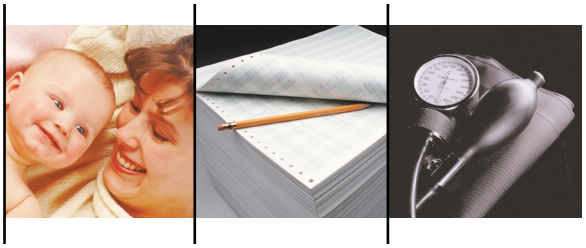
Issue Brief
Findings from HSC



COMMUNITIES PLAY KEY ROLE IN EXTENDING PUBLIC HEALTH INSURANCE TO CHILDREN

by Laurie E. Felland and Andrea M. Benoit

Nearly all low-income children are now eligible for public health insurance coverage through Medicaid or the State Children's Health Insurance Program (SCHIP), but millions of eligible children still lack coverage. Increasingly, states have turned to local communities to assist with SCHIP outreach. The Center for Studying Health System Change's (HSC) recent site visits to 12 nationally representative communities found many organizations not traditionally involved in public health insurance activities—such as schools, employers and religious and community groups—playing important outreach roles. Local social service agencies, health departments and providers also are helping children gain coverage. For policy makers seeking to increase enrollment, these community efforts offer a valuable road map. Local SCHIP outreach generally is considered successful but is costly. And, state budget shortfalls and reduced federal SCHIP funding could threaten outreach efforts.

States Partner with Local Organizations

Approximately 2.7 million children were enrolled in SCHIP in December 2000—the most current monthly enrollment information available—but more than 2 million children likely were eligible but not enrolled.[1,2] Additionally, The Urban Institute reports that lack of information, confusion about eligibility requirements and administrative hassles create significant barriers to SCHIP enrollment.[3] And, a recent HSC study indicates improved outreach, rather than additional eligibility expansions, is key to extending coverage to low-income children.[4]

Over the past two years, states have turned increasingly to communities to help identify and enroll eligible individuals in SCHIP, which allows states to expand coverage to children in families whose income is too high for Medicaid but too low to afford private health insurance. States may structure SCHIP as a separate program or a Medicaid expansion to provide coverage to children in families with incomes up to 200 percent of the federal poverty level—about $35,000 for a family of four in 2001—or higher. To reduce the stigma often associated with government programs, states have worked to show that public health insurance is no longer linked to welfare and to create more user-friendly programs. For example, many states have made their programs appear more like commercial health plans by giving them names such as Washington state's Healthy Kids Now and providing enrollees with insurance cards resembling private plans'.

Despite these features and ambitious mass-media campaigns to promote SCHIP, many states initially struggled to enroll children. In response, states have streamlined application processes and provided funding and training to local organizations to generate awareness about SCHIP, identify eligible children and help them apply. In many communities, health departments, local social service agencies that administer

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NO. 44 • OCTOBER 2001

Data Sources and Methodology

The role of local organizations in SCHIP outreach was one of several special study topics in HSC's 2000-01 sites visits to 12 nationally representative communities. The 12 sites are Boston; Cleveland; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Greenville, S.C.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

Researchers interviewed individuals in each community who are involved directly or indirectly in outreach, including representatives of state government and health agencies, local health departments, SCHIP agencies, consumer advocates, health care providers and plans. This Issue Brief is based on a systematic analysis of these individuals' personal assessments of local SCHIP outreach, formal evaluations and informal tracking at participating organizations.

SCHIP and Medicaid or consumer advocacy groups coordinate outreach and subcontract with other organizations, which are often unaffiliated with welfare programs. The HSC site visits found a broad array of local organizations—including health providers, schools, employers and community and religious groups—highly involved in targeting hard-to-reach children.

Preliminary observations of state and local leaders working with SCHIP suggest local organizations can play an important role in boosting enrollment in public programs. A number of states and communities report significant strides in enrollment over the past year. Because outreach for SCHIP and Medicaid often are intertwined and states are required to first screen SCHIP applicants for Medicaid eligibility, many respondents reported that SCHIP outreach also has helped to increase Medicaid enrollment.

There are a number of reasons for the success of local outreach. First, because locally led efforts can be better customized to the needs of a specific community, they identify and target key populations more effectively. Second, the involvement of organizations that low-income families trust and have frequent contact with has helped increase participation in public health programs.

