers to staying enrolled. In part, this is because most states require payment in the form of a check or money order, which burdens the family with additional expenses and effort.

Some states are trying alternative payment schedules. In California, enrollees can pay all of their premium charges annually in one lump sum. The state encourages prepayment by providing the fourth month of coverage free when enrollees pay for three months in advance. According to early reports, 59 percent of enrollees pay premiums in this way. Other states have not yet instituted multi-month prepayment, although some are considering such mechanisms.

States are seeking ways to maintain Medicaid enrollment by using CHIP outreach methods.

In every state we visited, respondents believe that a large number of families who are eligible for Medicaid are no longer enrolled because they do not understand that they are still eligible. Some states are now actively trying to keep enrollees on Medicaid when they leave welfare. In this manner, outreach for Medicaid is now more similar to outreach for CHIP. Medicaid needs to seek out a population that is no longer automatically reached through welfare applications. Some state Medicaid enrollment workers are approaching this challenge by forming relationships with workers in welfare offices and offering to retrain welfare workers to encourage people to stay enrolled in Medicaid.

IV. ISSUES ON THE HORIZON

Steep Declines in Medicaid Enrollment Across the Nation

States are having a difficult time achieving the goal of providing CHIP coverage to 5 million previously uninsured children. Reaching this goal is being further complicated by a rapid decline in Medicaid enrollment. Failure to maintain Medicaid coverage for eligible children undercuts states' own efforts to enroll new children. Estimates of total Medicaid enrollment by the Employee Benefit Research Institute indicate that Medicaid enrollment fell from 12.7 percent of the population in 1994 to 11 percent of the population in 1997.²³

While some of the decreases in Medicaid enrollment could be related to the improved economy, many believe a significant proportion of the decrease is related to welfare reform. Families USA estimates that 675,000 people, 420,000 of whom were children, lost Medicaid coverage in 1997 and became uninsured as a result of welfare reform.²⁴ With the implementation of the 1996 welfare reform law, the connection between welfare and Medicaid was severed and linkages between the programs have become confused and misunderstood. As families move from welfare to work and lose their cash benefits, they are also losing Medicaid, although many are still eligible. Families who might have learned of their eligibility for Medicaid through welfare applications are now being discouraged from applying for welfare or are being diverted into employment programs—thus reducing their opportunities to learn about Medicaid. Families who are not eligible for welfare benefits may assume they are also not eligible for Medicaid.

Welfare reform legislation specifies that Medicaid eligibility should be maintained even if welfare benefits are lost and that states should not erect barriers to the Medicaid application process. HCFA is concerned about state performance in this regard and is investigating the situation. In New York, for example, HCFA is examining stringent new welfare policies that a federal judge and advocates say have prevented poor people from getting prompt access to Medicaid coverage.²⁵ New York Medicaid rolls have dropped by 276,973, or 9 percent, since welfare reform legislation was passed. A federal district judge has ruled that New York City had improperly denied applications for Medicaid from poor people because they had not complied with work requirements in exchange for welfare benefits. Welfare offices were cited for failure to provide Medicaid applications promptly and failure to meet federal standards to process applications within 45 days.

²³ "Sources of Health Insurance and Characteristics of the Uninsured," EBRI Issue Brief No. 204, December 1998. Available at: <http://www.ebri.org>.

²⁴ Families USA, *Losing Health Insurance: Unintended Consequences of Welfare Reform*, May 1999.

²⁵ Hernandez, R., "Inquiry Grows as Rolls Fall for Medicaid," *New York Times*, June 6, 1999.

HCFA expects states to monitor and correct welfare reform implementation problems that are adversely affecting Medicaid enrollment. To reach the goal of universal insurance coverage for children, states must develop policies and program strategies for TANF, Medicaid, and CHIP that work together to assure access to health insurance, timely enrollment, and maintenance of coverage.

