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November 2009

ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

Uninsured And Eligible for Public Coverage:

Underlying Causes And Policy Solutions

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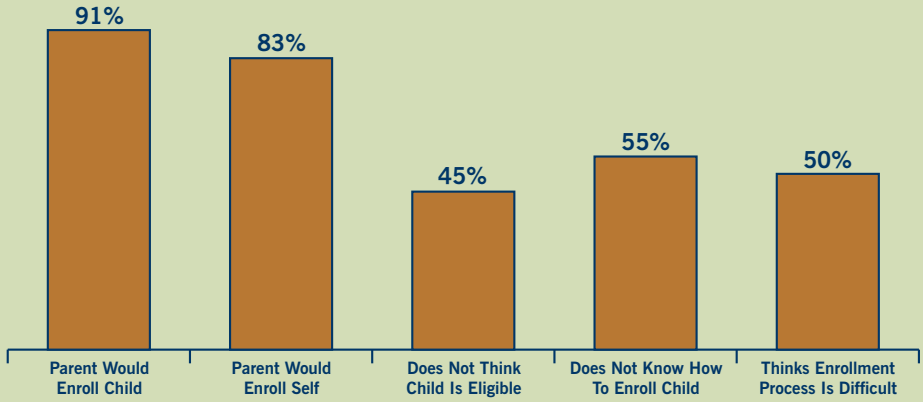
The most recent Census Bureau data indicate that more than 46 million people in the United States lacked health insurance coverage in 2008. Prior research has shown, however, that millions of those without health insurance are actually eligible for existing public coverage.[1] New estimates based on 2007 data indicate that approximately two in every three uninsured children — or about 5 million children — appear to have been eligible for public coverage but were not enrolled. While only 30 percent of uninsured parents and 10 percent of uninsured childless adults were eligible for public coverage, another 5.9 million people could have been covered by enrolling these eligible adults.[2]

In this essay I describe the important role of public health insurance programs, discuss why eligible individuals are not enrolled and offer thoughts on how recent and pending policy changes could address this problem.

Figure 1. Perceptions of Public Coverage Among Low-Income Parents



Sources: Kaiser Commission on Medicaid and the Uninsured. Tabulations from the 2007 Kaiser Survey of Children's Health Coverage. Kenney G, Haley J, Pelletier J. "Health Care for the Uninsured: Low-Income Parents' Perceptions of Access and Quality." Covering Kids and Families Evaluation, RWJ Foundation, Princeton, NJ, October 2009.

The Role of Public Health Insurance

The Medicaid eligibility expansions of the 1980s and the creation of the Children's Health Insurance Program (CHIP) in 1997 greatly increased the number of children and pregnant women eligible for public health insurance. These expansions, coupled with investments in outreach and enrollment simplification, led to dramatic enrollment increases in public programs and corresponding reductions in uninsurance among these groups.

In contrast, public coverage for parents and childless adults remains much more limited.[2, 3] Currently, only 16 states provide full Medicaid benefits to working parents with incomes above the federal poverty level (FPL), and only six extend this coverage to low-income non-disabled, non-pregnant childless adults under age 65. While improving program enrollment rates among eligible parents and childless adults can certainly help to reduce uninsurance, the larger issue for these populations is that they are rarely eligible for public coverage to begin with.

Families Want to Enroll, But Face Barriers

Medicaid and CHIP have achieved higher participation rates than other means-tested programs, especially for children.[4] Low-income families have generally positive perceptions of public coverage. Very few say that insurance coverage is not needed or that enrollment in a public program is not desirable.[5] About nine in ten low-income parents say they would enroll their uninsured child in Medicaid or CHIP if told their child were eligible, and similar responses are given by uninsured low-income parents when asked about their own enrollment in a public program (Figure 1).

Despite this interest, families face numerous barriers to enrolling in these programs and to staying enrolled. These barriers include the time and non-monetary costs to complete the application and renewal processes as well as real money costs of premiums that may be required as incomes rise above the FPL.

Parents' lack of knowledge about program eligibility is a critical barrier to enrollment for children, with almost half (45 percent) of low-income families not knowing if their uninsured children are eligible for coverage. Even when aware of program eligibility, over half do not know how to enroll their children, and half think the enrollment processes are difficult. Confusion about eligibility requirements, difficulty communicating with eligibility workers due to language barriers, and concern about immigration status likely pose additional challenges for eligible children who are citizens but who have non-citizen parents.[6]

Some Success, but More to be Done

Increasing participation in Medicaid and CHIP requires addressing existing knowledge

and enrollment barriers at both the state and federal levels with the ultimate aim of making enrollment and retention more automatic.

