



IMPLEMENTING NEW YORK'S FAMILY HEALTH PLUS PROGRAM: LESSONS FROM OTHER STATES

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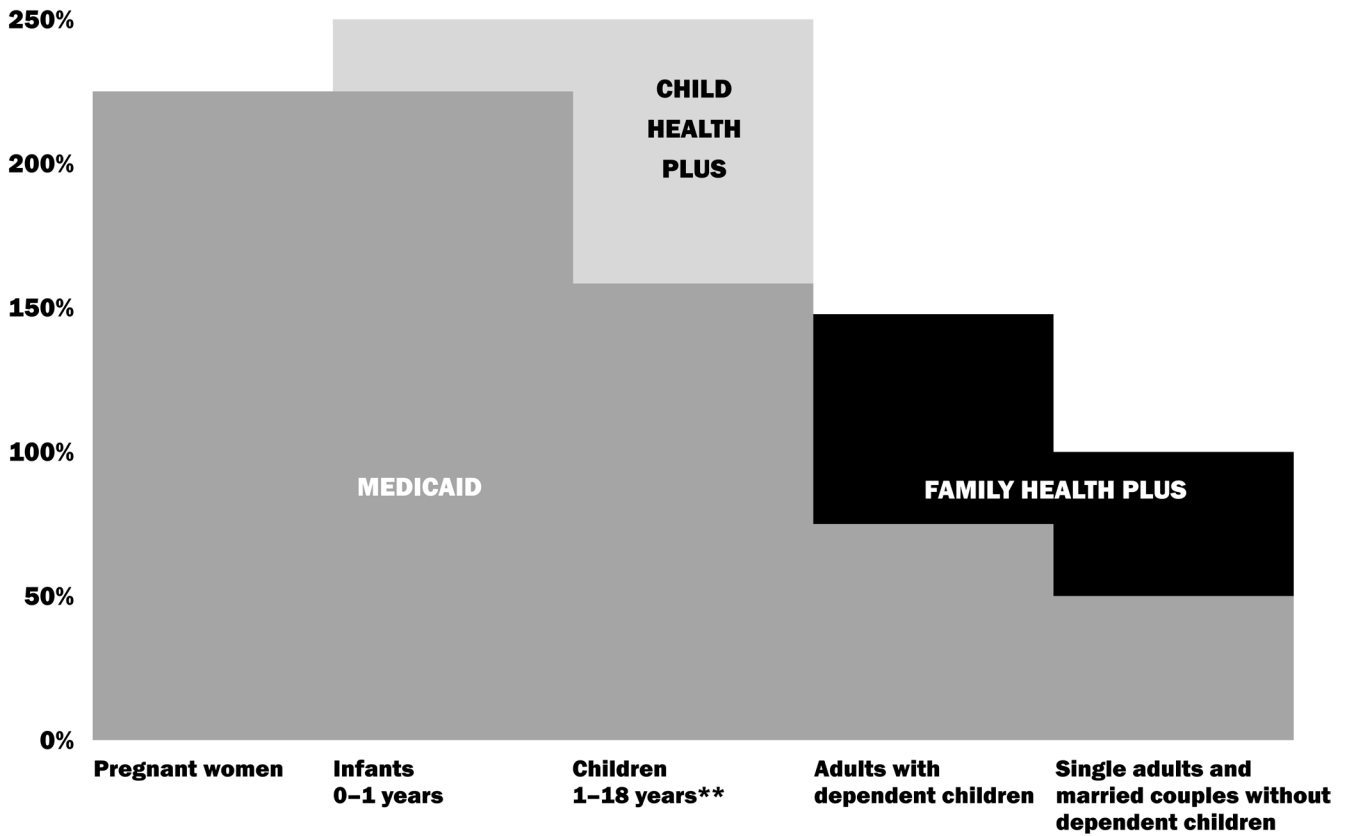
EXECUTIVE SUMMARY

New York has begun implementing Family Health Plus (FHP), a new program authorized in the Health Care Reform Act of 2000 that will make comprehensive health coverage available to over 600,000 low-income working adults in the state.¹

If it is successful at enrolling and retaining eligible individuals, FHP will measurably reduce the number of uninsured residents of New York and will make the state a national leader in providing health coverage to adults. However, without a careful design that promotes ease of enrollment and coordination with New York's existing health insurance programs, FHP could fail to reach many eligible individuals and add to the confusion about the state's increasingly complex patchwork system of public and private coverage.

The success of FHP will also be affected by the design and administration of Medicaid and Child Health Plus (CHP), since the application and enrollment processes of all three programs are closely linked. For example, CHP and FHP applicants must be screened first for Medicaid,² and the state is in the process of combining FHP, CHP, and Medicaid on a single application. In addition, recent studies have documented that many uninsured individuals do not know about these programs, fail to apply because the application process is too complicated and difficult, or fail to renew their insurance while they still qualify for coverage.³

**Income Eligibility Levels for New York’s Public Health Insurance Programs
(as a percentage of the Federal Poverty Level*)**



* Although income eligibility levels are shown as gross percentages of the Federal Poverty Level (FPL), they may be commonly expressed in net/gross, depending on the program.

** Medicaid eligibility for children ages 6–18 years will expand to 160 percent gross (133 percent net) of the FPL, subject to Centers for Medicare and Medicaid Services (CMS) approval of the NYS Plan Amendment or the achievement of 50 percent Medicaid managed care enrollment across the state, whichever comes sooner.

These challenges are not unique to New York. More than a dozen states in recent years have extended coverage to adult populations. Typically they do this by stitching together a number of funding sources and combining a variety of health insurance options available through the federal Welfare Reform Act, Medicaid demonstration authority, the State Children’s Health Insurance Program (CHIP) and its demonstration authority, and state-funded initiatives.

While each of those states has a unique configuration of programs, they face strikingly similar challenges with respect to designing and implementing their programs to reach their target audience and integrate multiple insurance plans into a streamlined coverage system. New York can benefit by incorporating strategies implemented by other states to address these challenges into a design for FHP and modifications to CHIP and

Medicaid that respond to New York's unique circumstances and enable all of the state's public health insurance programs to reach their fullest potential.

This report examines key FHP design and implementation issues and how Medicaid and CHP could affect or be affected by FHP, and it provides promising strategies that New York should consider for maximizing enrollment and minimizing turnover, gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters. The report focuses primarily on the development of effective outreach strategies; the simplification of application and enrollment procedures; the coordination of two or more health insurance programs so that their administrative systems, program rules, and benefit delivery systems are aligned; and the streamlining of recertification processes.

Outreach and Marketing Strategies

Eligible individuals often fail to apply for health insurance programs because they are unaware of the programs or assume they do not qualify for coverage.⁴ With the implementation of FHP, New York will need to devise new strategies for educating uninsured working adults about this new program. And, the state could step up current efforts to educate the general public about existing health care options, in particular, Medicaid, which has never been aggressively promoted.

Other states that extend coverage to parents and childless adults use representatives of these populations in their advertisements, promotional material, and community-based outreach efforts. In those states where various funding streams are coordinated under one umbrella program, the component programs are frequently marketed as a single plan with an appealing name, encouraging childless adults, parents, and, in general, a wider range of potentially eligible individuals to apply for coverage. Additional strategies include marketing programs at locations with a relatively high proportion of single, working adults, and mailings of health insurance promotional materials to individuals who participate in other public benefit programs with similar eligibility criteria.

Recommended Outreach and Marketing Strategies	Examples of States Utilizing Strategy*
Aggressive, multifaceted advertising and outreach campaigns for all health insurance programs, including specific strategies for reaching nontraditional coverage populations, such as childless adults	New Jersey, Tennessee
Review of databases of state programs with eligibility guidelines similar to public health insurance programs' eligibility criteria to identify and reach out to individuals who may be uninsured and eligible for subsidized coverage	Massachusetts, Minnesota, New Jersey, Tennessee
Compensation for facilitated enrollers for each successful health insurance application submitted; coupons, products, or other incentives offered to individuals who complete and submit health insurance applications.	California, Colorado, New Jersey, Rhode Island
Supplementation of state-sponsored outreach efforts with corporate-sponsored outreach activities	New Jersey

* This table provides examples of states, within the 13 states studied for this report, that employ each specific strategy; the list of states singled out under each strategy is not meant to be all-inclusive.

Simplification of Application and Enrollment Procedures

A complicated and demeaning application process often prevents individuals from enrolling in state health insurance programs, even when they know about them and suspect they may qualify for coverage.⁵ A critical component of any serious effort to help individuals gain access to FHP is the design of a simple application and enrollment system, especially if it is coupled with similar reforms to Medicaid's enrollment procedures.

Many states have significantly pared down their applications by eliminating questions not required by federal or state law; by standardizing across several programs definitions of income, family size, and allowable deductions from income; by eliminating their asset tests; by accepting self-declarations of age, identity, social security number, living arrangement, and/or residence; and by eliminating the requirement that individuals apply in person for coverage. In addition, a growing number of states in recent years have automated aspects of their eligibility determination and enrollment processes for health insurance programs.

Recommended Simplification Strategies	Examples of States Utilizing Strategy*
Single, streamlined application for all public health insurance programs that eliminates questions not required by federal law, requires applicants to provide only those documents necessary to verify information that cannot be confirmed by existing state databases, and standardizes across programs definitions of items like disregards, deductions, and family size	California, Massachusetts, Minnesota, New Jersey, Ohio, Tennessee
Elimination of requirement that individuals apply in person for coverage; allow mail-in applications	New Jersey, Delaware, Massachusetts, Ohio, Oregon, Rhode Island
Outstationing Medicaid eligibility workers in disproportionate-share hospitals and federally qualified health centers	New Jersey, Wisconsin

* This table provides examples of states, within the 13 states studied for this report, that employ each specific strategy; the list of states singled out under each strategy is not meant to be all-inclusive.

Coordination of Multiple Programs

Though New York has taken important steps in recent years to coordinate health coverage programs for children, CHP and Medicaid still have different information systems, participating health care plans, and eligibility criteria. FHP, whose features mirror aspects of both CHP and Medicaid, will introduce a third set of rules and processes into New York’s system of publicly sponsored health insurance.