Withdrawal of Plans from Medicaid Managed Care Markets

Many plans thought that participation in Medicaid managed care would be a relatively simple and lucrative endeavor. They mistakenly assumed that Medicaid populations could be served by the same delivery systems that treat the middle class and they underestimated the costs of serving this population when they submitted their bids. Most of our study states are now experiencing plan withdrawals from the Medicaid market.

In Washington, for example, three plans that contract with the state have already scaled back their participation in public insurance programs. Sisters of Providence withdrew from both Healthy Options and BHP. Premera Blue Cross pulled out of Spokane and Lincoln counties, and QualMed dropped out of BHP and Healthy Options. In Massachusetts, two large plans, Blue Cross and Tufts Associated Health Plan, are no longer contracting with Medicaid, and only one HMO still operates in the greater Boston area.

Children's health insurance program administrators fear that an increasing number of plans will experience similar difficulties and will withdraw from the Medicaid managed care market. In addition to reducing plan choice, these withdrawals may decrease the number of providers who participate in Medicaid and CHIP managed care contracts. Some observers believe states may begin to reconsider their decision not to use primary care case management programs (PCCM), as an alternative to health maintenance organizations. PCCM affords the state more control over provider contracting.

Adequacy of Networks

Network adequacy is not, for the most part, a pressing challenge for states at this time. However, many people fear the emergence of potentially troublesome provider availability issues in the future. They cite three primary reasons for these concerns: the expansion of Medicaid eligibility levels, the extensive administrative demands that children's health insurance programs place on providers and plans, and the withdrawal of health plans from the Medicaid managed care market. Although it is still too early to assess network adequacy in Title XXI plans, this issue should be carefully monitored in the future.

Children with Special Health Care Needs

States are making concerted efforts to assure that services are accessible for children with special health care needs. The challenges are considerable. Many health care plans do not have adequate specialty provider networks that serve children. As a result, children with special needs often have to see unaffiliated providers in order to receive the care they need. This can place an additional burden on their families, who must navigate complex referral processes.

States are employing different strategies to assist families with children with special health care needs. Rhode Island's RiteCare program requires that managed care plans coordinate services for these children, including services provided by physicians and organizations outside of a plan's network. In California, county-run programs continue to provide specialized medical services to children with special needs, and participating plans are required to coordinate with them. However, this structure—in which a government agency provides some services directly and a health plan provides others—raises questions about who is accountable for providing services and coordinating benefits.

In Colorado, a group of community providers developed the “Care Coordination for Children with Special Health Care Needs” program to assist the families of these children. The program is offered through public health offices and public health agencies that serve all 63 counties in the state. For a fee, each family is assigned a care coordinator who works with the family and its primary care physician to develop and implement a plan of action that will ensure access to needed services. Massachusetts has avoided some of the issues experienced in other states by maintaining its PCCM program as an option along with managed care for enrollees. Many families of children with more severe medical needs choose to stay in this loosely managed program, which provides access to a broad panel of specialists.

Some states elect not to extend the Medicaid-required comprehensive EPSDT coverage to children from higher-income families. However, children with special needs may need enhanced care regardless of their family's income level. Advocates are concerned that children with special needs are not well served by the typical private sector insurance plan. They prefer including in any plan the assurance provided by EPSDT, especially if the plan is a managed care plan.

Training and Support to Teach Enrollees How to Use the Health System Effectively

Many uninsured people use emergency rooms (ERs) as their main providers of health care services. Two goals that states pursued as they moved Medicaid enrollees into managed care were to reduce use of ERs for nonemergency care and to increase the use of preventive services. To these ends, they created penalties for unnecessary ER visits and provided enrollees with a

reliable source of medical care. Now states are discovering that educating enrollees about obtaining care is necessary to achieve these ends.

Most states request that enrollees select a health plan when they apply for a program. If they fail to indicate a specific plan, these states will assign them to a plan by default. California's application process is designed to encourage applicants to select a primary care physician as well. Some states, including both New York and Washington, require plans to engage in follow-up outreach efforts, like making welcome calls to all new enrollees.

