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OPENING DOORWAYS TO HEALTH CARE FOR CHILDREN

10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance

Prepared by

Dawn Horner and Beth Morrow,
The Children's Partnership

April 2006

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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ACKNOWLEDGEMENTS
The authors would like to thank The Henry J. Kaiser Family Foundation and the Kaiser Commission on Medicaid and the Uninsured for funding this report. We offer our deepest gratitude to Diane Rowland and Barbara Lyons for their guidance, support, and commitment to this project.

We thank the following individuals for their assistance and expert guidance: Donna Cohen Ross, Center on Budget and Policy Priorities; Stan Dorn, Economic and Social Research Institute; Tom Epstein, Blue Shield of California; Leighton Ku, Center on Budget and Policy Priorities; Genevieve Kenney, The Urban Institute; Bruce Lesley, Senator Bingaman's Office; Gabrielle Lessard, National Immigration Law Center; Eric Rollins, Congressional Budget Office; Tom Selden, Agency for Healthcare Research and Quality; Bob Tomlinson, Centers on Medicare and Medicaid Services; and Mary Wood, Washington State Department of Social and Health Services.

We also thank our colleagues at The Children's Partnership for their insightful review of the report: Wendy Lazarus, Laurie Lipper, Theresa Blackinton, Jenny Kattlove, Terri Shaw, and Kristen Testa, And we offer our gratitude to Laura Hogan with The California Endowment for her continuing support to find better ways to enroll children into health insurance.

And last, we thank Wendy Jacobsen for her superb editing of and suggestions for the report.

The Children's Partnership
The Children's Partnership (TCP) is a national, nonprofit organization working to ensure that all children—especially those at risk of being left behind—have the resources and the opportunities they need to grow up healthy and lead productive lives. TCP focuses particular attention on the goals of securing health coverage for uninsured children and ensuring that the opportunities and benefits of digital technology reach all children and families. With input from its highly respected advisors, TCP advances its goals by combining national research with state-based activities that translate analysis into local action. TCP has offices in Santa Monica, CA and Washington, DC.

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A Message From

Wendy Lazarus & Laurie Lipper
Co-Presidents and Founders, The Children's Partnership

Our country is surprisingly close to solving one of its most vexing social problems: ensuring all children have health insurance coverage. If we can enroll the six million children who are currently eligible for public health insurance programs, but still not signed-up, then 95% of our nation's children will be covered.

The good news is we know how to do it: states have nearly a decade of experience enrolling these children, and they understand well what the hurdles are. This report brings together that knowledge and experience and lays out a vision for re-engineering children's health insurance enrollment so that it really works.

We propose here a set of fundamental—though not revolutionary—reforms that build on the federal-state partnership that insures low-income children through Medicaid and SCHIP. The report recommends using technology to deploy hospitals in enrolling newborns, and it shows how schools and public nutrition programs, among others, can be enrollers for uninsured children. It also shows how to modernize a host of outmoded systems that are wasting taxpayer dollars without getting the job done for children.

Taken together, the recommendations in this report provide a roadmap for change—change that is achievable if the commitment is there. We look forward to working with the federal government, the states, and other interested parties so that 95% of our nation's children have the health insurance coverage they need. The investments that will be required are a down payment for making sure that America's children are healthy and thriving.

Foreword

Health insurance coverage matters for children in America. Health coverage supports a growing and active childhood and healthy adolescence. Compared to children who are uninsured, children with health coverage are more likely to have a usual source of care, access to services that they need, and to have better outcomes. The work of The Kaiser Commission on Medicaid and the Uninsured has documented the key role that Medicaid and SCHIP play in the health of America's children. Together these programs help assure that low-income children receive preventive care, regular check-ups, vision and dental services, and if needed to treat an injury or health condition, access to a doctor, specialist or a hospital.

Medicaid and SCHIP have proven to be enormously successful in expanding health coverage of children. State and federal decisions to invest in outreach and to facilitate Medicaid and SCHIP enrollment have paid off. Over the last decade, these programs have been primarily responsible for reducing the number of low-income uninsured children by one third. Despite this accomplishment, more work is needed to reach the 8.4 million children under age 18 who remain uninsured.

The Children's Partnership has proposed a set of reforms that build on the success of Medicaid and SCHIP to invest in our children's health. These reforms harness strategies to move forward on children's coverage by employing new enrollment "doorways", adopting technology to increase the efficiency of the enrollment process, and implementing policies that assure access to health coverage for all low-income children. The cost associated with these investments in children's health coverage is modest. Policymakers at the state and federal level can take action on behalf of children by devoting leadership and resources to make children's coverage a national priority.

-The Kaiser Commission on Medicaid and the Uninsured

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EXECUTIVE SUMMARY

Steadily rising health care costs and an emphasis on voluntary, employer-based health coverage are just two reasons the uninsured continue to pose a significant public policy challenge. Yet, a number of factors make it possible to move the agenda forward by providing health coverage to nearly every American child.