States that have successfully addressed these concerns nearly always integrate their information systems so there is one database, or several connected databases, of enrollee information. With an integrated information system in place, a state can easily provide a single point of entry for applicants of all health insurance programs, immediately determine whether applicants for health insurance are already enrolled in another public program, and automatically screen individuals for all health coverage options when they lose eligibility for one program. In addition, some states require health plans accepting enrollees of one program to participate in all programs, enabling family members enrolled in different programs to get their care from the same health plans, and to maintain their current providers if they shift among health insurance programs.

Recommended Insurance Program Coordination Strategies	Examples of States Utilizing Strategy*
Information systems integrated for multiple health insurance programs	Minnesota, Vermont, Washington, Wisconsin
Program rules and procedures aligned or made as uniform as possible across health insurance programs	Delaware, Oregon, Vermont, Wisconsin,
Health plans that participate in one program required to accept enrollees from all programs	Massachusetts, Minnesota, Wisconsin
Automated enrollment procedures that make health insurance applications available on-line, allow the electronic submission of applications, enable state eligibility workers and facilitated enrollers to screen applicants electronically for more than one program, and/or determine eligibility electronically	California, Colorado, New Jersey, Ohio, Vermont, Washington, Wisconsin
Multiple programs administered through a single agency	Massachusetts, Minnesota, Wisconsin

* This table provides examples of states, within the 13 states studied for this report, that employ each specific strategy; the list of states singled out under each strategy is not meant to be all-inclusive.

Simplification of Recertification Procedures

A significant percentage of individuals enrolled in Medicaid and CHP—perhaps 50 percent or more each year—drop out of these programs before or during the annual recertification process, even though they are still eligible for coverage and may need medical services.⁶ New York’s burdensome recertification process contributes to this problem. FHP calls for a recertification process that should be somewhat less complicated than Medicaid’s process, but key details are being worked out now.⁷

Recent reports suggest that New York could substantially reduce disenrollment from its insurance programs by streamlining complex recertification processes, as a growing number of states have done with their health insurance programs.⁸ Typical state-based reforms include dramatically reducing the number of questions on the recertification forms, sending preprinted forms that require enrollees to document only circumstances that have changed since they originally applied for coverage, eliminating in-person interviews for coverage renewals, and allowing family members to renew their insurance on the same dates even if they applied for coverage at different times or are participating in different health insurance programs.

Recommended Recertification Strategies	Examples of States Utilizing Strategy*
Number and complexity of steps enrollees must take to recertify their eligibility for coverage reduced by shortening recertification forms and providing enrollees with preprinted information from the original application that beneficiaries can modify to reflect changes in their circumstances	Massachusetts, New Jersey, Wisconsin
Applicants required to provide only those documents necessary to demonstrate changes in circumstances that cannot be verified through data matches with existing government records	Massachusetts, New Jersey
Recertification dates aligned for all family members	Colorado, Oregon, Wisconsin
Enrollees allowed to mail in their renewal forms	Delaware, Massachusetts, Minnesota, New Jersey, Ohio, Oregon, Rhode Island, Tennessee, Vermont, Wisconsin
Enrollees educated about recertification process when they first enter the program; use terminology familiar to most enrollees like “renew” instead of “recertify” and “member” instead of “enrollee”	New Jersey, Vermont
Specific unit or program staff within the administering agency dedicated to targeting individuals in danger of disenrolling	New Jersey

* This table provides examples of states, within the 13 states studied for this report, that employ each specific strategy; the list of states singled out under each strategy is not meant to be all-inclusive.

FAMILY HEALTH PLUS IMPLEMENTATION: LESSONS FROM OTHER STATES

INTRODUCTION

Family Health Plus (FHP), which was signed into law in December 1999, will make comprehensive health insurance available to low-income working adults in New York State who earn too much to qualify for Medicaid but do not have access to affordable employer-provided coverage. Before the passage of FHP, Medicaid was the only statewide public health insurance program available to nonelderly adults, but its stringent income guidelines for most adults excluded all but the poorest. For example, adults with dependent children qualify only if their income is less than approximately 85 percent of the federal poverty level (FPL) or \$15,003 for a family of 4, and adults without dependent children qualify only if they earn no more than about 50 percent of the FPL, or \$4,295 per year, per individual.⁹ In addition, most adult Medicaid recipients must document that their assets and other non-income resources do not exceed state-established levels—further limiting eligibility for the program.

FHP was created to address the paucity of affordable health insurance options for the growing group of uninsured individuals who cannot afford to buy insurance on their own, but whose incomes or assets disqualify them from Medicaid. When implemented, FHP will be available to adults without dependent children if their gross income is under 100 percent FPL, and parents with dependent children if their income is under 150 percent FPL, regardless of their assets—a significant expansion of eligibility.

Though technically a Medicaid program that must meet certain federal requirements, in several important respects FHP is designed to look more like Child Health Plus (CHP) or a commercial health insurance product than like traditional Medicaid. For example, the state calls for the development of a single application for Medicaid and FHP that is “easy to understand and complete,” and individuals will be able to apply for coverage through community-based workers who are trained to assist prospective enrollees with the application process (“facilitated enrollers”) as well as through their local Medicaid office. Furthermore, recertification is annual, renewal forms can be mailed in, and FHP has no asset test. Finally, FHP enrollees will be eligible for a comprehensive set of benefits—nearly identical to the services available through CHP, but less rich than Medicaid’s benefits. FHP enrollees, like Medicaid recipients, will not pay premiums or copayments for services.

These features signal the state’s interest in establishing application and recertification procedures for FHP that pose fewer barriers to potential enrollment than Medicaid’s current eligibility determination system. However, because all of New York’s health insurance programs are so closely linked—most notably because individuals must be deemed ineligible for Medicaid before they can enroll in FHP or CHP—Medicaid’s enrollment process must be simplified and all three programs must be coordinated in order to ensure a streamlined application process for FHP.

This report looks at various features of the public health insurance systems in 13 other states—California, Colorado, Delaware, New Jersey, Massachusetts, Minnesota, Ohio, Oregon, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin—in order to glean lessons from these states’ experiences in designing and implementing their programs. These states were chosen primarily because of their similarity to New York with respect to the way their health insurance programs evolved and/or the populations their programs cover, though several of the study states were included because their health insurance programs have interesting or effective features that could be replicated in New York, even though the configuration of their programs bore only slight resemblance to New York’s health coverage system.

Information about health insurance programs in other states was obtained from structured interviews with officials administering these programs, researchers, and consumer advocates in those states; and a review of state statutes, regulations, Federal waiver requests, press accounts, and studies.

EXAMPLES OF STATE INNOVATIONS

Outreach and Marketing Strategies

Expansions of public health insurance programs do not automatically translate into broader coverage and better health care if eligible individuals are unaware of the programs, assume they do not qualify for coverage, or anticipate a demeaning application process. To overcome these barriers to enrollment, coverage programs must be vigorously promoted using messages that resonate with diverse target populations. To maximize their efficacy, these efforts must be coupled with a convenient and dignified application process.

New York’s efforts to boost enrollment in its existing health insurance programs have focused primarily on recruiting children into CHP. A multimedia campaign (at a cost of \$4 million in 2000) publicizes the availability of CHP. In addition, state-established facilitated enrollers conduct community-based outreach to educate families about CHP and children’s Medicaid, and to guide them through the application process.¹⁰ Before the

implementation of facilitated enrollment, contracted managed care plans, which market CHP and process program applications, and the state’s advertising campaign were largely the engines of that program’s enrollment growth. However, Medicaid for adults has never been promoted statewide—the program has no outreach or advertising budget—and Medicaid managed care health plans are generally prohibited from marketing the program.

The state plans to launch an outreach campaign for FHP using a portion of the funds that the FHP legislation sets aside for administrative activities, including outreach and facilitated enrollment.¹¹ In promoting FHP, the state will need to devise new strategies for appealing to adults—a population that has not been the target of its previous enrollment campaigns. Childless adults may prove particularly difficult to reach, since they often have no connection to the public benefits system.

The states examined for this report use a wide variety of approaches to market their health insurance programs, from statewide radio, print, and television ads, to community-level outreach and education. Children’s coverage programs tend to be promoted the most aggressively, but a number of states also employ innovative methods for appealing to adults. Several states have consolidated multiple programs with different funding streams under one health insurance program that is marketed as a single plan covering children and adults. States usually give these plans appealing names that make the programs sound like commercial insurance rather than public coverage, and they de-emphasize distinctions between the component programs like General Medical Assistance, the Children’s Health Insurance Program (CHIP), and Medicaid.

Following are strategies these states have employed to reach various populations, from families to single adults and childless couples.

- **Outreach to Adults.** New Jersey’s multi-pronged effort to publicize its NJ FamilyCare program targets all eligible populations: parents, childless couples, single adults, and children.