The second phase of education involves teaching enrollees about the appropriate use of health care services. Florida, for example, plans to hire a special coordinator to develop materials that explain the value of preventive care. Toll-free numbers that enrollees can use to call for answers to questions are also available in most states. In addition to making information readily available to enrollees, some states are considering incentives to encourage the use of preventive care services. Studies of other programs have shown the effectiveness of such tactics. For example, WIC sites in Chicago witnessed a 33 percent increase in child immunization rates when WIC offered food vouchers to families who participated in its immunization program.

Other states are implementing outreach programs to assist enrollees in accessing services. Missouri, for example, requires health care plans to operate a notification system for families about upcoming and/or missed EPSDT screenings. Outreach workers in Pennsylvania's "Love 'Em with a Checkup" program help enrollees schedule appointments and follow up with them to see if the appointments were kept. Blue Cross of California's outreach program provides a striking example of the impact of outreach interventions on health care-seeking behaviors. If a California enrollee goes to an ER for primary care services, an outreach worker contacts the family to ask if it has any problems—e.g., child care or transportation issues—in accessing its primary care provider. A six-month study of 400 plan members who used ER services inappropriately showed that after implementation of outreach intervention, ER use declined by 46 percent while visits to primary care providers increased by 133 percent.

Access to Services for Rural Residents

A shortage of physicians in rural areas is a perennial problem, both for states and the entire health care industry. Approximately 20 percent of the U.S. population lives in rural communities, but fewer than 11 percent of the nation's physicians practice in rural areas. The U.S. Department of Health and Human Services recommends that the provider-to-patient ratio for an "adequately served population" should be one primary care doctor for every 2,000 people. Most rural areas, however, have a ratio of 1 to 3,500 or worse, and many have been designated "health professional shortage areas" by the federal government.

Because they live in underserved rural areas, many uninsured and low-income families must travel substantial distances to obtain health care services. Difficulty getting to service locations is most common for rural residents, particularly for the eastern portion of Washington and for Colorado's rural areas. Distance from service locations is also an issue for residents of urban areas like Los Angeles and Denver that do not have extensive public transportation systems or widely distributed networks of community clinics. Most state children's health insurance programs, however, do not directly address transportation concerns. The exception is Rhode Island's RIteCare program, which provides bus passes for enrollees and supplies vouchers for taxi or van services when bus lines do not service enrollees' neighborhoods.

In addition to traditional rural physician recruitment and retention challenges, states often face substantial difficulties in introducing managed care to rural communities. Many doctors who are willing to practice in rural settings are reluctant to take on the risk and instability inherent in working under managed care contracts in rural areas. Also, the plans themselves often do not want to expand to rural areas, not only because of the difficulty of establishing adequate provider panels but also because of the significant infrastructure required to cover a relatively small group. Colorado's Child Health Plus program, for example, intended to use only managed care products to deliver coverage. However, only 24 of the 63 counties in the state have a managed care presence. The program must therefore continue to pay providers in the remaining 39 counties on a fee-for-service basis until managed care networks are operational. Other states, including Washington and Florida, have encountered similar difficulties.

States are discovering that they need to be flexible if they wish to bring managed care to rural communities. Some states have attempted to introduce managed care to these areas gradually by offering more lenient financing structures and risk-sharing strategies in the first few years. Other approaches include purchasing reinsurance for plans to cover catastrophic cases and offering year-end bonuses to physicians who agree to participate in managed care plans. California's CHIP plan specifically authorizes up to five demonstration programs to fund collaborative health care networks to address provider access issues in rural areas of the state. In fiscal year 1998–99, the state distributed \$6 million to plans to improve geographic accessibility or to address access issues for special populations.

Cultural Competency in the Delivery of Health Care Services

Many aspects of the health care delivery system are not sensitive to the needs of either low-income populations or people of different cultural backgrounds. This lack of "cultural competence" is a significant and pervasive access barrier for enrollees in publicly funded health insurance programs and was highlighted by respondents in each state we studied.