To educate hard-to-reach populations, organizations translate SCHIP program materials into native languages and hire outreach workers of the same racial, ethnic or cultural background as target groups. Many organizations focus on minority groups and people with relatively higher incomes, reasoning that stigma associated with government programs might deter them from applying on their own. Also targeted are eligible immigrants who might be unable to apply because of language barriers or are afraid that participation could threaten their immigration status. In addition, many communities focus on their unique populations. For example, many outreach efforts in Miami are directed at Haitians and migrant farm workers.

While local leaders view targeted outreach as successful, the downside is that intensive one-on-one outreach tends to be costly. Outreach funding generally comes from state and federal SCHIP and Medicaid administrative funds, Temporary Assistance to Needy Families (TANF) dollars and other state and local funds. Local organizations can receive lump-sum or per-application payments, generally ranging from $25 to $50 for each application. However, the costs of outreach often exceed the funding organizations receive. As a result, many organizations use their own resources and funds from other private sources, such as The Robert Wood Johnson Foundation's Covering Kids initiative.

Local Outreach Involves a Wide Range of Organizations

The emphasis on local SCHIP outreach has attracted a large network of local organizations. The most significant players to date have been health care organizations and schools. Community and religious groups increasingly are involved, and employers are beginning to participate in some communities (see Table 1).

Health Care Organizations. Although local health departments, providers and health plans have conducted Medicaid outreach in the past, many have intensified their efforts under SCHIP. Hospitals and community health centers, in particular, have committed extensive resources to identify uninsured children when they seek services and then help their parents apply.

In general, providers have a financial incentive to help uninsured patients enroll in SCHIP because providers may receive higher payments for enrolled children. In some cases, however, SCHIP payments are relatively low and may be lower than payments received from a charity care pool or other public sources.

Local health departments and social service agencies often assist other providers with SCHIP outreach in addition to conducting their own outreach activities. For example, the Ingham County Health Department in Lansing, Mich., trains area providers about MIChild and assists them with screening potentially eligible children. These departments and agencies also attempt to locate uninsured children who do not seek regular medical services by conducting neighborhood health fairs, using mobile health vans and going door to door.

In some communities, health plans promote general awareness of SCHIP through

Table 1
Types of Local Organizations Extensively Involved in SCHIP Outreach in HSC's 12 Study Sites

Organization Type	Number of HSC Sites
Hospitals and Health Centers	12
Community Groups	11
Social Service Agencies/ Health Departments	11
Schools	10
Health Plans	7
Religious Organizations	7
Employer-Related Activities	5

broad public information campaigns and materials. However, plans in many states are restricted from promoting their SCHIP products because of concerns of inappropriate influence on beneficiaries' plan selection at the time of enrollment.

Schools. Schools have played a major role in SCHIP outreach in many communities, and school-based outreach has become a leading strategy. School nurses often coordinate these efforts and screen students for health insurance at annual school registrations, send letters home and discuss the program with parents at meetings. Many schools coordinate SCHIP outreach with the federal free-and-reduced school lunch program. However, South Carolina schools remain concerned that SCHIP outreach may stigmatize school children by drawing attention to their financial status.

States and communities with lagging SCHIP enrollment are promoting outreach in schools. For instance, the Arizona Legislature recently passed a law allowing the state to contract with schools for outreach.

Community and Religious Groups. To locate some of the most difficult-to-reach children—particularly those outside the school system—community groups play important roles in SCHIP outreach. Some common types include child-care centers, food banks, homeless shelters, children's groups and VISTA volunteers. Local organizations also distribute SCHIP applications through small businesses, such as neighborhood grocery stores and beauty salons.

Religious organizations increasingly are involved in SCHIP outreach, in part, because relatively recent changes in federal rules allow states to contract with faith-based groups if the individuals they target are not required to participate in religious activities. For example, the Indiana SCHIP agency distributes TANF funds to Indianapolis churches to help members complete applications for Hoosier Healthwise. Similarly, the United Methodist Church of New Jersey is planning to identify leaders in 300 churches to help ensure eligible congregation members are aware of New Jersey's Family Care program.

Employers. Some communities target outreach to business groups or employers with low-wage workers, such as small businesses and temporary employment agencies. Many of these employers do not offer health insurance to workers or their dependents, or, if they do, it is too costly for low-income employees. Employers can play an important role in directing employees to SCHIP, particularly workers who might not realize they are eligible for public insurance.

