HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Participation

The issue

Participation in publicly sponsored health insurance programs depends on the success of program outreach, the ease of enrollment and recertification processes, and ultimately, enrollment action on the part of the individual. When employers offer coverage, employee enrollment generally takes place more automatically through the employment and payroll process.

Once individuals become aware of an assistance program, the decision to participate or not is influenced by multiple factors including the level of need for assistance, its perceived value, and the burden associated with applying for and enrolling in the program. Limited finances and other pressures facing those living near poverty make this population sensitive to the burden associated with seeking entry into a program and likely to be deterred by procedural barriers.

Tens of millions of people currently participate in Medicaid and the State Children's Health Insurance Program (SCHIP), but millions more who could benefit from the programs are not aware of them, do not believe they are eligible, or are discouraged by the enrollment process.

The evidence

Many who are eligible for public health insurance are not enrolled. Data from surveys and focus groups indicate that among individuals who are eligible for Medicaid or SCHIP but uninsured, lack of knowledge about the programs' eligibility rules hinders their participation.

Researchers have also found a relationship between the burden or ease of Medicaid and SCHIP application and enrollment procedures and participation in the programs. Low-income individuals report that complex applications and enrollment procedures impose difficult material burdens on them. Requirements for extensive documentation and procedures that impose transportation costs or necessitate time off from work prevent many low-income families from obtaining or retaining needed coverage. By the same token, streamlined and simple application and enrollment procedures with minimal requirements appear to lead to increased participation without fundamentally weakening program integrity. Simple procedures also ease program administration for states and providers. Finally, family-based eligibility – a form of simplification – has been associated with increased participation.

Studies indicate that the diversity represented in the low-income population calls for varied outreach strategies. Research suggests the need for outreach and marketing efforts that use multiple media and venues, appropriate languages, and messages that convey the value of the assistance and explain how to obtain it.

The rate of participation in health insurance programs for low-income people is sensitive to the burden of enrollment and recertification requirements. Also, experience with public programs suggests that diverse outreach strategies are needed to reach the target population effectively. Simplification of enrollment and renewal procedures, family-based coverage, and improved outreach could all help to increase and stabilize participation in publicly sponsored health coverage among low-income people.

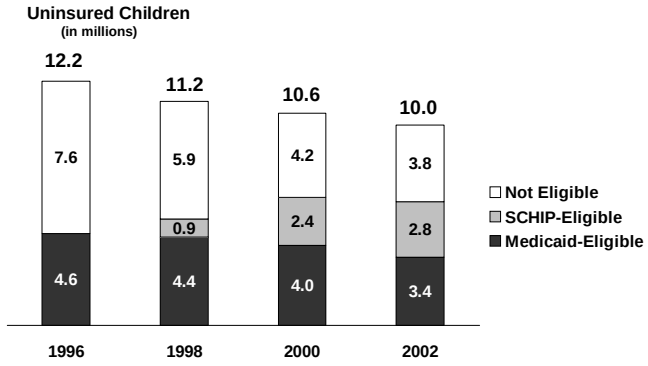
Key Evidence

Many who are eligible for publicly sponsored health insurance are not enrolled in the programs. Inadequate outreach and gaps in knowledge about the programs pose barriers to participation.

- A large proportion of uninsured children are low-income children who are likely to be eligible for Medicaid or SCHIP (Fig. 17). Of the 9 million children who lacked insurance in 2005, 6.6 million were in families with income below 200% of the federal poverty level.[1] [2]

Figure 17

Uninsured Children by Medicaid/SCHIP Eligibility Status, 1996-2002



SOURCE: Selden et al, "*Tracking Changes in Eligibility and Coverage Among Children, 1996-2002*." Health Affairs, September/October 2004.

- Just over half of low-income adults without private insurance who qualify for public coverage are enrolled, and the poorest adults are least likely to enroll.[3]

- In research on children who are eligible for Medicaid or SCHIP but uninsured, parents' lack of awareness and knowledge about the programs emerge as major barriers to participation. Many parents, even if aware of the programs, do not think their children are eligible.[4] [5]

- In a national survey, nearly half (46%) of Spanish-speaking parents of uninsured but Medicaid-eligible children reported that they did not complete the enrollment process because the Medicaid information and forms were not translated into their language.[6]

- A national survey of low-income parents found that direct outreach efforts to inform parents about Medicaid failed to reach many parents. Parents whose eligible children were uninsured were the least likely to have been reached; only 1 in 4 parents of children who were eligible for Medicaid but uninsured had ever talked to someone or received information about enrolling in Medicaid.[7]

- There are many reasons eligible adults do not enroll in coverage, including lack of knowledge about eligibility, difficulty completing the enrollment process, and individual choices not to enroll. The low enrollment rates particularly among the poorest adults and those without dependent coverage suggest that these adults are less connected to assistance programs and that they would likely benefit from increased outreach efforts.[8]

Burdensome enrollment and renewal procedures present high barriers to participation for low-income people.