The inability of non-English-speaking enrollees to communicate effectively with program administrators and providers is perhaps the largest systemic barrier to accessing health care services, especially in states with large immigrant populations, such as California, Washington, and Florida. In these states, non-English-speaking people sometimes constitute the majority of program eligibles. In many states, program information materials are available only in English (and possibly poorly translated Spanish). In addition, there are minimal numbers of bilingual operators on the toll-free hotlines, and few qualified translators at health care delivery sites. States are attempting to address this challenge. In Washington, for instance, Healthy Options now requires materials to be translated into 25 different languages.

Effective Monitoring Systems for CHIP Programs

Policy and program design for effective monitoring of CHIP programs is complex. Monitoring systems are still immature, and it is unclear whether or not states will get the information they need to show if children are established in a medical home, if they are immunized, if they are receiving preventive services, and to what degree and why they are disenrolling from programs. Nevertheless, states are pursuing some promising monitoring initiatives, mainly focused on the creation of individual identifiers for enrollees, and the collection of data to track reasons for disenrollment.

Colorado is considering whether to use its Medicaid eligibility system to assign a unique Medicaid identification number to all new CHIP+ enrollees for tracking purposes. Massachusetts and Florida conduct computer matches between Medicaid and CMSP to detect and manage transitions between programs. In California, all Healthy Families and MediCal enrollees get individual and family identifiers. The state also routinely collects information about reasons for disenrollment and publishes this information along with other enrollment data on its website. It appears that the unrestricted publication of these data is galvanizing public discussions and generating a number of suggestions and changes to make the program more accessible and easier to navigate.

V. FINDINGS AND IMPLICATIONS

The federal government enacted Title XXI approximately 20 months ago. During this period states have taken significant steps to design and implement their CHIP plans. Politically, the CHIP program has been very well received. Although states have taken different philosophic approaches to design and implementation, beneficiaries, the general public, and state legislatures have all expressed support and enthusiasm for the program. Despite this support, CHIP is now at a critical evaluation point. The Congressional Budget Office (CBO) previously estimated that by 1999, CHIP programs would cover roughly 2.8 million children, thus extending coverage to 25 percent of the 10.7 million uninsured children in the United States.²⁶ Only \$260 million of Congress's \$4.2 billion CHIP allocation, however, was used in 1998.²⁷ With this in mind, it is important that states evaluate their program administration and outreach efforts to ensure that they are maximizing enrollment numbers.

Getting CHIP up and running has been a slower process than many had anticipated. Most states—even those that had existing programs upon which to expand—are still in or just completing the early stages of plan implementation. The CHIP program represents a significant shift in national attitudes toward public assistance. Historically, states have not recruited people to enroll in public programs; potential beneficiaries were expected to seek out available assistance. The expressed goal of CHIP, however, is to enroll as many uninsured children as possible into health insurance plans. Consequently states are grappling with issues like outreach for the first time. Although these new considerations have caused unexpected delays in program implementation, the lessons learned in the process are relevant for future expansions of health insurance coverage.

Implementing a health insurance expansion program often requires setting up a new administrative infrastructure—a time-consuming and costly process.

When Title XXI was enacted, many did not foresee the challenges that would arise as states attempted to establish their CHIP programs. There was the perception that starting up the new programs would be quick and relatively simple. This proved to be untrue. States faced numerous challenges simply in designing feasible programs. First, the political negotiations at the state level that are necessary to enact enabling legislation are very time-consuming. An unavoidable consequence of a state–federal initiative is that those attempting to implement the program have

²⁶ Cohan, S., *State Tools to Provide Family Health Insurance Coverage*. Available at: <http://www.nga.org/Pubs/IssueBriefs/1999/990104SCHIP.asp>.

²⁷ Pear, R., “Many States Slow to Use Child Health Plan,” *New York Times* (online), May 9, 1999. Available at: <http://www.nytimes.com>.

to work within state political philosophies as well as within federal guidelines. Before states could move forward with their programs, they had to receive approval from both state and federal governments.