Though NJ FamilyCare actually comprises several programs with different eligibility guidelines, benefits, and cost sharing, New Jersey markets NJ FamilyCare as a single program. Promotional materials and the program’s Web site describe NJ FamilyCare as “affordable health coverage for kids, grown-ups, and just about everyone in between.” To illustrate the breadth of the program’s coverage, the NJ FamilyCare description is preceded by a picture of a variety of individuals and family arrangements standing along a tape measure: there is a toddler above the “XS” (i.e., extra small) mark on one end of the tape, a single

woman above “S” (small), a couple embracing above “M” (medium), and families above “L” and “XL” (large and extra large) at the right end. In addition to direct mailings to parents of children eligible for the former Medicaid and NJ KidCare programs (both of which have been folded into NJ FamilyCare), a statewide, multimedia campaign announced the transition of NJ KidCare to NJ FamilyCare and encouraged enrollment in the new program. The state advertised the program on buses, in movie theaters, and on the radio. TV ads for NJ FamilyCare, which were recorded in English and Spanish, alternated images of nontraditional program recipients like adult males with images of families and children.¹²

Tennessee hired a public relations firm to craft the TennCare promotional slogan, “It’s good for you, it’s good for Tennessee,” and to design billboards and radio and TV advertisements targeting a broad range of individuals beyond the state’s former Medicaid population. The marketing campaign appealed to single adults by featuring racecar drivers in its ads, and it reached out to minority families through ads with ministers and gospel singers on radio stations popular with minorities. Phone banks open seven days a week advised people who had questions that stemmed from the advertising campaign. In addition, TennCare hired adult males and other members of hard-to-reach target groups to educate residents of their communities about the program and to facilitate the application process.¹³

- **Intergovernmental Coordination.** A number of states allow agencies beyond those administering health insurance programs to use information in their databases to identify populations that are potentially eligible for subsidized health coverage.¹⁴ For example, the Minnesota Department of Human Services partnered with the State Department of Revenue (DOR) to mail health insurance information packets to 150,000 families who were enrolled in a DOR tax credit program with eligibility guidelines similar to MinnesotaCare’s. The packets included general information about the health insurance program, a toll-free number to request further information, and a stamped return card for application requests. This effort generated nearly 7,000 requests for applications.¹⁵ Similarly, Tennessee’s Health Department compared enrollment lists for several means-tested programs like Food Stamps with its Medicaid roster, and mailed a TennCare application to anyone who was not already enrolled in Medicaid.¹⁶ With a \$50,000 grant from the federal government, Middlesex County in New Jersey is identifying children whose parents cannot provide them with health insurance as part of their court-ordered support obligations. An “in-court facilitator” helps these parents determine whether their children are eligible for NJ FamilyCare and, when appropriate, guides them through the application process.¹⁷

The Massachusetts Division of Medical Assistance (DMA) partnered with several state agencies, including the Department of Education and the Department of Corrections, to design, produce, and distribute informational fliers promoting the MassHealth program to 1.5 million preschool and school-aged children.¹⁸

Finally, California and Washington use money allotted to them through the 1996 Federal Welfare Reform Law to provide grants to local governments to increase outreach to their Medicaid populations.¹⁹

- **Financial and Other Incentives.** Several states use monetary or product incentives to attract applications. As part of a NJ FamilyCare promotional campaign, New Jersey handed out coupons for free ice cream at Friendly’s shops and tickets for admission to the state aquarium to individuals who filled out a NJ FamilyCare application.²⁰ Rhode Island pays designated community-based agencies \$15–\$35 for each successful RItE Care application they submit to the state;²¹ California rewards certified application assistants \$50 for each application they submit that results in program enrollment;²² and Colorado pays satellite eligibility determination offices \$12.55 for each paper application and \$15 for each electronic submission.²³
- **Community-Based Outreach.** Some of the most effective strategies are implemented at the community level, where education and marketing campaigns can be tailored to local conditions and conducted by community residents and employees of trusted local organizations. Most of the states reviewed for this report encourage community organizations and businesses to hand out program literature and applications, and several train social service workers to counsel clients about their health insurance options. For example, Vermont Health Plan distributes program information through employers and commercial establishments like grocery stores,²⁴ and Massachusetts offers community-based organizations \$10,000–\$15,000 grants to publicize MassHealth and assist individuals in applying for coverage.²⁵ A number of state officials noted that health care facilities are particularly good venues for providing potential enrollees with health insurance information and counseling. Pharmacies in Vermont include literature about the state’s health program in the bags given to customers with their prescription medication orders,²⁶ and RItE Care places program information and applications in medical settings like community health centers and Planned Parenthood clinics—a strategy the state calls “inreach” and finds more helpful than traditional outreach efforts at health fairs and other community events.²⁷ Likewise, Oregon Health Plan administrators generate interest in their program by making literature and

applications available in 200 health care facilities across the state, including hospitals, family planning clinics, Federally Qualified Health Centers, and drug and alcohol centers.²⁸

- **Public–Private Partnerships.** Some states supplement their marketing campaigns with corporate-sponsored outreach activities. New Jersey, for example, has teamed up with businesses across the state to advertise NJ FamilyCare. ACME supermarkets distribute program flyers in English and Spanish in high-traffic areas in their stores, and they sponsor “enrollment days” during which NJ FamilyCare officials are in the stores’ pharmacies to answer customers’ questions about the application process. Pathmark and Eckerd pharmacies across the state also distribute program materials, and Pathmark stores have donated space on milk cartons to display NJ FamilyCare advertisements. Other corporate sponsors include Kmart, Wal-Mart, and McDonalds, all of which distribute program information in their stores.²⁹

In an alternative approach, Schering-Plough channels resources to its “adopted” city of Elizabeth, New Jersey, where it has distributed \$50,000 to local organizations that help children enroll in NJ FamilyCare; and the corporation supplied school nurses with laptop computers for accessing the program’s Web site and other on-line health information. Other pharmaceutical companies have established similar programs in their adopted towns.³⁰

Outreach and Marketing Strategies

New York

Children's Medicaid and Child Health Plus

- CHP promoted through statewide multimedia campaign (\$4 million in 2000) and product giveaways like Frisbees and refrigerator magnets
- Facilitated enrollers and health plans conduct community outreach
- Statewide toll-free information hotline
- Billboard ads, toll-free information hotline, mobilization of many city agencies to identify uninsured families, and telephone-based eligibility screening program for New York City residents (established through New York City Mayor's office)

Adult Medicaid

- Toll-free state and local information hotlines

Family Health Plus

- State plans to conduct extensive advertising and outreach campaign
- Facilitated enrollers and health plans will conduct local outreach

Reforms in Other States

- Multimedia campaigns stressing availability of health insurance to a broad range of populations
 - Advertising targeted specifically to hard-to-reach populations like minority single adults without children:
 - images of single, working adults in television and billboards ads
 - mailings to institutions with high proportion of single adults (e.g., colleges and universities)
 - advertisements in minority-focused media (radio and print)
 - Multiple health insurance programs given one appealing name and marketed as a single plan covering diverse populations
 - Use databases of other state agencies to mail health insurance information to recipients of programs with similar eligibility guidelines (e.g., food stamps and low-income tax credits)
 - Reward individuals who fill out program applications with coupons and product giveaways; pay facilitated enrollers for each complete application submitted on behalf of applicant
 - Post program information at local businesses and health care provider sites
 - Supplement state marketing efforts with corporate-sponsored outreach activities
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Simplification of Application and Enrollment Procedures

Effective outreach campaigns can generate interest in health coverage programs, but they will fail to boost enrollment if a complicated and time-consuming eligibility determination process discourages individuals from applying. Lengthy applications that must be completed at a government office and require individuals to produce numerous documents to verify the information they provide pose serious obstacles to enrollment, especially for working individuals who may lose wages during this process. Burdensome

requirements also increase administrative costs, complicate the efforts of eligibility workers and community organizations to help families apply for coverage, and may contribute to stigma about the programs.

New York has taken important steps in recent years to simplify enrollment in its children's health coverage programs, though additional reforms could further ease enrollment into these programs.³¹ The implementation of the streamlined Growing Up Healthy application, which screens children for Medicaid, CHP, and the Women, Infants, and Children (WIC) program, as well as the establishment of community-based enrollment sites, provide children with a single point of entry into Medicaid and CHP and a more convenient, family-friendly application process.

Less attention has been focused on streamlining the Medicaid application process for adults. With few exceptions, adults must submit to an in-person interview at a local district social services office (LDSS) if they live outside of New York City, or the Human Resource Administration (HRA) in New York City, complete a complicated, eight-page application, and provide significant documentation, including four consecutive pay stubs and proof of age, identity, citizenship status, residence, and Social Security number.³² In some instances, New York uses front-end fraud detection systems like Eligibility Verification Review³³ and applicant finger imaging, further adding to the complexity and humiliation of the application process. These requirements, many of which reflect Medicaid's history as a by-product of welfare and are not explicitly required by New York Medicaid law,³⁴ were designed mainly to identify applicants who may not qualify for coverage rather than ensure that individuals receive the benefits to which they are entitled. Finally, New York has not yet made full use of computer technology to simplify the application and enrollment processes for CHP and Medicaid, although state officials are exploring ways to automate application and enrollment procedures for CHP and children's Medicaid.³⁵

FHP should have a somewhat simpler application process than the current process for adult Medicaid because individuals will be able to apply for the program through community-based facilitated enrollers,³⁶ and enrollees will not need to establish that their assets and other non-income resources fall below a state-established standard.³⁷ In addition, the state will begin to use two applications, the Growing Up Healthy application for children, and a new, single application that screens children and adults for all three public health insurance programs.³⁸ However, the fact that FHP applicants first have to be deemed ineligible for traditional Medicaid, a program that requires enrollees to document their resources and to apply at an LDSS office, and that FHP's information system will be

integrated into Medicaid's but not CHIP's, may mitigate some of the benefits of FHP's more streamlined enrollment system.

Federal law gives states considerable flexibility to simplify Medicaid and CHIP enrollment procedures, and the U.S. Centers for Medicare and Medicaid Services (CMS, formerly HCFA) has assured states that they can exercise this freedom without compromising program integrity.³⁹ Specifically, federal law requires Medicaid applicants to provide only information concerning their citizenship status or lawful immigration status, Social Security number, and possible alternative sources of medical coverage.⁴⁰ The only documentation requirement is for non-citizens, who must produce proof of their immigration status. Furthermore, a provision of the 1996 federal welfare reform law provides funding to states at a 90 percent federal matching rate to, among other things, simplify the Medicaid application form and streamline the enrollment process.⁴¹ States have used this flexibility to simplify enrollment in their children's health insurance programs and, to varying degrees, streamline the application process for parents and childless adults. The most significant reforms employed by the states that were reviewed for this report include shortened applications that screen for several public programs, creation of a single point of entry into the health insurance system, elimination of face-to-face interviews, reduced documentation requirements, and automation of eligibility and enrollment processes.

Following are specific reforms that states have implemented to ease the process of applying for health insurance programs.