Consultants and insurance brokers are involved in educating employers and employees about SCHIP in some communities. For instance, Cuyahoga County, Ohio, contracted with a human resources development firm to conduct presentations and provide application assistance to workers at several hundred small firms in the Cleveland area. The project enrolled 590 children and adults, and the county estimates outreach costs averaged $157 per enrollee. Brokers in Orange County, Calif., signed on with the state to conduct Healthy Families outreach through their small employer clients but pulled back, saying payments were too low.

One of the greatest concerns about employers' involvement in SCHIP outreach is that it will cause crowd-out, or lead employees to substitute SCHIP for employer-sponsored coverage. States are required to have provisions to prevent crowd-out, such as checking that a child has not had private health insurance for a certain period before receiving public coverage. Some states are concerned that crowd-out will become

Local organizations can play an important role in boosting enrollment in public programs.

more of a problem as the economy softens. In response, many are attempting to measure crowd-out so they can adjust eligibility requirements, if needed. For example, states could extend the waiting period for children previously covered by private insurance.

Policy Implications

To date, SCHIP has expanded health insurance coverage to millions of children nationally, and some communities and states are approaching or exceeding enrollment goals. While local outreach is not solely responsible for this progress, local organizations' creativity in customizing outreach strategies and their ability to conduct one-on-one outreach have had a significant payoff, albeit at a fairly high price.

Many states that continue to struggle with enrollment, such as Arizona and California, are shifting their focus to local activities. In California, for example, the success of school-based outreach recently influenced the governor to increase local outreach funding, and preliminary reports indicate the change has helped boost enrollment. Similarly, the federal government has taken steps to promote broader diffusion of successful local strategies. For example, the Centers for Medicare and Medicaid Services, the federal agency that administers SCHIP, has encouraged states to establish school-based outreach activities.

Despite the success of local outreach, SCHIP continues to face many challenges. Many states and communities have struggled to enroll eligible children, and millions of children are eligible but not enrolled. Some respondents point to enduring problems with language barriers, stigma and cumbersome application processes.

In addition, retaining enrollees is difficult given frequent fluctuations in family income or insurance status affecting eligibility. Many enrollees unintentionally lose coverage when they are required to renew every six or 12 months. For every three children newly enrolled in SCHIP, one drops out, according to reports in several communities studied. Several states are now turning to local organizations to help address the turnover problem. For example, a Massachusetts pilot program will tap into local health care providers to help patients re-enroll, using streamlined enrollment forms with fewer documentation requirements. In general, however, many organizations are unable to track the enrollment status and renewal dates of children they brought into the program.

Finally, lack of funding may present the greatest challenge to local SCHIP outreach efforts. Many states are facing budget shortfalls and higher-than-expected Medicaid and SCHIP enrollment and costs per enrollee. Additionally, federal funding for SCHIP in fiscal year 2002 will decline about 25 percent, dropping from $4.2 billion in 2001 to $3.1 billion in 2002. The reduced funding will continue through fiscal year 2004.

Some relief may come from the federal Benefits Improvement and Protection Act of 2000, which allows states to use some unspent SCHIP funding from fiscal year 1998 to step up outreach. In addition, legislation recently introduced in the U.S. Senate would provide federal grants to community organizations for outreach activities. However, the dwindling federal budget surplus is likely to dampen interest in such new spending.

Presumably, many communities could adapt to reduced outreach funding as more children are insured and outreach and retention strategies become more efficient. However, communities require resources to maintain enrollment, locate difficult-to-reach children and enroll newly eligible people, such as adults. Orange County is one community trying to address these concerns and has formed a task force to determine how to leverage existing local funds to preserve the county's extensive outreach infrastructure if federal and state support is cut. Many other states and communities will likely face tough decisions about how to continue successful local outreach activities with less funding. ●

Notes

1. Smith, Vernon K., et al., *CHIP Program Enrollment: December 2000.* The Kaiser Commission on Medicaid and the Uninsured (September 2001).
2. U.S. General Accounting Office, GAO-01-993R, *SCHIP Enrollment and Expenditures* (July 2001).
3. Kenney, Genevieve, and Haley, Jennifer, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* The Urban Institute, Series B, No. B-35 (May 2001).
4. Cunningham, Peter J., "Targeting Communities with High Rates of Uninsured Children," *Health Affairs*, Vol. 20, No. 5 (September/October 2001), full text exclusively at *www.healthaffairs.org* (posted July 2001).

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