After receiving approval for plan design, many states, particularly those opting to create separate state stand-alone programs, then had to develop administrative infrastructures. Both the costs and the time involved in developing such infrastructure are substantial.

Recognizing the increased costs, California implemented a single point of entry for children enrolling in either Healthy Families or Medi-Cal in April 1999. The California Legislative Analyst's Office predicted that implementation of the Family Coverage Model, which includes a provision to consolidate and simplify intake procedures for Medi-Cal and Healthy Families, could generate savings for the state of \$170 to \$179 million.²⁸

The complexity of program design can result in significant administrative challenges.

Complex programs often necessitate complex infrastructure. Because of the difficulties inherent in designing such infrastructure, complicated programs typically also have a harder time getting applications to people, processing applications, and coordinating enrollment. To the extent that it is possible, states should attempt to minimize the complexity of plan design. For example, placing administrative responsibility for the program within the purview of only one agency—as opposed to multiple agencies—reduces complexity while increasing accountability. Another approach to infrastructure simplification is dovetailing administrative tasks among programs. This approach lets states save time and money by avoiding duplicated efforts, yet still maintains the individual characteristics of the programs involved.

Coordination among public insurance programs is key to maintaining enrollment levels.

One of the biggest challenges states have faced is ensuring that Medicaid and stand-alone programs are synchronized. Ideally, the programs should serve as bridges to one another—many beneficiaries experience fluctuations in their income levels, and on occasion, they may need to transfer from one program to the other. States should also try to make their programs compatible. However, there is no one obvious approach to achieve better coordination between programs. States may want to experiment with different approaches—including efforts to standardize enrollment requirements and processes—and to evaluate the effectiveness of various approaches.

²⁸ California Legislative Analyst's Office, *A Model of Health Coverage for Low-Income Families*, June 1, 1999.

Implementation of new insurance expansion initiatives presents opportunities to improve existing programs as well.

In developing and implementing innovations in separate stand-alone programs, states have often found that the innovations can be applied to Medicaid programs as well. One Massachusetts administrator said that the current scrutiny of state CHIP plans provides a window of opportunity for policymakers to streamline administration, improve outreach, and simplify enrollment in their Medicaid programs.

Outreach efforts need to be tailored to target populations.

While statewide media outreach campaigns raise awareness of public insurance programs among large numbers of people, they are typically unable to communicate the concept of, need for, or benefits of, insurance coverage. As a result, such campaigns may have a limited impact if they are not used in conjunction with smaller community-based efforts. The latter can offer a flexibility in their outreach approaches that is not possible at the state level. Smaller community-based efforts, for example, can be designed to be sensitive to the ethnic and cultural backgrounds of different target populations and to address enrollment barriers for these groups.

Simplified application processes reduce barriers to enrollment.

Simplifying application processes is not only advantageous from an administrative perspective, but from a beneficiary perspective as well. State stand-alone and Medicaid programs have successfully experimented with various approaches to increase enrollment—e.g., shortening application forms, reducing the paperwork required to apply, introducing presumptive eligibility, eliminating the need for face-to-face interviews, providing application assistants at enrollment sites. Another promising approach is the coordination of enrollment efforts with other kinds of public assistance programs such as WIC and school lunch programs. This approach may be particularly effective for expansion programs that target entire families. Not only does this tactic increase the likelihood that the program will be exposed to key populations, but it also simplifies enrollment processes for families.

State and federal cooperation and flexibility are critical to program implementation.

Restrictions and rules set by the federal government under Title XXI—including the requirement that states demonstrate efforts to reduce substitution, limitations on coverage for immigrant populations, and the need for all applicants to be screened for Medicaid—contribute to the

complexity of programs. Successful implementation of new initiatives requires that federal policies be interpreted broadly, and revisited regularly, to accommodate the practical needs of states.

States need to monitor the issue of access to health care services.