- **Streamlined Applications.** A number of states have dramatically reduced the length and complexity of their applications and created a single application pathway to multiple health coverage programs. These states typically eliminate questions that are not required by federal law, and some standardize definitions of elements like income and family size. For example, The California HealthCare Foundation, a philanthropic and research organization, contracted with experts in federal and state Medicaid law to review each element on its MediCal/Healthy Families application for pregnant women and children. The analysis revealed that California could eliminate or simplify many questions and still comply with federal and state requirements.⁴² California trimmed its application with the help of this and other similar analyses. Minnesota's four-page application—pared down from 21 pages and implemented in February 2000⁴³—screens applicants for Medicaid, MinnesotaCare, General Assistance Medical Care, and several health insurance programs for seniors and disabled individuals.⁴⁴ To the extent that program

guidelines differ between the programs or for various eligible populations, applicants are referred to additional questions attached as appendices.⁴⁵ Tennessee whittled down its TennCare application to a single page—one side contains questions and the other side instructions—with the help of a design team that field-tested draft forms with potential program recipients before producing the final version of the application.⁴⁶ Ohio uses a two-page combined program application for Healthy Start, Healthy Families, WIC, Child and Family Health Services, and Children with Medical Handicaps.⁴⁷ The NJ FamilyCare program has a single foldout application with three panels of questions and instructions that apply to all the NJ FamilyCare component programs.⁴⁸ Massachusetts's single application for health coverage screens for all of the component programs under the MassHealth umbrella as well as a smaller state-financed safety net program for children ineligible for Medicaid.⁴⁹

- **Mail-in Applications.** An increasing number of states have eliminated the requirement that individuals apply in person for health insurance coverage. For example, New Jersey abandoned its face-to-face interview requirement, enabling potential FamilyCare enrollees to fill out and mail in an application without visiting a government or community enrollment site or to apply by phone for NJ FamilyCare (provided they mail in relevant documents along with a completed and signed paper application, which is sent to them with a self-addressed, stamped envelope following the phone interview).⁵⁰ Several states, including Delaware, Massachusetts, Ohio, Oregon, and Rhode Island, allow mail-in applications for their child and adult health insurance programs.
- **Reduced Documentation.** Federal law gives states considerable flexibility to reduce the number of supporting documents individuals must produce when they apply for public health insurance programs. Some states have used this flexibility to reduce or nearly eliminate verification requirements. Ohio, for example, allows self-affirmations of age, identity, Social Security number, citizenship, living arrangement, and residence;⁵¹ MassHealth applicants are not required to provide a birth certificate and need only two pay stubs to verify their income.⁵² Vermont confirms applicant earnings through regular tape matches with the Internal Revenue Service and the Vermont Department of Employment and Training requires applicants only to verify claims that they are pregnant, disabled, or self-employed.⁵³

A number of states have eliminated their assets tests for health insurance applicants (except for those applying for Medicaid long-term care), which reduces the burden on both eligibility workers, who must review the documents, and those applying for coverage, who must produce the documents. Massachusetts partially credits the elimination of MassHealth's asset test in 1995 with a significant drop in the amount of time it takes the state to process applications. MassHealth officials note that asset verification was the most time-consuming task involved in determining eligibility, and served largely as a barrier to enrollment rather than a useful screening tool because applicants at lower income levels typically have no assets.⁵⁴ Ohio officials came to the same conclusion as did Oklahoma program administrators, who estimated that elimination of the asset test for Oklahoma saves the state over \$1 million annually.⁵⁵ In addition to improving the productivity of eligibility workers, elimination of the asset test makes it easier for states to adopt automated eligibility determination systems, establish Medicaid as a health insurance program separate from welfare, and lower overall administrative cost.⁵⁶ Other programs in the states studied for this report that have no asset test include Washington's Basic Health Plan, the NJ FamilyCare program, Rhode Island's RItE Care, Delaware's Diamond State Health Plan, and Wisconsin BadgerCare. In an alternative approach, Minnesota's "Delayed Verification" system gives very low-income individuals 30 days after they submit an application and are enrolled in the program to provide documentation to verify their income, assets, immigration status, Social Security number, residency, and child support payments.⁵⁷

- **Electronic Application and Enrollment.** An increasing number of states are using computer software programs and the Internet to facilitate enrollment in public health insurance programs. For example, Washington and New Jersey post program applications on their Web sites that individuals can download, complete, and mail from their homes, while Ohio residents can fill out applications on the computer, print them out, and mail them along with required documents.⁵⁸

Other states can process information that is transmitted electronically from eligibility workers in remote sites and determine immediately whether applicants qualify for health insurance or other public benefits programs. For example, Wisconsin's statewide automated mainframe program—the Client Assistance for Reemployment and Economic Support (CARES) system—takes county workers and their clients through an interactive interview that prompts the client to provide family, financial, and employment information. This information is transmitted to CARES, which uses it to determine eligibility electronically for

traditional Medicaid, BadgerCare, Food Stamps, child care, and Temporary Assistance for Needy Families (TANF). CARES also calculates the premium amount, if any, a family is required to pay to participate in BadgerCare and transfers this information to EDS, the Medicaid fiscal agent, which issues ID cards, enrolls families in HMOs, and establishes the premium payment method.⁵⁹ Delaware's more advanced system allows workers with minimal understanding of program guidelines to collect information from their clients and, through use of an electronic "cascading" system, immediately determine eligibility for Medicaid, food stamps, and TANF.⁶⁰

Colorado collaborated with Child Health Advocates, a nonprofit organization that administers the state's CHIP plan, to decentralize and automate the eligibility determination process for children's health coverage. This joint effort produced a system that enables staff located in 67 satellite eligibility determination sites—clinics, schools, community-based organizations, and others that contract with the state—to enter applicant information into a database where it is analyzed immediately for Child Health Plan Plus (CHP+) eligibility.⁶¹ In addition, potential applicants can log on to the Web site from any computer, enter basic eligibility information, and determine whether they and their family members are likely to be eligible for CHP+ or Medicaid, and the approximate premium they would be required to pay.⁶²

MassHealth's automated eligibility system, MA21, is largely credited with decreasing the average time it takes to process applications from 24.0 days in June 1997 to 3.3 days in June 1998. MA21 checks data on applications for completeness and invokes a series of "decision trees" that assess the applicant's eligibility for the various MassHealth benefit plans and determines which of these plans offers the applicant the most comprehensive coverage.⁶³

Several states are pilot-testing powerful Internet-based tools that streamline enrollment into health insurance programs. The state of California and two nonprofit organizations—the California HealthCare Foundation and the Medi-Cal Policy Institute—collaborated on an effort to electronically enroll pregnant mothers and children into the state's Healthy Families (CHIP) and Medi-Cal (California Medicaid) programs. Health-e-App is a Web-based application used by state Certified Application Assistants (CAAs) to help families apply for coverage.⁶⁴ CAAs are equipped with laptops with wireless Internet connections, electronic signature pads, and portable printers, allowing them to conduct enrollment in

schools, community centers, clinics and even applicants' homes.⁶⁵ The Web-based program prompts applicants on specific information that is needed to determine whether they qualify for coverage and delivers a real-time preliminary eligibility determination for Medi-Cal or Healthy Families. The application captures and submits applicants' signatures electronically. The system also produces a fax cover sheet and documentation verification checklist for applicants, who must fax a complete set of documents to the state's single point of entry for both programs. A bar code on the fax coversheet allows the documentation to be matched electronically with the appropriate application, keeping the transmission process paperless. Applications, signatures, and supporting documentation are electronically forwarded to the county for Medi-Cal or to the state for Healthy Families.⁶⁶ Families receive immediate, on-line feedback about their eligibility, and they are able to select physicians and health plans on-line, based on criteria like language capacity, medical specialty, and geographic accessibility. An independent business case analysis of the Health-e-App pilot test found that the automated Web-based system decreased the time between application submission and eligibility determination by 21 percent, reduced application errors by 40 percent, and resulted in over 90 percent of eligibility workers and consumers preferring the on-line application system to the traditional paper application process.⁶⁷

The Vermont Agency of Human Services is pilot-testing an Intranet-based system that allows individuals and families to apply on-line for more than 15 public programs that provide benefits ranging from health insurance to job training. Currently, one nonprofit agency is using the system; when it is fully operational, applicants will be able to use the system with the help of trained staff in outpost offices located across the state who have access to a restricted Web site. After the eligibility worker logs on to the site and enters the applicant's name, date of birth, and gender, the system identifies the person, indicates whether he or she is already in the database, and displays information on the screen for the applicant to update or supplement. The individual then provides information to the worker, who completes a series of questions relevant to these programs, prints out and signs a signature form, and mails it to the relevant agency. The information is stored in electronic files on a secure server; staff of the various programs for which the individual applied are notified by e-mail of the pending application, and can download the information from the Web site and process the applications.⁶⁸

- **Outstationed Enrollment Sites.** Several states have greatly expanded the number of locations where individuals can apply for coverage and receive

assistance in filling out forms. While applicants for the NJ FamilyCare program can complete and mail in the application on their own, they can also get assistance filling out forms at one of the 400 outreach and enrollment sites scattered throughout the state. These locations, which are listed by county on the NJ FamilyCare Web site, include local health departments, faith-based organizations, hospitals, schools, and city council members' offices. One New Jersey county alone has over 100 of these sites.⁶⁹ Likewise, BadgerCare applicants can apply for coverage at a wide variety of locations, including tribal agencies, county social or human service departments, and W-2 (Wisconsin Works) agencies; or one of 80 outstation sites, including disproportionate share hospitals (which receive additional government payments for the comparatively large share of care they provide to the poor and uninsured) and Federally Qualified Health Centers.⁷⁰

Simplification of Application and Enrollment Procedures

New York

Children's Medicaid and Child Health Plus

- Children's Medicaid, CHP, and WIC combined on streamlined Growing Up Healthy application
- Fewer documentation requirements than adult Medicaid
- No asset test
- Enrollment through community-based facilitated enrollers and health plans
- Medicaid requires in-person interview at LDSS/HRA or facilitated enroller site; CHP has no interview requirement
- Paper application and enrollment process

Adult Medicaid

- Lengthy (8-page) application
- Significant documentation requirements
- Asset test
- Requires in-person interview at LDSS/HRA
- Manual application and enrollment

Family Health Plus

- State is developing a single application for FHP, CHP, Medicaid, Family Planning, and WIC (will continue to use Growing Up Healthy application for children-only applications)
- No asset test (self-attestation if applying only for FHP; assets must be documented if uncertain whether eligible for Medicaid or FHP)
- Enrollment through community-based facilitated enrollers and LDSS/HRA
- Requires in-person interview
- No immediate plans for electronic application or enrollment

Reforms in Other States

- Simplified applications that screen for multiple health insurance programs and eliminate questions not required by federal law
 - Reduced documentation requirements through self-attestation of Social Security number, residence, age, family size, and income (verification through data matches with other government agencies)
 - Allow mail applications
 - No asset test for health insurance programs or allow self-attestation of assets
 - Electronic or Internet-based application and enrollment processes
 - Medicaid eligibility workers outstationed in disproportionate share hospitals and Federally Qualified Health Centers
-

Coordination of Multiple Insurance Programs

States with multiple public health insurance programs face unique challenges. Layering one program on top of another without careful coordination can create a fragmented system that results in gaps in coverage and disruptions in care. Variations among and within programs and their administrative structures add to the complexity of application and eligibility determination processes and make it difficult for families and individuals to navigate public programs. A coordinated public health insurance system promotes continuity of coverage and care, lower administrative costs, and less applicant and enrollee frustration with the system.