1) States and local communities have learned over the last decade how to maximize coverage through Medicaid and SCHIP.
2) An overwhelming majority (90%) of the public believes that providing insurance to children is the right thing to do.
3) There is bi-partisan support both in Washington, D.C. and the states.
4) The price tag is affordable.

According to the most recent data, 8.4 million children under age 18 in America remain uninsured, yet more than 70% of these are eligible for public health coverage. By focusing on these "eligible but uninsured" children, we can cover up to 95% of America's children. This report sets out a 10-step plan for opening doorways to Medicaid and the State Children's Health Insurance Program (SCHIP) coverage for all of these eligible children. The enrollment doorway approach will

- Increase and make routine families' access to enrollment opportunities;
- Streamline the administration of public health insurance programs;
- Broaden eligibility minimally to help the system make administrative sense; and
- Assure program integrity so only eligible children obtain insurance.

Health Insurance Matters to Kids

Children who have no health insurance are less likely to receive appropriate health care when they need it. This situation increases the likelihood of avoidable hospitalizations and unnecessary emergency room visits, both of which are expensive. Meanwhile, children whose health coverage is conditioned upon jumping bureaucratic hurdles are regularly dropped from coverage—most of them only to re-enroll soon thereafter at great public expense and inconvenience. These inefficiencies just do not make sense.

The United States needs a public health insurance enrollment structure that is designed to keep children covered, not one that aims to keep them out. With such a structure, everyone benefits: the children who are healthier and better able to learn; the children who surround these healthier, more productive members of society; the families who are relieved of the stress of not knowing how to get their children the help they need; and society at large—which currently pays heavily, though indirectly, for all the inefficiencies in the system.

Learning from Our Mistakes

Since the introduction of SCHIP nearly ten years ago, extensive effort has been made to reach and enroll eligible but uninsured children in all available health insurance programs. And, yet, nearly 6 million of these children remain uninsured. Looking at this experience, there are some obvious conclusions that should be factored into any solutions that are developed.

First, it is clear that outreach and enrollment assistance are not enough to reach and enroll these children. Second, major administrative and technological inefficiencies burden the public health insurance system and keep it from moving into the modern era. Third, failure to retain children in the system means that they lack continuity of care while also saddling the program with the cost of re-enrolling them later. Fourth, because children's health coverage depends so heavily on states' economies, funding for the system is less stable than it needs to be.

Ten Steps to Create an Effective Enrollment Doorway System

This report lays out a plan for creating a series of enrollment doorways that make enrollment and renewal both routine and timely—as close to automatic as possible. The following steps require a combination of both state and federal action, as discussed at greater length in the report.

1. *Enroll children into Medicaid and SCHIP through multiple doorways to ensure maximum efficiency and greatest reach.* A system of enrollment doorways will give low-income families the opportunity to enroll their children in public coverage at convenient public access points that are a routine part of their lives (including schools, hospitals, and certain means-tested public program application spots).

2. *Institute a one-stop process for establishing eligibility that also provides immediate coverage to children.* When a family enters these designated public access points (the doorways), the family already provides information that can initiate an application for Medicaid or SCHIP. Under the enrollment doorway system, the family will be able to give limited additional information and receive immediate temporary coverage if uninsured.

3. *Establish a mechanism for income evaluation that eliminates unnecessary documentation, creates system efficiencies, and maintains program integrity.* Under an enrollment doorway system, the eligibility evaluation will proceed *ex parte*, without requiring any action from a large portion of families, through greater coordination of the information already held by government agencies.

4. *Re-establish coverage for low-income, legal immigrant children who have been cut out of the system.* Since Congress imposed limits on coverage for legal immigrant children in 1996, nearly half of states have opted to insure legal immigrant children with state funds. They have done so for public health reasons, fairness, and because it is very difficult to make eligibility sensible and simple with special rules for certain children. It makes good policy and administrative sense to again authorize eligibility for health insurance for all legal immigrant children.

5. *Redefine Medicaid/SCHIP immigration rules to allow the social security number to establish qualifying status for children.* In order to obtain a social security number, families already present proof of legal immigration status and/or citizenship to the Social Security Administration (SSA), which verifies that information through the same channels currently used by Medicaid and SCHIP. The streamlined enrollment doorway system would take advantage of the effort already made by the SSA, allowing the presentation of the social security number to establish that a child is of eligible immigration or citizenship status. The new federal policy enacted as part of the Deficit Reduction Act of 2005 imposes new documentation requirements of United States citizenship. Although the guidelines have yet to be issued, this new requirement could make enrollment more complicated and runs counter to efforts to streamline bureaucratic enrollment hurdles.

6. *Establish a renewal system that encourages uninterrupted participation of eligible children in Medicaid/SCHIP.* At each periodic encounter with a doorway, a family should have the opportunity to renew coverage, just as it has the opportunity to enroll—with the difference being that renewal will be accomplished by updating any change of circumstances, building upon the information already held in agency databases.