- Among parents seeking to enroll their children in Medicaid, the most-often-cited barriers to participation include difficulty assembling all the required documents and the overall hassle of the enrollment process. The "hassle factor" was defined as including the length of time it

takes to apply, enrollment offices not being open when parents could go, and the office being too hard to get to.[9]

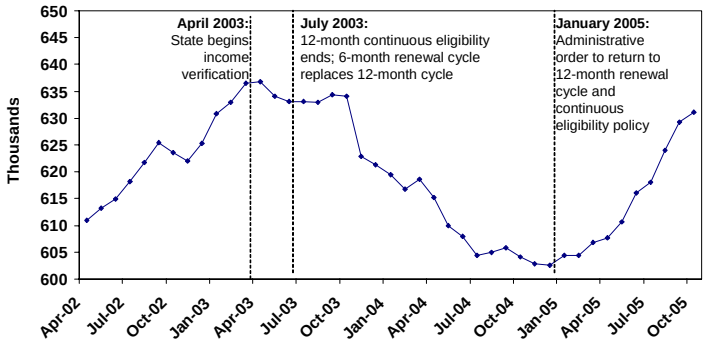
- Researchers have found that children who are eligible for but not enrolled in Medicaid are somewhat healthier than children who are enrolled but are more likely to face obstacles to access and to have family out-of-pocket medical spending exceeding $500. Citing these findings, the researchers suggest that a large portion of Medicaid-eligible children who are uninsured may face high barriers to Medicaid enrollment that deter their participation.[10]

- State officials interviewed in case studies have expressed concern that administrative barriers and confusion among parents of children enrolled in Medicaid or SCHIP are significant causes of disenrollment. Some parents in focus groups reported that they had not intended to disenroll their children,but did not realize what the renewal process entailed.[11] [12]

- States that have imposed more restrictive or burdensome enrollment and renewal policies and shorter eligibility periods in their Medicaid or SCHIP programs have documented subsequent declines in program participation. To illustrate, after a long period of rising enrollment of children in Washington State's public insurance programs, the caseload began to decline when the state instituted increased verification requirements, and it fell steeply when a few months later, the state eliminated its policy of 12-month continuous eligibility and required families to recertify every six months. When, by court order, the state reinstituted 12-month eligibility, enrollment rebounded (Fig. 18).[13] [14] [15] [16] [17]

Figure 18

Children's Enrollment in Washington State's Public Insurance Programs
April 2002-October 2005



SOURCE: Summer and Mann, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies,* Commonwealth Fund, June 2006.

- A study of four states found that states that require parents to actively verify eligibility to renew their children's SCHIP coverage experienced disenrollment rates as high as 50%. The study also found that up to 1 in 4 children who were disenrolled at recertification time returned to the SCHIP rolls within two months, suggesting that the children had not secured other coverage.[18]

Complex enrollment procedures impose administrative burdens and costs on states.

- Medicaid officials from states that eliminated the asset test for families reported that while their chief objective was to simplify the application process for families, the step was also seen as promoting larger agency goals of streamlining the eligibility determination process, improving worker productivity, and permitting the adoption of automated eligibility systems. While only one state was able to quantify its administrative cost savings from policy change, other states had a clear view that administrative savings were significant.[19]

- A study comparing the typical Medicaid enrollment process in New York City with the dramatically simplified enrollment process implemented following the September 11, 2001 terrorist attacks found that up to 80% of enrollment costs under the typical process are associated with the rules, verifications, and calculations surrounding eligibility. Outreach and health insurance education account for only about 20% of the costs. The study found further that enrollment costs would be reduced by about 40% in a simplified system, primarily from reduced time and costs associated with eligibility screening, application completion, and document assembl7.[20]