At the current stage of Title XXI implementation, it is too soon to draw definitive conclusions regarding the adequacy of access to services once beneficiaries are enrolled in new programs. This is an issue, however, that should be closely monitored and evaluated. States need not design revolutionary systems to monitor quality, but should try to utilize evaluation instruments already in place. These include Section 1115 waiver external review policies and the National Committee for Quality Assurance (NCQA) guidelines. In addition, states should build quality-management requirements into the contracts that they form with HMOs to cover the CHIP population. The most important quality-control issue for states is to ensure that data gathered through these methods are collected in a uniform and useful manner.

VI. CONCLUSION

States enthusiastically designed and implemented CHIP, a politically popular program that most states endorse as consistent with state plans to incrementally expand coverage to uninsured populations. However, state programs are far from meeting the expected CHIP enrollment levels, which projected covering 5 million new children. This lag in enrollment is complicated by (1) a rapid decline in Medicaid enrollment that appears to be related to implementation of welfare reform, and (2) a breakdown of systems that assure that children of low-income families receive Medicaid or CHIP even if their families are not eligible for welfare cash assistance.

In tailoring their CHIP design choices to meet philosophical and policy objectives, states may have erected barriers to enrollment and access. CHIP programs are unexpectedly complex and costly to administer. This complexity is related to:

- political influence on program design decisions;
- difficulty complying with federal regulations;
- conflicting policy objectives regarding enrollment and substitution;
- varying philosophical beliefs about government's role in helping vulnerable populations; and
- inadequate understanding of the constraints low-income families face.

Consumers find it difficult to navigate the fragmented insurance system; states need new methods for reaching and enrolling new target groups.

As program enrollment increases, and as other incremental expansions occur, states can use CHIP to experiment with ways to:

- Simplify programs by establishing uniformity in benefits, provider networks, eligibility determination processes, and enrollment procedures across publicly supported health insurance programs;
- Market insurance plans to new users with consumer-friendly approaches individualized for each market segment;

- Coordinate and integrate administration to achieve efficiency and streamline programs, including the development of processes that would allow families to move easily among TANF, Medicaid, and CHIP; and
- Develop CHIP monitoring and quality-assurance programs that link to and build on private sector insurance and Medicaid quality-management and reporting processes.

The results of this preliminary study make the CHIP opportunity clear. As states pursue incremental insurance expansion for low-income families, they would benefit greatly if they would use the lessons they learned while implementing CHIP to establish a vision of the ideal health care insurance system.

APPENDIX A
SIMPLIFIED MEDICAID APPLICATION MEASURES

Mail-in Application (35)	Short Application (41) (Applications are the same length or shorter than the HCFA model application)	No Assets Test (40)	Presumptive Eligibility (6)	12-month Continuous Eligibility (10)
Alabama	Missouri	Alabama	Mississippi	Alabama
Alaska	New Jersey	Alaska	Missouri	Arkansas
California	New Mexico	Arizona	Nebraska	Connecticut
Colorado	North Carolina	California	New Hampshire	Louisiana
Connecticut	North Dakota	Connecticut	New Mexico	Maryland
Delaware	Ohio	Delaware	New York	Mississippi
District of Columbia	Oklahoma	District of Columbia	New York	Nebraska
Florida	Oregon	Florida	North Carolina	New Mexico
Hawaii	Pennsylvania	Georgia	Ohio	South Carolina
Illinois	Rhode Island	Hawaii	Oklahoma	Washington
Louisiana	South Carolina	Illinois	Pennsylvania	
Maine	South Dakota	Indiana	Rhode Island	
Maryland	Utah	Kansas	South Carolina	
Massachusetts	Vermont	Kentucky	South Dakota	
Michigan	Virginia	Louisiana	Tennessee	
Minnesota	Washington	Maine	Vermont	
Mississippi	West Virginia	Maryland	Virginia	
	Wyoming	Massachusetts	Washington	
		Michigan	West Virginia	
		Mississippi	Wisconsin	
		Missouri		

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