7. *Maintain confidentiality and promote trust*. Efforts to build upon existing relationships that families have with the doorways must enhance, not jeopardize, the trust that is part of that relationship. In addition to maintaining existing confidentiality rules, the use of enrollment doorways will likely require corresponding changes in confidentiality rules at the federal and state levels.

8. *Invest in technology to enhance the interface between doorway programs and Medicaid/SCHIP administrative processes*. The efficiency and success of the enrollment doorway process will depend on achieving the following capabilities in the technology available to agencies:

- Allow privacy-protected data entry and retrieval across agencies;
- Link enrollment doorways directly with Medicaid/SCHIP;
- Automate database review of current health program enrollment; and
- Allow *ex parte* inquiry by the health agency into available databases.

9. *Maintain employer coverage as a piece of the solution*. Efforts to improve, rather than radically overhaul, the current health insurance system cannot afford to lose employers as crucial providers of affordable dependent coverage. For the public and private insurance systems to work together through the enrollment doorway system, a mechanism must be established that allows Medicaid or SCHIP dollars to be used for the purchase of quality employer-based dependent coverage when an uninsured child passes through the doorway.

10. *Provide sufficient federal funding and incentives to states.* Because states are pushed to the limit by their health care expenditures, the successful implementation of a doorway system will require enhanced funding for planning and technology development as well as reliable funding for new enrollees. Ideally, to assist states all children enrolled in Medicaid and SCHIP would receive an enhanced federal match, rather than just those in SCHIP.

It Is Possible

Such a simple, family-friendly approach is not a pipe dream but rather an achievable goal that must be built now as part of the unfolding technological revolution in government and the healthcare industry. An effective doorway system will require substantial investment in technology up front, but that investment will support a truly streamlined, interoperable, functional structure and will have financial pay-offs in the form of efficiency and reduced bureaucracy. The enrollment doorway system maintains the integrity of Medicaid and SCHIP while investing in the technology and procedural streamlining that can strengthen the system as a whole.

Though it runs counter to some of the new proposals and policies at the federal level—most particularly, some of the changes enacted in the Deficit Reduction Act of 2005—the enrollment doorway approach in this report grows out of what experience shows will make the greatest difference in insuring children. As such, it builds new efficiency and reaches children who need coverage rather than erecting procedural hurdles that create a need for duplicative bureaucracy.

While some of the streamlining that underlies the doorways system can occur now, the agenda will require some legislative changes as well as dedicated funding—for additional coverage, enrollment assistance, and technology—in order to move forward as a complete system. If 80% of "eligible but uninsured" children were to enroll and remain covered through these doorways, the cost of their coverage would be about $8.8 billion annually—only $3.6 billion more than we already spend on medical care for these uninsured children. At least $1 billion will be required to support this major technology overhaul, as well. Whatever the cost incurred, it will remain a miniscule part of the Medicaid budget, which runs at $316 billion per year, only 16.5% of which funds children. This investment in an effective enrollment doorway system is worth every penny, because it will improve the health of our health insurance system at the same time that it improves the health of our children.

INTRODUCTION

It is a simple truth with consequences that are both far-reaching and complex: there are too many uninsured people in the United States. Among those most affected by this state of affairs are our nation's children, whose health and well-being will predict the course of their adult lives. Steadily rising health care costs and our emphasis on voluntary, employer-based health coverage are just two reasons the uninsured pose a significant public policy challenge. Yet we have, right now, a convergence of factors that makes it possible for us to address this problem head on and provide health insurance to nearly every American child:

1) After close to a decade of experience and experimentation, states and local communities have learned how to maximize coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) (the federal government's two principal public health insurance programs for children);

2) An overwhelming majority of the public believes that providing insurance to children is the right thing to do. In fact, 90% of Americans say they want adequate funding for health care for low-income children;[i]

3) There is bi-partisan support in both Washington, D.C. and the states for improving children's health status and their school readiness by enrolling those who are uninsured in health coverage;[ii] and

4) The price tag is affordable given the modest cost of covering kids, the high cost of having them go without coverage, and the savings achievable through greater efficiencies in the system.

With these essential elements in place, providing health coverage to the great majority of the nation's children is within our reach. According to the most recent data, 8.4 million children in America remain uninsured,[iii] yet more than 70% of these are eligible for public health coverage.[iv] By simply focusing on these "eligible but uninsured" children, we can cover up to 95% of America's children.

While the costs associated with insuring these children may quickly be cited as prohibitive, analysis of the figures suggests otherwise. First, phased-in enrollment would take a number of years. When a realistic implementation rate is eventually achieved we estimate that the federal and state enrollment costs could run up to $8.8 billion a year.[v] In the context of current federal and state/local spending on Medicaid ($316 billion) or the cost of the tax subsidy for private insurance (over $200 billion), this additional investment in children and public health would be, in fact, quite modest.[vi]

The Challenges

For nearly ten years, states have tried various strategies for finding, enrolling, and keeping children in Medicaid and SCHIP, yet millions of eligible children remain uninsured. The failure is mostly attributable to problematic enrollment, renewal, and eligibility practices.[vii] While some states have been successful in limiting barriers, the underlying structure of the programs remains fragmented and continues to rely on inefficient, archaic administrative practices. Some of these practices date back to an era in which the goal of enrollment was to keep children *out* of the system, rather than to facilitate coverage. In addition, some states are now deliberately imposing new obstacles, such as assets tests, in order to keep costs down.