Different strategies have been utilized to overcome enrollment and retention barriers, and successes in several states illustrate the importance of addressing these barriers in a holistic way. For example, Louisiana reduced the number of children who lost coverage for administrative reasons at the time of renewal to less than 1 percent of total Medicaid/CHIP enrollment by automating as much of the process as possible, relying on third-party data to renew eligibility, allowing renewal by phone or online and actively following up with parents as needed to obtain additional information. Renewal forms were a last resort, used only when all other methods failed.[7] And, working within the context of an individual mandate and generous subsidies, Massachusetts has achieved high rates of participation in publicly-funded coverage through a multi-faceted approach that included an extensive public relations campaign, funding for community-based outreach and enrollment, incentives for providers to enroll patients into subsidized coverage, automatic eligibility strategies and a streamlined and integrated application and eligibility-determination system that allows most eligible, low-income households to enroll without completing application forms.[8]

Several other cities and states are using innovative "data sharing" approaches to find and enroll eligible but uninsured residents.[9] For example, Iowa, Massachusetts, Maryland and New Jersey have added questions about health insurance status to their tax forms, giving them an opportunity to send families information on public coverage or automatically enroll families in programs based on reported income and insurance status. Other localities find potentially-eligible children by using lists of people participating in other income-support programs such as food stamps and the school lunch program.

Despite these successes, there is still much room for improvement. Fewer outreach, enrollment and retention efforts have been made in Medicaid than in CHIP and for adults compared to children.[3] In addition, state and local funding for outreach and enrollment efforts, such as community-based enrollment workers, is not consistently maintained, especially during recessionary periods.[3] Likewise, while data sharing approaches show promise, a lack of federal guidance and funding for changes to data systems, along with other procedural difficulties, has limited the move toward this type of automatic or "express lane" enrollment.[9]

Figure 2. CHIPRA "Five of Eight" Provisions

- Eliminate in-person interviews for application and renewals
- Eliminate asset tests or simplify verification of assets
- Use administrative or *ex parte* verification of ongoing eligibility at time of renewal
- Adopt presumptive eligibility while a final eligibility decision is pending
- Adopt 12-month continuous eligibility regardless of changes in financial status
- Use same application and renewal forms and verification procedures for Medicaid and CHIP
- Offer "Express Lane" eligibility based on eligibility for other government programs
- Offer premium assistance to support enrollment in employer coverage

Outlook for the Future

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) took several steps to increase enrollment in Medicaid and CHIP. The federal CHIP allotments were increased to help states maintain existing CHIP caseloads and expand them further. CHIPRA also included a number of provisions aimed at increasing participation among children already eligible for Medicaid and CHIP, including: new performance bonuses for states that adopt five of eight simplification/outreach processes (Figure 2) and exceed Medicaid enrollment targets; $100 million for outreach and enrollment grants; higher federal match rates for translation and interpretation services; and new options for express lane eligibility and complying with citizenship documentation requirements.

It is still too early to assess the impact of the new CHIPRA provisions. While current state budget shortfalls may make states reluctant to enact policies that increase enrollment in public programs, the higher federal Medicaid match rates that were approved in the American Recovery and Reinvestment Act of 2009 could help them maintain or even expand program enrollment, at least in the near term. Beyond these ad hoc infusions of funds, however, Medicaid funding rules may need to incorporate automatic increases in federal match rates during recessionary times to help states meet the greater need for public coverage that arises during economic downturns.

Under our current system, enrolling more of the uninsured children who are already eligible for public coverage would substantially reduce uninsurance rates among children. The story is quite different for adults, where addressing coverage shortfalls will require sizeable policy changes, such as the Medicaid expansions, new subsidies and individual mandate recently enacted in Massachusetts and now under consideration at a national level. The lesson from years of experience under Medicaid and CHIP and now from the broader reforms in Massachusetts is that the structure of the enrollment and reenrollment processes will be critical to the success of initiatives to expand coverage. Policies that provide coverage and subsidies as automatically as possible will minimize burdens on families and ultimately be most successful. ■

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