Since state lawmakers expanded children's health coverage, New York has been moving its children's Medicaid and CHP programs toward an integrated health insurance system with uniform enrollment procedures and continuous care, although the goal of a truly seamless children's health coverage system has not yet been realized.⁷¹ Historical differences remain in the programs' administrative structures, marketing strategies, benefits, program rules, application processes, and delivery systems. Furthermore, few attempts have been made to coordinate adult Medicaid with children's health insurance programs. The implementation of FHP will add another layer of complexity to this system and, perhaps more troubling, reverse some of the strides that have been made with respect to simplifying children's health programs. While FHP shares features of both CHP and Medicaid, it will introduce into the system a new set of eligibility standards and program rules, a new population of enrollees, unique documentation requirements, and additional responsibilities for facilitated enrollers. In addition, FHP will use Medicaid's information database, which is separate from CHP's information system, and family members who qualify for different programs may not be able to enroll in the same managed care plans or maintain their existing provider relationships if they transfer between programs, since participating health plans are not required to accept enrollees of all programs.⁷² A coordinated health insurance system allows states to channel limited resources away from program administration and toward the provision of health care to families in need.

The states examined for this report use a variety of strategies to coordinate their health insurance programs so that families and individuals can more easily navigate the system and experience fewer disruptions in care. Many have integrated their information systems so that there is either one database of enrollee information for multiple programs or interfaces between the separate databases. This enables program administrators to determine whether applicants for health coverage are already enrolled in a program and to shift enrollees more easily among programs. Coordination is also easier to achieve when one agency determines eligibility for all health insurance programs and when states align

application procedures, documentation requirements, program rules, service delivery systems, and eligibility redetermination processes.⁷³

Following is a sample of some of the most promising efforts that states have undertaken to coordinate coexisting health insurance programs.

- **Common Service Delivery Systems.** When different programs within a state contract with the same health care plans, individuals transferring between programs can maintain existing provider relationships and avoid unnecessary lapses in coverage, and family members in different programs can enroll in the same health plan. Recognizing this, Minnesota requires managed care organizations that wish to participate in any of three state-sponsored health care programs—MinnesotaCare, Medical Assistance, and General Assistance Medical Care—to accept enrollees from all three programs.⁷⁴ Likewise, Wisconsin’s BadgerCare, Healthy Start, and Medicaid programs use the same managed care plans, a common identification card, and a single point of entry into all three programs,⁷⁵ and all of Vermont’s health insurance programs use the same providers and service delivery networks.⁷⁶ A top priority of the Washington Basic Health Plan (BHP) is to provide seamless coverage for family members who are enrolled in different components of the program. To accomplish this goal, Washington created Basic Health Plan+ (BHP+), a Medicaid-funded program for children administered by BHP. Parents applying for BHP can enroll in the same managed care plans as their children in BHP+.⁷⁷
- **Alignment of Program Rules.** Eligibility determinations are simpler and less error-prone when a state’s health insurance programs use the same rules for calculating income, family size, and allowable deductions from income. Furthermore, the paperwork burden on applicants and program administrators can be reduced when programs have uniform and simplified verification and asset requirements.⁷⁸ Wisconsin’s Medicaid, Healthy Start, and BadgerCare programs have nearly identical disregards, deductions, non-financial requirements, and benefits packages, and the programs use a single “Forward” identification card.⁷⁹ Delaware’s Diamond State Health Plan and the Oregon Health Plan have a single eligibility level for all nonelderly adults—100 percent of the FPL—regardless of family status or other circumstances,⁸⁰ and Vermont’s health insurance programs have nearly identical benefits packages.⁸¹

- **Seamless Transitions Between Programs.** Some states have mechanisms that enable enrollees to transfer from one health insurance program into another without submitting a new application or experiencing a break in coverage. For example, MassHealth’s automated eligibility system, MA21, stores applicant information so that enrollees who lose eligibility for one of MassHealth’s component programs can be automatically screened and enrolled in another program without submitting a new application.⁸² Similarly, Wisconsin’s automated eligibility determination system, CARES, uses enrollee information stored in its database to move Medicaid enrollees automatically to BadgerCare without completing a new application.⁸³ When Minnesota’s Medicaid recipients are no longer eligible for the program due to excess income and/or assets, the counties, which administer Medicaid, automatically send the enrollee’s application electronically to MinnesotaCare, which shares a single management information system with Medicaid.⁸⁴ The integration of these information systems also helps to keep administrative costs low for both programs.⁸⁵
- **Common Administrative Agency.** Coordination is easier to achieve if a single agency administers multiple health insurance programs, or if agencies share administrative functions. For example, Minnesota achieves efficiencies by operating three programs—Medical Assistance, General Assistance Medical Care, and MinnesotaCare—out of a single office within the State Department of Human Services. This office oversees policies and operations for the programs and divides administrative functions among various units or “clusters” within the Department. For example, the Health Care Eligibility and Access cluster is charged with MinnesotaCare eligibility and enrollment operations, and the Purchasing and Service Delivery cluster negotiates and contracts with health plans and maintains a customer services office to assist enrollees.⁸⁶ Other examples include Wisconsin’s Department of Health and Family Services, which oversees both BadgerCare and Medicaid; the Division of Medical Assistance, which administers all of MassHealth’s component programs; and the Ohio Department of Job and Family Services, which administers both the Medicaid and CHIP portions of the Healthy Start and Healthy Families program.

Coordination of Multiple Insurance Programs

New York

Child Health Plus and Medicaid (for adults and children)

- NY recently instituted efforts to coordinate CHP and children's Medicaid:
 - CHP benefit package expanded to mirror Medicaid's benefits
 - single application screens for both CHP and children's Medicaid (as well as WIC)
 - children's Medicaid renamed "CHP A"
- Remaining differences between CHP and Medicaid (for adults and children):
 - Medicaid and CHP benefit packages vary
 - participating health plans vary across programs
 - CHP information database separate from and unconnected to Medicaid's database
 - adult Medicaid application separate from CHP and children's Medicaid application (though the state is developing a single, combined application for CHP, Medicaid, and FHP)
 - CHP marketed statewide; no statewide marketing of Medicaid
 - enrollment procedures, documentation requirements, and definitions of income, family size, and income disregards vary between programs
 - Medicaid administered separately from CHP
 - family members who participate in Medicaid managed care must be enrolled in the same health plan, but siblings enrolled in CHP do not need to enroll in the same plan

Family Health Plus

- NY has instituted efforts to coordinate FHP with Medicaid and CHP, but substantial differences remain between programs:
 - FHP benefits differ from Medicaid
 - FHP and Medicaid share a single information database, separate from CHP's
 - Enrollment through facilitated enrollers or LDSS/HRA
 - FHP has more documentation requirements than CHP and children's Medicaid, but less than adult Medicaid
 - Administered through Medicaid office (i.e., separate from CHP)

Reforms in Other States

- Benefit packages aligned across programs
 - Managed care plans required to participate in all public health insurance programs and provider networks are coordinated across programs
 - Single agency or office administers multiple programs
 - Participants who lose eligibility for one program are automatically screened and when appropriate transferred to another program
 - Definitions of income, family size, and income disregards aligned across programs
 - Multiple programs have single information database or interfaces between databases
 - Single point of entry into all public health insurance programs
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Recertification

Simplifying the application process is crucial to ensuring that eligible individuals can access public health insurance programs, but many states have found that maintaining enrollment is an equally important, and often daunting, challenge. Patients who disenroll from health insurance programs can experience gaps in coverage and more limited access to health care and case-management services to which they are entitled. High rates of enrollee “churning”—movement in and out of health insurance coverage—can often be traced to burdensome requirements for reestablishing eligibility. Enrollees may be asked to supply information about their income, family composition, or other circumstances, and to submit to an in-person interview to renew their coverage. Families who do not understand this process or find it too difficult and time-consuming may let their coverage lapse and reapply only when they need medical services.

While New York has moved aggressively in recent years to recruit children into Medicaid and CHP, like many other states, it experiences a troubling level of enrollee churning. A recent report found that one-half of Medicaid and CHP beneficiaries lose their insurance each year, though most still qualify for coverage.⁸⁷ A follow-up report by the same authors points to confusing, burdensome, and uncoordinated eligibility redetermination rules and procedures as major contributing factors.⁸⁸ For example, New York State requires CHP and adult Medicaid enrollees to recertify their eligibility annually or whenever their income or other circumstances change. These rules can result in permanent loss of insurance because of temporary income fluctuations. Children enrolled in Medicaid and adults enrolled in FHP are the only groups entitled to a full year of coverage.