Recent federal actions have also derailed accomplishments in children's health coverage. The Deficit Reduction Act of 2005 (DRA) enacts significant changes in the Medicaid program for children, giving states the option of increasing co-payments and premiums and reducing benefits. In addition, the DRA requires all U.S. citizens or nationals who apply for or receive Medicaid to produce a birth certificate, passport, or other specified document to prove their citizenship status. All of these changes will cause beneficiaries, including children, to unnecessarily lose coverage—the opposite direction of where we need to go.

A Ten-Step Plan

Based on lessons from the last decade, and incorporating the promise of newly available technology, this report sets out a smart, ten-step plan for opening the doorways to Medicaid and SCHIP coverage for all eligible children. Taken together—and with sufficient federal funding to give states the incentive to increase participation—the ten steps detailed in this report will

- ***Increase access to enrollment opportunities.*** The proposed changes will provide families with the opportunity to enroll their children in public coverage at convenient, routine public access points: schools, hospitals, and other public program enrollment "doorways;"

- ***Streamline administration.*** The proposed changes will harness technology to create an application and renewal process that eliminates unnecessary, duplicative documentation while maintaining family confidentiality; and

- ***Broaden eligibility.*** The proposed changes will extend health insurance eligibility to legal immigrant children and significantly streamline the enrollment process for them by allowing use of the social security number instead of immigration documentation.

Implementing the recommendations in this report will require a federal leadership role and close federal-state partnerships. Federal authorities must make key changes to federal law, lay out a set of requirements for states, and establish incentives that push states to implement their part of the policy. While states would maintain administrative authority over their programs, they would be required to use new enrollment doorways (hospitals, schools, and other public programs) and to implement key streamlining measures.

History shows that we can do this. It shows that when we make a national commitment to coverage rather than exclusion, devote the required resources, and design our efforts to be "smart and lean," the results are impressive. Medicare now reaches 97% of all seniors age 65 or older[viii] and 95% of children entering school are up to date on their immunizations.[ix] This report takes lessons from those success stories and applies them to insuring children.

Why Health Insurance Matters

Everyone agrees that children need to see a doctor for routine screenings and to receive immunizations and treatment for childhood illnesses, like ear infections. But is health insurance coverage a proven avenue for providing this care? Studies say that the answer is yes: health insurance is an important predictor that children will receive needed health services and will be healthier than their uninsured counterparts.

- Children who are insured are more likely to have a regular source of medical care than those who lack health care coverage.[x]

- Children with a regular source of care get preventive screenings and treatment on a more timely and routine basis than those who are uninsured.[xi]

- A lack of health insurance is associated with students missing more school days, which can have a negative impact on their educational achievement.[xii]

Providing health insurance to children also makes economic sense. Health care that is provided without benefit of prevention and continuity is less cost-effective. At this higher-cost, uncompensated care is paid for with federal, state, local, and private dollars. In 2004, the U.S. spent $40.7 billion in 2004 dollars on healthcare for people without insurance—$5.4 billion of this was for children.[xiii] And we are all shouldering this burden through increased taxes and insurance costs. The government pays about 85% of the uncompensated care bill,[xiv] and private employer health insurance was on average $922 higher per family with such coverage in 2005 due to the cost of uncompensated care provided to the uninsured.[xv] These funds would be better spent on health insurance that helps families access the care they need, when they need it.

About This Report

Because the principal impetus for the changes described in this report must come from the federal level, this report is primarily for federal policymakers and staff and advocates for children. However, it should also prove useful to state and local leaders as they explore the available options for simplifying health insurance enrollment and to foundations interested in supporting these efforts. The report is divided into the following sections:

- ***Lessons From The States.*** What we can learn from efforts to date to enroll uninsured children into Medicaid and SCHIP;

- ***10 Steps To Effective Enrollment.*** The "how to" of a streamlined enrollment process;

- ***A Closer Look At The Most Promising Enrollment Doorways.*** A detailed review of how an enrollment doorway system would work in hospitals, schools, and other public programs; and

- ***Moving Forward.*** How to make it happen, including how to pay for it.

This report is based on The Children's Partnership's analysis of the experiences of states across the country. It also is grounded in our direct experience over the last seven years in California and a handful of other states, developing the research, policy, and technical assistance guidance required to implement simplified enrollment systems. Critical support and advice was provided by a number of national and local health advisors. (See Acknowledgements.)