- A survey of 12 states that allow certain groups of Medicaid applicants to self-declare their income rather than submit pay stubs, tax returns, or other documentation found that this simplification measure led to increased productivity by eligibility workers. The reduced documentation requirements allowed faster processing of applications and generally increased the speed of eligibility determination. Most state officials reported that error rates did not increase as a result of the self-declaration of income policy, and the study found that by using effective third-party income verification procedures, the states were able to maintain low rates of eligibility error. Quality control audits documented that program integrity was effectively safeguarded.[21]

- An analysis of the potential impacts of allowing self-declaration of income for low-income families applying for Medi-Cal concluded that, net of new administrative costs associated with increased intakes, added case maintenance, and monitoring activities, a self-declaration policy would yield an annual $3 million in state and federal administrative savings stemming from reduced time associated with processing eligibility.[22]

Instability in enrollment, which is exacerbated by burdensome renewal procedures and shorter enrollment periods, imposes costs on the providers that serve low-income patients.

- Research on the impact of unstable enrollment on providers is limited. However, a study of Washington's Medicaid program examined this issue. The medical groups, hospitals, and health plan interviewed for the study cited payment delays and increased charity care associated with patients temporarily disenrolled from Medicaid. They also reported substantial administrative costs attributable to verifying Medicaid enrollment, troubleshooting enrollment problems, and seeking payment for patients retroactively re-enrolled by the state. The health plan cited the difficulty of managing care for patients who cycle on and off the program, particularly those with chronic illnesses or high-risk pregnancies, and children with asthma or other special health care needs.[23]

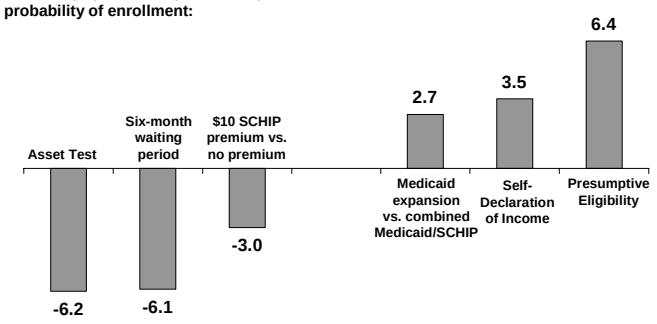
Simple enrollment and renewal procedures facilitate participation.

- Simple Medicaid and SCHIP enrollment and renewal procedures have been associated with relatively high rates of program enrollment and retention. For example, in states that renew SCHIP eligibility automatically unless the family reports changes that affect eligibility, SCHIP disenrollment rates are low compared with the rates in states that require active verification of eligibility for renewal.[24] [25] [26] [27] [28] [29]

- A study of the relationship between states' program design choices and children's enrollment in Medicaid and SCHIP found that enrollment simplification, type of SCHIP administrative model, waiting periods, and premiums all affect enrollment. Presumptive eligibility and allowing self-declaration of income both increase the probability of enrollment. Asset tests reduce enrollment, as do waiting periods and premiums. Enrollment levels were higher in SCHIP programs that were Medicaid expansions than in Medicaid/SCHIP combination programs or separate SCHIP programs (Fig. 19).[30]

Figure 19

Effects of Key Program Policies on Enrollment of Children in Medicaid and SCHIP



Note: Results significant at $p < 0.5$.
SOURCE: Kronebusch and Elbel, "*Simplifying Children's Medicaid and SCHIP*," Health Affairs, May/June 2004.

- Medicaid officials from states that eliminated the asset test for families applying for Medicaid reported that dropping the asset test made outreach and enrollment at the community level more successful and increased application activity. No state reported an increased Medicaid eligibility error rate due to removal of the asset test.[31]

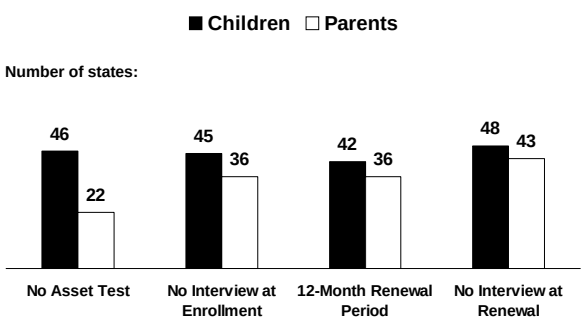
- Eligibility for Medicaid and SCHIP can be linked to applications for other public assistance benefits such as Food Stamps and WIC. This "express lane eligibility" model reduces the burden of lengthy and repetitive applications on low-income families. California's "express lane eligibility" program has had success using the free school lunch application to identify and initiate enrollment of children who are income-eligible for Medicaid but not enrolled. Participating families have been very pleased with the process.[32] [33] [34]