Medicaid and CHP recertification involves completing lengthy forms containing questions that were asked during the initial application process and, in the case of adult Medicaid, supplying copies of documents that the state already has. While CHP enrollees can recertify by mail, most Medicaid recipients must submit to a time-consuming, face-to-face interview at the LDSS/HRA. The LDSS sends enrollees a letter assigning a specific date for each recertification interview. While some of these requirements may help to identify ineligible enrollees, they lead to far more disenrollment of those who still qualify for coverage.⁸⁹ FHP will allow recertification by mail,⁹⁰ but many other details of the eligibility redetermination process have not yet been determined.

Federal law and CMS guidance give states wide latitude to streamline their eligibility redetermination processes for Medicaid and CHIP. For example, states can dispense with face-to-face interviews, allow up to a year of continuous eligibility, shorten

redetermination forms and fill in information already available to the state, and ask the enrollee to send in a signed form with any changes noted.⁹¹ States seeking to improve retention rates in their public health insurance programs have used this flexibility to simplify recertification requirements. Some allow mail-in recertification and preprint the eligibility information provided on the original application so that clients need only report if their circumstances change. States have also reduced documentation requirements, limited eligibility redeterminations to no more than one time per year, and made it easier for enrollees to mail back recertification forms by providing them with self-addressed, stamped envelopes.

These and other key reforms implemented by the states examined for this report include the following:

- **Mail-in Recertification.** Delaware, Massachusetts, Minnesota, New Jersey, Ohio, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin allow beneficiaries to mail in recertification forms in lieu of a personal interview, and some of these states make it particularly easy for enrollees to comply with this requirement. For example, Minnesota’s recertification form is two pages (in the past, enrollees had to fill out the original four-page application), and New Jersey preprints information from the original application and asks only that the enrollee note changes and include one-month verification of income. New Jersey also includes a self-addressed, stamped envelope with the forms.⁹² Wisconsin is considering the testing of “no response” recertification, which would allow program administrators to renew coverage automatically if an enrollee fails to return a preprinted application. MassHealth is piloting “express renewal,” a new system designed to ease the current, annual process of recertifying health insurance coverage. Under this system, families enrolled in MassHealth longer than six months who have had no changes in income or health insurance status and do not receive cash assistance can recertify their eligibility at any time during the second six months of their enrollment in the program. Families can recertify their coverage through managed care organizations—for example, when they call their health plan to inquire about benefits—or at a clinical site when they arrive for a medical appointment. Enrollee information is verified through database matches, and those who are found eligible continue to receive health coverage for one year following the date of recertification. Massachusetts is in the process of expanding the number of community-based organizations where families can use the express renewal process.⁹³

- **Same-Day Recertification for Families.** Over half the states reviewed for this report allow entire families to recertify their health insurance coverage on the same date, even if family members are enrolled in different programs and/or applied for coverage on different dates. For example, Colorado redetermines eligibility for the entire family based on when the first child was certified for coverage,⁹⁴ while Wisconsin recertifies the entire family’s eligibility for health coverage if any family member’s eligibility needs to be confirmed for any of the state’s means-tested programs.⁹⁵ Oregon automatically recertifies coverage for the entire family if one new member joins either Medicaid or CHIP.⁹⁶
- **Enrollee Education and Outreach.** Recognizing that the concept, as well as the process, of reestablishing eligibility for health insurance may confuse program recipients, states have implemented mechanisms to educate enrollees about their recertification responsibilities. For example, enrollees may not understand that their coverage is time-limited or that an unintentional failure to comply with all recertification procedures, even though they still qualify for a program, could lead to a termination of coverage. New Jersey begins the education process when individuals first enter NJ FamilyCare by highlighting in the information packet given to new enrollees that they will need to renew their coverage annually. The notice uses terms that are likely to be familiar to program recipients, such as “renew” instead of “recertify.”⁹⁷ Similarly, Massachusetts uses the term “renewal” instead of “recertification,” and refers to enrollees as “members.”⁹⁸ NJ FamilyCare conducted a pilot program in which staff telephoned and paid home visits to those who were in danger of disenrolling—a system that New Jersey officials say has been responsible for a 50 percent increase in retention rates. As a result of this pilot program, New Jersey plans to create a “Retention Unit,” which will be responsible for keeping eligible individuals enrolled in NJ FamilyCare.⁹⁹ Vermont sends enrollees a reminder letter six months prior to the date they must renew their coverage. Enrollees who fail to respond to the letter receive another notice two months later, and further notices at shorter intervals of time until they mail in their recertification forms.¹⁰⁰

Recertification

New York

Child Health Plus and Children's Medicaid

- Children's Medicaid provides year-long, continuous coverage; CHP requires recertification whenever family circumstances change
- Medicaid enrollees must recertify in person at the LDSS/HRA or through facilitated enrollers, while CHP allows mail-in recertification
- Medicaid and CHP recertification combined on the Growing Up Healthy application
- Family members in different programs recertify on different dates

Adult Medicaid

- Adults must recertify in person at LDSS/HRA
- 8-page recertification form with significant documentation requirements

Family Health Plus

- Recertification through facilitated enrollers or LDSS/HRA
- Mail-in recertification allowed
- State plans to design streamlined recertification form

Reforms in Other States

- Streamlined, mail-in recertification forms with preprinted information from original application that beneficiary can modify to reflect changes in circumstances
 - Reduced documentation requirements
 - Same-day recertification for all family members
 - Efforts to educate enrollees about the recertification process as soon as they are accepted into a program
 - Terminology that is understandable to beneficiaries (e.g., “renew” vs. “recertify” and “member” vs. “enrollee”)
 - Resources dedicated specifically to reaching out to beneficiaries who are in danger of disenrolling
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CONCLUSION

The enactment of Family Health Plus (FHP), which calls for the single largest expansion of subsidized health insurance coverage in New York since the enactment of Medicare and Medicaid over 35 years ago, holds tremendous promise for reducing the ranks of the state's low-income working uninsured. It also provides New York with a valuable opportunity to review the outreach, enrollment, recertification, and coordination practices in its existing health insurance programs—CHP and Medicaid for children and adults—and adopt improvements to these programs and to FHP's design and implementation. Such an effort could improve CHP's and Medicaid's efficacy while ensuring that FHP reaches its full potential.

Fortunately, New York is neither the first nor the only state to face challenges with respect to assuring healthy enrollment and retention in its public health insurance programs. At least a dozen other states have tested a variety of reforms to their programs' procedures, and a growing body of literature documents the nature and success of these reforms. Likewise, many individuals who work directly with public health insurance programs have important insights about the efficacy of their states' policies. A review of successful strategies in states with similar public coverage systems, an assessment of whether and how particular innovations could be incorporated into New York's health insurance programs, and strategic thinking about how federal welfare reform grant money and other funding sources can be used to implement these innovations can help to guide New York as it implements FHP.

APPENDIX. SUMMARIES OF PUBLIC HEALTH INSURANCE PROGRAMS IN SELECTED STATES

Delaware: The Diamond State Health Plan uses a Section 1115 Medicaid waiver to cover nonelderly adults up to 100 percent of the Federal Poverty Level (FPL), pregnant women and infants up to 200 percent FPL, children through age 5 up to 133 percent FPL, and children through age 19 up to 100 percent FPL. It also uses State Children Health Insurance Plan (CHIP) funds to cover children with incomes up to 200 percent FPL who are not eligible for health insurance under the Medicaid waiver. Children with family incomes that exceed the Medicaid limit can enroll in the CHIP portion of the program and pay a sliding-scale monthly premium.

Massachusetts: MassHealth consists of several component programs supported by a Medicaid 1115 waiver, CHIP money, and state funds, including cigarette taxes. The three largest components of MassHealth are MassHealth Standard, which covers pregnant women and infants up to 200 percent FPL, children ages 1–18 up to 150 percent FPL, and parents up to 133 percent FPL; CommonHealth, which covers disabled children and adults who are not eligible for MassHealth Standard; and the Family Assistance program, which subsidizes premiums for families and childless adults with incomes up to 200 percent FPL who have access to state-approved employer sponsored insurance (ESI), and provides a direct coverage option for children with no access to ESI.

Minnesota: MinnesotaCare covers uninsured families with incomes up to 275 percent FPL and childless couples and single childless adults up to 175 percent FPL. Enrollees pay a sliding-scale premium based on income. A Section 1115 Medicaid waiver and a combination of state taxes, enrollee premiums, and copayments support the program. Certain low-income pregnant women and children are eligible for both MinnesotaCare and Medicaid and have the option to join either program.

New Jersey: NJ FamilyCare extends coverage to parents up to 200 percent FPL, children up to 350 percent FPL, and single adults and childless couples up to 100 percent FPL. A Section 1115 waiver, state funds, CHIP funds, and enrollee premiums support NJ FamilyCare. State-only dollars are used to cover legal immigrants on the same basis as citizens.

Ohio: Ohio's Healthy Start and Healthy Families programs combine Medicaid and CHIP funding to cover families up to 100 percent FPL and children up to 200 percent FPL.

Families with incomes between 150 percent and 200 percent FPL may have to pay a small annual premium to enroll their children in the program.

Oregon: The Oregon Health Plan (OHP) comprises several programs aimed at different segments of the uninsured population. These programs include OHP-Medicaid, which uses a Section 1115 Medicaid waiver to cover uninsured adults up to 100 percent FPL; OHP-CHIP, which uses CHIP funds to extend Medicaid benefits to children with incomes up to 170 percent FPL; and the Family Health Insurance Program, which provides subsidies to qualified individuals to help them pay for employer-sponsored coverage or health insurance sold in the individual market. Nonpregnant adults on OHP-Medicaid must pay a premium to participate in the program if they are eligible for the program through Oregon's Medicaid expansion.

Rhode Island: The RItE Care program uses its Section 1115 Medicaid managed care waiver to provide health coverage to parents with incomes up to 185 percent FPL, children up to 250 percent FPL, and pregnant women up to 350 percent FPL. Families with children enrolled in RItE Care may have to pay a small copayment or monthly premium in order to access health services. The RItE Care Share program provides premium assistance to individuals purchasing private insurance coverage.