The plan proposed in this report will benefit millions of children and is, we believe, immediately achievable. We hope it will inspire the many critical stakeholders to come together to achieve the results we all desire for our nation's children.

LESSONS FROM THE STATES

Children's public health insurance coverage was created with a built-in set of enrollment barriers to keep many children out of the system. The intention was to save money as well as to limit fraud and, ostensibly, to make sure resources were targeted to those most in need.

With the creation of the State Children's Health Insurance Program (SCHIP) in 1997, however, states began to explore ways to increase enrollment in children's health programs while also maintaining program integrity. The results can be seen in both Medicaid and SCHIP, where states have made admirable attempts at reducing the complexity of the enrollment process by creating shorter, mail-in applications, allowing families to self-declare income, and limiting or even eliminating cumbersome eligibility requirements like asset reporting.[xvi] The appendix outlines current federal Medicaid and SCHIP rules.

States also invested heavily in comprehensive outreach strategies, including toll-free hotlines, television and billboard advertising, community outreach, and direct assistance. In 2000, California spent $21 million in combined federal and state funds on Medicaid/SCHIP outreach efforts. New York spent $11.7 million in federal funds for Medicaid outreach associated with welfare reform, as well as $4.6 million in state funds for standard Medicaid/SCHIP outreach.[xvii]

In addition, millions of private and/or foundation dollars have supported outreach efforts. For example, the Robert Wood Johnson Foundation's Covering Kids & Families initiative is a four-year, $55 million dollar investment in efforts to decrease the "eligible but uninsured" population in every state. This initiative followed a significant earlier investment in 1997.[xviii] Other foundations, such as the Henry J. Kaiser Family Foundation, have also put significant resources and effort into expanding coverage and streamlining enrollment with considerable success.

Taken together, these efforts proved beneficial. Between 2000 and 2003, while poverty among children and lack of insurance among adults was on the rise, the number of uninsured children declined due to an increase in Medicaid and SCHIP coverage.[xix]

Despite this progress, however, about six million eligible children are still uninsured.[xx] Most studies show that enrollment barriers remain the principal culprit. While some of these barriers are intrinsic to the way the programs are currently configured, others are

policies deliberately aimed at keeping children out in order to decrease costs. To better understand these obstacles, it is instructive to review the lessons learned by states that have been working to increase enrollment over the last ten years.

Outreach and Enrollment Assistance Are Not Enough

Outreach and enrollment assistance under SCHIP have increased the number of children with Medicaid or SCHIP coverage. Yet despite this success, outreach and enrollment assistance have not been a panacea. Studies show that large numbers of children are not enrolled in Medicaid or SCHIP because their families have faced insurmountable documentation requirements and/or been unable to complete the long and complex application process.[xxi] One survey found that 67% of children who were eligible but not enrolled had applied for coverage at some point, but that over half had been denied, often due to procedural complications.[xxii] Further complicating the matter, outreach and enrollment assistance do not have a reliable public funding base. When states experience an economic downturn, these are usually the first outlays to be cut.[xxiii]

Administrative and Technology Inefficiencies Hamper Progress

Excessive bureaucracy in the Medicaid and SCHIP programs adds to the cost of administration while at the same time driving children out of the system. One New York study found that of the $280 it costs to enroll each child, up to 80% is associated with the complex rules, proofs, and calculations surrounding an eligibility determination.[xxiv] Further, many states rely on outdated technology that inhibits simplification and perpetuates long-standing inefficiencies in the system. For example, states that operate separate Medicaid and SCHIP programs often have not configured the two systems to talk to each other. Furthermore, due to limited inter-operability between health and other program databases, few links have been made with outside programs despite the opportunity this would provide to chip away at duplicative information-gathering efforts. When states tackle problems like these and simplify their application and renewal procedures, they report administrative cost savings and increased productivity.[xxv]

Children Come in the Front Door but Go Out the Back

Even when a state is successful in enrolling children in Medicaid and SCHIP, some of the children drop off their coverage when up for renewal, despite their continued eligibility. Studies suggest this is caused by the proliferation of misinformation and difficulties in complying with program requirements, such as returning copies of supporting documents by a deadline.[xxvi] Either way, intermittent coverage not only diminishes the likelihood of quality health care, but it also creates an administrative expense that is shouldered by

taxpayers. One study estimated that between two and 12% of the administrative cost of processing applications is saved by instituting a policy of "twelve-month continuous eligibility" rather than requiring children to re-confirm their eligibility every three or six months.[xxvii] In California, a recent study showed that the state spent more than $120 million over three years to re-process eligible children dropped from Medi-Cal because of untimely or incomplete paperwork at renewal even though the state allows twelve-month continuous eligibility.[xxviii]

Investment in Children's Health is Dependent on the Economy

Despite the initial success of Medicaid and SCHIP in increasing children's coverage, recent state fiscal constraints have demonstrated that the funding for these programs is not as stable as it should be. In response to shrinking budgets, most states have curtailed outreach efforts in order to decrease enrollment; a number of states have implemented policies, like an assets test, that make it more difficult for families to get enrolled and stay enrolled.[xxix] As a result, SCHIP participation fell for the first time in the program's history during the second half of 2003.[xxx] Without a dedicated funding source and a national commitment to cover all children, tight budget times will lead to policies that limit enrollment, despite the fact that families most need the support during these tough times.