- Strategies in which private or public benefit programs automatically confer eligibility and benefits based on information available from related or complementary programs have demonstrated success in a number of spheres. Researchers estimate that with improvements in information technology and increased flexibility for Medicaid and SCHIP to accept income determinations from other means-tested programs, Medicaid and SCHIP could reach many eligible-but-uninsured low-income children and adults. To illustrate, over two-thirds (71%) of uninsured low-income children who are likely to be eligible for Medicaid or SCHIP live in families who participate in the National School Lunch Program, WIC, or the Food Stamp Program. The 53% of poor uninsured parents who have children already enrolled in Medicaid might be reached by auto-enrolling them on the basis of their children's Medicaid eligibility.[35]

- Fewer states have taken steps to simplify Medicaid enrollment and renewal for parents than have done so for children. For example, while 46 states have eliminated asset tests for children, only 22 disregard assets for parents. Parents lag behind children similarly in other areas of Medicaid simplification (Fig. 20).[36]

Figure 20

State Actions to Simplify Medicaid Enrollment for Children vs. Parents, July 2005



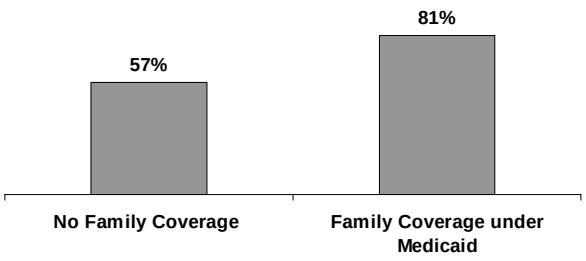
SOURCE: Cohen Ross and Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families,* Kaiser Commission on Medicaid and the Uninsured, October 2005.

Family-based eligibility appears to boost participation.

- Researchers have found that expanding family coverage in Medicaid not only increases enrollment of parents, but also boosts participation among eligible children (Fig. 21). Other research shows that among Medicaid-eligible parents without private insurance, those whose children were enrolled in Medicaid were more likely than parents overall to enroll in Medicaid.[37] [38] [39] [40]

Figure 21

Children's Participation in Medicaid Poverty-Related Expansions, 1999



SOURCE: Dubay and Kenney, *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Kaiser Commission on Medicaid and the Uninsured, October 2001.

- An analysis of Medicaid and SCHIP disenrollment showed that children with a sibling in one of the programs were 39% less likely to drop out than those without siblings in either program.[41]

Diverse outreach and marketing efforts and clear messages about the value of coverage are needed to reach and inform those eligible to participate in public insurance programs.

- All six states studied in the congressionally mandated evaluation of SCHIP adopted multiple, diverse strategies to market SCHIP to families with uninsured children, and several reported that their approaches became more targeted over time. The states created new and appealing names for their programs, promoted them through radio and television advertising either statewide or to particular neighborhoods and/or ethnic markets, developed attractive print materials and distributed them strategically, enlisted health plans as outreach partners, and worked with community-based organizations to provide outreach and application assistance, especially for harder-to-reach populations.[42]

- Several states developed SCHIP outreach strategies targeted to particular racial and ethnic groups. Participants in parent focus groups agreed that such strategies would be successful and also recommended reaching out to eligible families in the many places they go in their daily lives, including health care providers, community centers, grocery stores, schools, and places of worship.[43]

- Participants in parent focus groups have expressed the importance of Medicaid and SCHIP marketing messages that emphasize that applying is simple and convenient and that coverage is valuable (i.e., it is no-cost or low-cost and offers many benefits). They also voiced the need for messages that convey that working families are eligible and provide details on who is eligible.[44]

- Low participation in Medicare savings programs, which assist low-income Medicare beneficiaries with their premiums and out-of-pocket costs, has been attributed to lack of awareness about the programs and cumbersome eligibility determination and enrollment procedures. A government study found that in the year following a congressionally mandated outreach effort by the Social Security Administration, enrollment in these programs nationwide was nearly double that in each of the three previous years; 35 states had statistically significant additional increases in enrollment.[45]

Endnotes

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