Tennessee: TennCare combines federal, state, and local funds to provide health coverage to the state's low-income and uninsured population. Through a Section 1115 waiver, Tennessee moved all its Medicaid recipients to managed care and expanded the program to include the uninsured and medically uninsurable. Individuals without access to health insurance can enroll in the program but pay an income-based premium if they are over 100 percent FPL. TennCare, the largest of the 1115 Medicaid expansions in the country, has no income limit but has stopped new enrollment because of high program cost. The state is now contemplating whether to close or modify its program when its current 1115 waiver expires in December 2001.

Vermont: The Vermont Health Access Plan is a Section 1115 Medicaid waiver program that provides coverage to all uninsured adults up to 150 percent FPL. An amendment to the 1115 waiver extends coverage to uninsured parents and caretaker relatives with incomes up to 185 percent FPL. Children are eligible for coverage up to 300 percent FPL through Dr. Dynosaur, Vermont's children's Medicaid and CHIP expansion program. Some enrollees are asked to pay a sliding scale premium.

Washington: The state-funded Basic Health Plan (BHP) coupled with traditional Medicaid and several smaller programs provide subsidized coverage to individuals and families with incomes up to 200 percent FPL. Those with incomes over 200 percent FPL can join BHP by paying the full premium. Washington is using CHIP funds to expand Medicaid coverage to children with family incomes up to 250 percent.

Wisconsin: Through its Medicaid and BadgerCare programs, Wisconsin provides comprehensive health coverage to uninsured families with incomes up to 185 percent FPL and to enrolled families until their income exceeds 200 percent FPL. An 1115 waiver and CHIP funds support these programs. Beneficiaries with incomes above 150 percent FPL must pay a monthly premium equal to 3 percent of the family income. Certain families are eligible to have their premiums paid by the state and employer premiums through BadgerCare's Health Insurance Premium Payment Program. Wisconsin is one of three states to use CHIP funds to cover entire families through its subsidy program.

Public Health Insurance Programs in Selected States

State	Program Name	Group Covered	Program Structure and Financing	Program Web sites
Delaware	Diamond State Health Plan	Adults up to 100% FPL, pregnant women and infants up to 200% FPL, children through age 5 up to 133% FPL and through age 19 up to 100% FPL CHIP covers children up to 200% FPL (children who exceed the age-based Medicaid limit must pay a sliding scale premium)	Section 1115 Medicaid waiver, CHIP funds, and enrollee premiums.	http://www.state.de.us/dhss
Massachusetts	MassHealth*		Section 1115 Medicaid waiver, CHIP funds, and state funds.	http://www.state.ma.us/dma/
	MassHealth Standard	Pregnant women and infants up to 200% FPL, children ages 1-18 up to 150% FPL, parents up to 133% FPL		
	CommonHealth	Disabled children and adults not eligible for MassHealth Standard		
	Family Assistance	Families up to 200% FPL, childless adults up to 200% FPL	Section 1115 Medicaid waiver, employer and employee contributions, and CHIP funds.	
Minnesota	MinnesotaCare	Families up to 275% FPL, single childless adults and childless couples up to 175% FPL (all program participants pay a sliding-scale premium)	Section 1115 Medicaid waiver, state taxes, enrollee premiums and copayments.	http://www.dhs.state.mn.us/hlthcare/asstprog/mncare/
New Jersey	NJ FamilyCare	Parents up to 200% FPL, children up to 350% FPL, single adults and childless couples up to 100% FPL. Legal immigrants covered on the same basis as citizens (some participants have to pay a sliding-scale premium)	Section 1931 authority, Section 1115 Medicaid waiver, state funds, CHIP funds, enrollee premiums.	http://www.NJFamilyCare.org
Ohio	Healthy Start and Healthy Families	Families up to 100% FPL, children up to 200% FPL (children between 150% and 200% FPL may pay a sliding-scale premium)	Section 1931 authority, Section 1115 Medicaid waiver, CHIP funds, and enrollee premiums.	http://www.state.oh.us/odjfs/ohp/bcps/hshf/index.stm

* The remaining two components of MassHealth are MassHealth Basic, which covers those who are chronically unemployed and have no access to health coverage, and MassHealth Buy-In, which provides premium assistance to those who are chronically unemployed and have access to health insurance for which they have to pay a premium.

State	Program Name	Group Covered	Program Structure and Financing	Program Web sites
Oregon	Oregon Health Plan (OHP)		Section 1115 Medicaid waiver, state funds, CHIP funds, and enrollee premiums.	http://www.omap.hr.state.or.us/
	OHP-Medicaid	Adults up to 100% FPL (non-pregnant participants pay a sliding-scale premium)		
	OHP-CHIP	Children up to 170% FPL		
	Family Health Insurance Program	All Oregon residents may qualify for subsidies to purchase employer-sponsored or individual-market health insurance (actual enrollment depends on state's budget)		
Rhode Island	RIte Care	Parents up to 185% FPL, children up to 250% FPL, pregnant women up to 350% FPL	Section 1931 authority, Section 1115 Medicaid waiver, CHIP funds, and enrollee premiums.	http://www.dhs.state.ri.us/dhs/famchild/mrtcare.htm
	RIte Care RI Share	Provides premium assistance to qualified individuals purchasing private insurance coverage		
Tennessee	TennCare	All adults and children, subject to state funding requirements; currently no new enrollment (participants > 100% FPL pay a sliding-scale premium)	Section 1115 Medicaid waiver, state funds, CHIP funds, local funds, and enrollee premiums.	http://www.state.tn.us/health/tenncare/
Vermont	Vermont Health Access Plan	Adults up to 150% FPL, uninsured parents and caretaker relatives up to 185% FPL, children up to 300% FPL (some participants pay a sliding-scale premium)	Section 1115 Medicaid waiver, CHIP funds, and enrollee premiums.	http://www.dsw.state.vt.us/
Washington	Basic Health Plan (coupled with traditional Medicaid and several smaller programs)	Adults up to 200% FPL, children up to 250% FPL (participants > 200% FPL pay full premium)	State funds, Section 1115 Medicaid waiver, CHIP funds, and enrollee premiums.	http://www.wa.gov/hca/basichealth.htm
Wisconsin	BadgerCare and Medicaid	Applying families up to 185% FPL; enrolled families up to 200% FPL (participants > 150% FPL pay a premium 3% of their income)	Section 1115 Medicaid and 1115 CHIP waivers, CHIP funds, and enrollee premiums.	http://www.dhfs.state.wi.us/badgercare/
	BadgerCare's Health Insurance Premium Payment Program	When cost-effective, BadgerCare subsidizes a qualified employer-sponsored insurance plan	CHIP funds and employer premiums.	

NOTES

¹ *New York State Request for a Section 1115 Waiver Amendment*, New York State Department of Health, June 30, 2000.

² *Ibid.*; M. Dutton, K. Chin, and C. Hunter-Grant, *Creating a Seamless Health Insurance System for New York's Children*, The Commonwealth Fund, February 2001.

³ A number of studies document barriers to enrollment and retention in public health insurance programs, including M. Perry et. al. *Medicaid and Children: Overcoming Barriers to Enrollment*, prepared for the Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, January 2000; *Barriers to Medicaid: Challenges and Opportunities for New York*, a report prepared by Care for the Homeless in collaboration with Greater Upstate Law Project and the Commission on the Public's Health System, March 2001; and Kalkines, Arky, Zall & Bernstein LLP, *Coverage Gaps: The Problem of Enrollee Churning in Medicaid Managed Care and Child Health Plus*, New York State Coalition of Prepaid Health Service Plans, June 2000.

⁴ *Supra* note 3.

⁵ *Ibid.*

⁶ *Supra* note 3 (Kalkines).

⁷ *Supra* note 1 and conversation with Kathryn Kuhmerker, New York State Department of Health, March 13, 2001.

⁸ Kalkines, Arky, Zall & Bernstein LLP, *Closing Coverage Gaps: Improving Retention Rates in New York's Medicaid and Child Health Plus Programs*, New York State Coalition of PHSPs, December 2000.

⁹ Pregnant women in New York are eligible for Medicaid coverage if they have incomes up to 200% FPL, a higher level than for nonpregnant adults, through the Medicaid Prenatal Care Assistance Program (PCAP).

¹⁰ *Supra* note 2 (Dutton).

¹¹ N.Y. Pub. Health Law § 2807-v (1)(d).

¹² Telephone conversations with Michelle Walsky, New Jersey Department of Human Services, November 2000, June 2001.

¹³ Telephone conversation with Gordon Bonnyman, Tennessee Justice Center, September 2000.

¹⁴ Of course, confidentiality concerns must be addressed when agencies exchange sensitive information. However, data sharing among agencies is not a new practice. New York and other states routinely verify information provided on applications for public programs by cross-matching it with information from other agencies' databases. But while agencies cooperate to weed out potentially ineligible individuals, they rarely share information for the purpose of encouraging people to apply for benefits. Allowing agencies to share information for purposes of identifying individuals potentially eligible for public programs does not necessarily introduce a new set of concerns.

¹⁵ *Interagency Partnership with the Minnesota Department of Revenue*, Minnesota Department of Human Services, July 2000.

¹⁶ *Supra* note 14.

¹⁷ “NJ Department of Human Services and Middlesex County to Create Program for Linking Children to NJ FamilyCare through Family Division of Superior Court,” *New Jersey Department of Human Services Press Release*, November 29, 2000.

¹⁸ Agency for Healthcare Research and Quality, “Massachusetts’ MassHealth Program: Outreach Strategy,” *State Children’s Health Insurance Program: Implementing Effective Programs and Understanding Their Impacts*, January 30, 2001. See http://www.ahcpr.gov/chip/content/outreach_enrollment/outreach10.htm.

¹⁹ M. O’Brien et al., *State Experiences with Access Issues Under Children’s Health Insurance Expansions*, The Commonwealth Fund, May 2000; Supra note 42.

²⁰ Supra note 12.

²¹ *RItE Care Outreach Report*, Center for Child and Family Health, Rhode Island Department of Human Services, October 2000; and telephone conversation with Lisa Dimauro, Rhode Island Department of Human Services, November 2000.