Given all of these challenges, it is clear that the goal of providing uninsured children with health care coverage will only be achieved by re-engineering the programs' enrollment, funding, and administrative systems. It is time to apply the valuable lessons learned, and take advantage of recent advances in technology to modernize the system. Ten steps for making this happen follow.

10 STEPS TO EFFECTIVE ENROLLMENT

A great public health insurance system would have an enrollment process that is simple for families to use, easy for states to operate, and assures program and fiscal integrity. It would be free of duplicative procedures and would take full advantage of available technologies to make enrollment routine and timely—as close to automatic as possible. Federal financial incentives would encourage the full participation of states and the use of all available enrollment doorways. Following are ten concrete steps that can be taken to create a great system.

1. Enroll children into Medicaid and SCHIP through multiple doorways to ensure maximum efficiency and greatest reach.

Children who are likely to be eligible for public health insurance regularly pass though the doorways of other public services. A successful health insurance enrollment system would take advantage of this fact, using these doorways to reach and enroll large numbers of children. The information families routinely provide to other public programs can be used to enroll children in health coverage. Further, children who are enrolled in public programs whose income rules are similar to those for Medicaid and the State Children's Health Insurance Program (SCHIP) should automatically be deemed income-eligible for subsidized health coverage. In addition to the potential for administrative streamlining, the doorway approach would make the health insurance enrollment process routine for families.

Research and analysis for this report found that the most viable enrollment doorways would be hospitals, schools, and public programs serving low-income children. Taken together, these doorways are likely to capture just about all children on a yearly basis.

- Hospitals are an ideal enrollment doorway because families are accustomed to dealing with health insurance and financial issues in this setting. Parents are, in effect, a "captive audience" for health insurance enrollment when they come to the hospital to have a baby.

- The public school system is an obvious choice as an enrollment doorway since nearly 90% of the nation's children attend public school, including most low-income children—the children who are most likely to be eligible for Medicaid and SCHIP but not yet be enrolled in them .[xxxi]
- Public programs like School Lunch, Supplemental Coverage for Women, Infants, and Children (WIC), and Food Stamps serve as logical enrollment doorways because they serve the same very low-income families as Medicaid and SCHIP. More than 70% of low-income, uninsured children live in families that receive benefits through these

three programs.[xxxii] In an average month, 29 million children—the majority of whom are likely to be eligible for public health insurance coverage—participate in school lunch.[xxxiii] In addition to these three programs, subsidized child care, Head Start, and the Earned Income Tax Credit (EITC) may also be promising doorways.

Technology will be needed in each setting to confirm a child's health insurance up front (so that effort is not wasted on processing applications for children who are already enrolled) and to facilitate enrollment. Then, at each subsequent contact with a doorway, updated information can be obtained, making renewal easier and increasing retention. While multiple doorways may mean families are approached more than once, experience shows that repeated contact is often required to complete the enrollment process.[xxxiv] Further detail on implementing an enrollment doorway system is provided in the section *A Closer Look At The Most Promising Enrollment Doorways*.

2. Institute a one-stop process for establishing eligibility that also provides immediate coverage to children.

The best enrollment systems do not, for most children, require follow-up in order to establish eligibility. Experience shows that at each follow-up stage a portion of the applicants are lost**.** For example, this phenomenon was demonstrated in Washington State, where the school lunch application was used to initiate a Medicaid application. A simple follow-up form was necessary to complete the process, and only 31% of applicants sent-in the required form.[xxxv] In Delaware, where an applicant is sent a completed application for signature, and required to copy and submit pay stubs, only 44% mail the package back.[xxxvi]

For most children it should not be difficult to create a one-stop enrollment process that can be used in any enrollment doorway. In most cases, doorway programs already collect the minimal information required to make a Medicaid and SCHIP determination:

- Contact information;
- Family size;
- Gross family income and applicable deductions;
- Date of birth;
- Sex;
- Social Security Number;
- Other health coverage; and
- Parent or guardian's signature.

With family consent, this already-gathered information can be used to form the basis of a Medicaid or SCHIP eligibility determination. Information that is not required for determining eligibility but is required later (such as health bills for the previous three months) can be collected after enrollment has been finalized.

For immigrant children, collecting the necessary documentation can complicate the enrollment process, but the challenges are not insurmountable. While some doorway programs may be reluctant to collect immigration information because doing so can raise trust and confidentiality issues, it is important to weigh these concerns against the guaranteed negative impact a two-step process will have on enrollment. Also, there are some relatively simple ways to secure the needed information:

- Parents could simply provide the child's social security number, which should be all that is needed to establish that a child is a citizen, national, or of eligible immigration status (New rules requiring new individuals to document their citizenship at application and renewal could complicate these efforts. See discussion below, Steps 4 and 5.); and/or

- Parents could give their consent for the agency to use *ex parte* means for filling-in any information gaps, i.e., using other available sources, such as files from a different public program or vital statistics databases.