²² E-mail communication with Claudia Page, Medi-Cal Policy Institute, April 2001.

²³ “Eligibility, Enrollment, and Cyberspace,” *State Coverage Initiatives*, Number 2, July 2000.

²⁴ Telephone conversation with Julie Rollo, Vermont Department of Prevention, Assistance, Transition, and Health Access, November 2000.

²⁵ *MassHealth 1115 Demonstration Project Draft Annual Report*, Massachusetts Division of Medical Assistance, May 28, 1999.

²⁶ Supra note 24.

²⁷ Telephone conversation with Joan Obara, Rhode Island Department of Human Services, September 2000.

²⁸ Telephone conversation with Jim Rowland, Oregon Department of Human Services, September 2000.

²⁹ See NJ FamilyCare’s Web site at <http://www.njfamilycare.org>.

³⁰ *Ibid.*

³¹ Supra note 2 (Dutton).

³² NYS Medicaid Reference Guide, Documentation Requirements Chart, DSS-2642, Attachment 1; Supra note 3 (Care for the Homeless).

³³ The Eligibility Verification Review (EVR) system, implemented in 1995, assesses applicants’ eligibility for public assistance, including Medicaid, through an office interview, home visits, and data matches with state and Federal databases to verify an applicant’s income, identity, and resources. See <http://www.nyc.gov/html/hra/home.html>.

³⁴ Under federal and state law, New York can verify an applicant’s eligibility for public health insurance by comparing answers on the application with federal and state databases like the Income and Eligibility Verification System and the Systematic Alien Verification System. See N.Y. Soc. Serv. Law §366-1 (8); Supra note 3 (Care for the Homeless).

³⁵ Letter from Statewide Coalition of Covering Kids to Judith Arnold, New York State Department of Health (DOH), in support of DOH’s joint application with The Children’s Defense Fund New York to the Robert Wood Johnson Foundation for a continuing grant under the Covering Kids and Families initiative to “explore the use of technology to improve enrollment efficiencies” in health insurance programs for children and their parents, June 19, 2001.

³⁶ Supra note 1.

³⁷ N.Y. Soc. Serv. L § 369-ee (2)(b).

³⁸ Communication with Marilyn Desmond, New York State Department of Health, May 2001.

³⁹ T. Westmoreland, *Letter to State Quality Control Directors*, September 12, 2000.

⁴⁰ *Supra* note 3 (Care for the Homeless).

⁴¹ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-93); Federal Register, Vol. 62 No. 93, May 14, 1997.

⁴² *Opening the Door: Improving the Healthy Families/Medi-Cal Application Process*, a report prepared by the Center on Budget and Policy Priorities in collaboration with the Medi-Cal Policy Institute, October 1998.

⁴³ 2000 Minnesota Low Cost Health Care Directory, Children's Defense Fund Minnesota, June 22, 2001. See <http://www.cdf-mn.org/HCCareDir2000.htm>; and e-mail communication with Cyndi L. Moosbrugger, Minnesota Department of Human Services, July 2001.

⁴⁴ *Health Care Access*, Minnesota Department of Human Services, July 12, 2000; Health Care Programs Application, Minnesota Department of Human Services.

⁴⁵ It is worth noting that in response to complaints by senior citizens applying for public health insurance, Minnesota is designing a separate application for seniors that will eliminate questions irrelevant to this population and enlarge the application typeface.

⁴⁶ J. I. Thorne, B. Bianchi, G. Bonnyman, C. Greene, T. Leddy, "State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island," *Health Care Financing Review* 16 (Spring 1995): 130.

⁴⁷ *Healthy Start, Healthy Families Combined Programs Application*, Ohio Department of Job & Family Services. The program application and requirements can be found at <http://www.state.oh.us/odjfs/ohp>.

⁴⁸ *New Jersey FamilyCare Application*, New Jersey Department of Human Services. See <http://www.njfamilycare.org>.

⁴⁹ *MassHealth Medical Benefits Request Application*, Massachusetts Division of Medical Assistance.

⁵⁰ *Supra* note 12.

⁵¹ *Supra* note 47.

⁵² *Supra* note 25.

⁵³ Vermont Department of Prevention, Assistance, Transition, and Health Access, <http://www.dsw.state.vt.us/docs/dsw2000.htm>, October 31, 2000.

⁵⁴ *Supra* note 24.

⁵⁵ V. Smith, E. Ellis, C. Chang, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, Kaiser Commission on Medicaid and the Uninsured, April 2001.

⁵⁶ *Ibid.*

⁵⁷ *Simplifying Health Care Programs Enrollment and Renewal for Applicants and Enrollees*, Minnesota Department of Human Services, Bulletin #00-21-1, January 18, 2000.

⁵⁸ *Supra* notes 30 and 48; Washington Basic Health Plan application can be found at <http://www.wa.gov/hca/basichealth>.

⁵⁹ Wisconsin Division of Health Care Financing, *State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act for Wisconsin*, March 31, 2000.

⁶⁰ Medical Assistance Program, Division of Social Services, *State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act for Delaware*, March 15, 2000; and telephone conversation with Maryann Nadzio, Delaware Health and Social Services, September 2000.

⁶¹ Colorado still requires a paper application to be completed, however, because an original signature must be obtained.

⁶² "State Coverage Initiatives," *States Extend Pharmaceutical Coverage*, Number 2, July 2000.

⁶³ Supra note 25.

⁶⁴ "California's Health-e-App: Easing Eligibility Determination," *Sign Them Up*, Children's Defense Fund, Spring 2001.

⁶⁵ The Health Strategies Consultancy, *State Public Benefit and CHIP Information Technology (IT) Initiatives*, Washington, D.C., March 2001.

⁶⁶ A demonstration of the Health-e-App along with information about the application and pilot sites can be found at <http://www.healtheapp.org>.

⁶⁷ B. Atlas, L. Chimento, and P. Shukla, *Business Case Analysis of Health-e-App: A Web-Based Enrollment Application for Public Health Insurance Programs*, The Lewin Group, June 2001. A copy of the report can be found at <http://www.healtheapp.org>.

⁶⁸ The common application and a demonstration can be found at Vermont's Agency of Human Services Web site <http://www.ahs.state.vt.us>; Eileen Underwood of Vermont's Agency of Human Services provided additional information about the Web-based application process.

⁶⁹ Supra note 48.

⁷⁰ J. Alberga, "Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage," *State Coverage Initiatives Case Study*, January 2001.

⁷¹ Supra note 2 (Dutton).

⁷² New York State Department of Health, "Questions and Answers: Recruitment of Family Health Plus Plans: Phase 1," February 20, 2001.

⁷³ C. Mann, D. Cohen Ross, and L. Cox, *Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children*, Center on Budget and Public Priorities, February 2000.

⁷⁴ L. Summer, *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs*, The Commonwealth Fund, April 1998; and e-mail communication with Jill Hovick and Cynthia Moosbrugger, Minnesota Department of Human Services, July 2001.

⁷⁵ Supra note 70.

⁷⁶ Vermont Statewide Health Reform Demonstration Fact Sheet, Centers for Medicare and Medicaid Services, <http://www.hcfa.gov/medicaid/vtfact.htm>; and telephone conversation with Ann Rugg, Vermont Office of Prevention, Assistance, Transition, and Health Access, November 2000.

⁷⁷ Supra note 19 (O'Brien).

⁷⁸ Supra note 73.

⁷⁹ Supra note 70.

⁸⁰ J. Alberga, L. DeFrancesco, S. Molinari, B. Wheatley, *State of the States*, produced for State Coverage Initiatives, January 2001.

⁸¹ Supra note 24 and 76.

⁸² Supra note 25 and telephone conversation with Michael Miller, Massachusetts Health Care for All, March 2001.

⁸³ Telephone conversation with Jim Jones, Wisconsin Department of Health and Family Services, October 2000.

⁸⁴ *DHS Introduced Retroactive MinnesotaCare for Individuals Leaving MA and GAMC*, Minnesota Department of Human Services, Bulletin #00-21-3, June 27, 2000.

⁸⁵ Supra note 74.

⁸⁶ Ibid.

⁸⁷ Supra note 3 (Kalkines).

⁸⁸ Supra note 8.

⁸⁹ Ibid.

⁹⁰ Supra note 1.

⁹¹ T. Westmoreland, State Medicaid Director Letter, April 7, 2000. This letter can be found at <http://www.hcfa.gov/medicaid/smd40700.htm>.

⁹² Supra note 12.

⁹³ Telephone conversation with Josh Greenberg, Massachusetts Health Care for All, June 2001.

⁹⁴ Telephone conversation with Al Hawker, Child Health Advocates, September 2000.

⁹⁵ Telephone conversation with John Haine, Wisconsin Department of Health and Family Services, September 2000.

⁹⁶ Supra note 28.

⁹⁷ Supra note 12.

⁹⁸ Telephone conversation with Mike Richards, Massachusetts Division of Medical Assistance, September 2000.

⁹⁹ Supra note 12.

¹⁰⁰ Supra note 24.

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#458 *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

Medicaid Managed Care in New York City: Recent Performance and Coming Challenges (March 2001). Derek DeLia, Joel C. Cantor, and David Sandman. *American Journal of Public Health*, vol. 91, no. 3. Copies are available from Derek DeLia, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399, E-mail: ddelia@uhfnyc.org.

#444 *Creating a Seamless Health Insurance System for New York's Children* (January 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

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#378 *Using Community Groups and Student Volunteers to Enroll Uninsured Children in Medicaid and Child Health Plus* (March 2000). Melinda Dutton, Sarah Katz, and Alison Pennington, Children's Defense Fund—New York. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

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#264 *The Commonwealth Fund Survey of Health Care in New York City* (March 1998). David R. Sandman, Cathy Schoen, Catherine DesRoches, and Meron Makonnen. This survey of more than 4,000 New York City residents, conducted by Louis Harris and Associates, Inc., found that a New Yorker was 50 percent more likely to be uninsured than the average American, that the vast majority of the City's uninsured live in working families and have low incomes, and that the City's public hospitals, emergency rooms, and clinics provide an important safety net for the uninsured.