For parents who cannot, or do not want to provide this information, a follow-up process would have to be developed.

Another way to ensure that the enrollment process is accomplished in a single stop is to make sure the doorway institution follows the enrollment protocols required by Medicaid and SCHIP, such as distribution of informational fliers, rights and responsibilities forms, and other introductory material.

Finally, an essential component of a truly one-stop process would be to provide the applicant with immediate coverage. Federal law allows enrollment systems to provide families who appear to be eligible with temporary, immediate eligibility. This ensures that children can get medical care immediately, without waiting up to 45 days for the Medicaid or SCHIP card to arrive. In addition, if there is a need for enrollment follow-up work, the family may have more incentive to stick with the process since they are already receiving medical services. At least 11 states have already implemented this kind of presumptive eligibility process.[xxxvii]

3. Establish a mechanism for income evaluation that eliminates unnecessary documentation, creates system efficiencies, and maintains program integrity.

Eligibility for most public programs, including Medicaid and SCHIP, is largely based on a family's income. There are two mechanisms for streamlining the income evaluation that would greatly improve the enrollment process for both agencies and families.

- Allowing self-declaration of income. Under current federal rules, states can enroll families based on self-declaration of income: a statement (under penalty of perjury) of a family's income and deductions. The state can then conduct verification to ensure the information is accurate. At least 12 states allow self-declaration of income and do so in a manner that has been found to maintain program integrity.[xxxviii]

- Sharing income determinations across programs. An enrollment doorway program should be allowed to provide its income determination (with the family's consent) to Medicaid or SCHIP to use in establishing income eligibility for their own programs, regardless of whether different methods were used for calculating income.[xxxix] All of these programs serve a similar group of low-income children, and all require families to prove their financial eligibility. And yet, minor differences in the ways programs calculate income can preclude one agency from using another's income finding without federal authorization. If Medicaid and SCHIP were allowed to adopt another program's income finding, the health agencies would no longer be required to collect information that has already been collected and verified by another public agency.

It is, of course, imperative to maintain quality control and ensure program integrity when an enrollment process is simplified. States' experiences with self-declaration of income have demonstrated that it is possible to use this streamlining mechanism and still maintain program integrity.[xl] For example, they still employ post-eligibility verification procedures such as the Income Eligibility and Verification System (IEVS) and the use of other state-specific databases. In addition, they can conduct third-party checks before the final eligibility determination—rather than simply as a post-eligibility review—to be assured that financial information is valid.

Any additional staff resources required to conduct verification would be offset by the simplifications in program administration. An enrollment system that takes full advantage of technology will have a simpler, more cost-effective quality control process as well because the information in the system will be available both for eligibility determinations and for effective verification at all stages of the process.

4. Re-establish coverage for low-income, legal immigrant children who have been cut out of the system.

In 1996, federal law was changed to allow only those legal immigrant children who have resided in the U.S. for more than five years to be eligible for Medicaid and SCHIP.[xli] While families of these children are still obligated to pay federal taxes during this five-year period, and the children's health has an ongoing impact on the community, this rule has cut many legal immigrant children out of the health care system. Understanding the short sightedness of this policy, 23 states maintain coverage during the five-year window, at state cost, to some or all immigrant children.[xlii] Extending Medicaid coverage to legal immigrant children, no matter their date of entry or number of years in the country, could ultimately bring 170,000 children into the federal program, at an approximate annual cost of $295 million.[xliii]

Re-opening eligibility to all children who legally reside in this country would have two important results. First, and most important, it would ensure that they get the health coverage they need. But it also would help streamline the enrollment process, making it more cost-effective. Currently, immigration status is determined by a series of questions on the Medicaid/SCHIP application that covers many different immigration categories. This section of the application is often quite confusing for families and staff and requires extra processing time.

There have been efforts in Congress to reinstate eligibility for lawful immigrant children (as well as pregnant women) through the Immigrant Children's Health Improvement Act.[xliv] Unfortunately, although the original bill received bi-partisan support in the Senate, it did not pass on its first go-round and has thus been reintroduced.

5. Redefine Medicaid/SCHIP immigration rules to allow the social security number to establish qualifying status for children.

Another essential change required to streamline administrative processes would be to allow an unrestricted social security number (SSN) to serve as *de facto* proof of United States citizenship, nationality, or eligible immigration status for Medicaid for children and SCHIP. This change to the health programs' immigration eligibility rules makes administrative sense, as well as serving the policy concerns set out in Step 4 above.

If a child has an unrestricted SSN, further immigration documentation should be unnecessary since that child can't get a SSN without providing official immigration papers to prove that he or she is a legal alien, a U.S. citizen, or national.[xlv] The Social Security Administration verifies all such immigration documents with the Department of Homeland Security and U.S. Citizenship and Immigration Services, through a number of immigration databases.

Federal Medicaid and SCHIP rules require all immigrant children to present documentation of their immigration status, regardless of whether or not they have a SSN. In addition to being duplicative, this blanket requirement is burdensome, intimidating, and can discourage involvement both in health coverage and in the enrollment doorway program. As evidence of this, about 26% of citizen children with non-citizen parents are uninsured, compared to 16% of children with citizen parents.[xlvi]

Unfortunately, at the same time that we see opportunities for enhancing the administrative effectiveness and efficiency of immigration rules for legal immigrant children, the federal government is moving on the other direction by imposing a new policy in the Deficit Reduction Act of 2005 requiring documentation of United States citizenship or nationality, in addition to the documentation requirement imposed on legal immigrants. Although the implementation guidelines have not yet been issued, this new requirement could be more of a bureaucratic hurdle than a real fraud-prevention mechanism[xlvii] and runs counter to the logic underlying the doorway proposal set out in this paper. If this new requirement goes into effect in states, it will inhibit all streamlining and simplification efforts, including the doorway approach laid out by this report.

By aligning the immigration requirements for Medicaid for children and SCHIP with those required for a SSN and then allowing a child's SSN to verify that he or she meets the immigration requirements for health coverage—whether a citizen, national, or legal alien—Medicaid and SCHIP would eliminate a bureaucratic obstacle that substantially complicates enrollment for families and requires states to waste precious resources. As with all proposed changes, it is important that current eligibility processes remain as a back up. In this case, where a child does not yet have a SSN, the family would need to provide immigration documentation to prove status.[xlviii]

6. Establish a renewal system that encourages uninterrupted participation of eligible children in Medicaid/SCHIP.

In addition to a streamlined initial eligibility determination, a successful enrollment system must also have a simplified re-enrollment process. Too many children lose coverage once they have it because renewal is complicated. Specifically, a renewal process should not require re-presentation of information that is already on file and has not changed. It should include the following elements:

- Twelve months continuous eligibility. At a minimum, states should provide twelve months continuous eligibility. Beyond that, since the vast majority of Medicaid and SCHIP users do not experience a change in eligibility from year to year, families should only be required to notify the health care agency of any changes in circumstances, including income, at their renewal time. And, importantly, coverage should automatically continue for an additional twelve months while the file is being updated and on-going eligibility confirmed.

- Automatic update and renewal capacity. Each time a family provides personal data at an enrollment doorway, those with children enrolled in Medicaid or SCHIP should be able to request that updated information be sent to the health agency to be used for renewal purposes. As a further streamlining measure, if new information comes in during the three months before a renewal date, the renewal period should begin at that point and extend for the full twelve-month eligibility period from that date. If the updated information finds the child no longer eligible, coverage would continue through the end of the previously existing eligibility period. This process would allow renewal times to be aligned for siblings in the same family.

- Screen and enroll procedures. Screening should be done to ensure that Medicaid coverage is granted where warranted, even where the child is already enrolled in SCHIP. This must be done at renewal in addition to being done at an initial eligibility determination. However, at this stage of the process, this screening may have to function with pared down information, due to streamlining procedures that are in place.

- Pre-populated renewal forms. Families who are not able to renew automatically through an enrollment doorway should be sent a pre-populated renewal application: a form that has updated information already printed on it so that it does not have to be filled-out manually. This will greatly reduce the incidence of errors and save time for the family and the system.

7. Maintain confidentiality and promote trust.

Enrollment doorway programs and families gain a lot from the trust that grows out of their relationship. Efforts to utilize this relationship to improve health coverage must enhance, not jeopardize, that trust. As a result, no matter how a family applies for Medicaid or SCHIP, confidentiality protections are imperative. In the enrollment doorway approach, enrollment must be opt-in rather than opt-out. This means that a family must give consent to be enrolled rather than being automatically entered and then asked later if they want coverage. And, like current immunization policies, a parent must have the option to decline coverage for religious or philosophical reasons.

Importantly, a successful enrollment doorway also must present families with information that is appropriate for their literacy level and their English language capacity. The doorway program must be confident that the family understands how their information will be used and to what they are agreeing.

In addition to maintaining existing confidentiality rules, the use of enrollment doorways will likely require some new procedures at the federal and state levels. These will ensure

the information presented by families is only used for the purposes of Medicaid and SCHIP enrollment and will not be shared with other government agencies except in investigations of fraud.

8. Invest in technology to enhance the interface between doorway programs and Medicaid/SCHIP administrative processes.

Much of the public sector is actively participating in our nation's technology revolution. In conjunction with welfare reform, states overhauled and improved their welfare database capability. Public programs are using better on-line applications. Both the private and public sectors are making major investments in electronic health records technology. And there is an ever-expanding role for the Internet as its functions improve and as privacy protections are strengthened.

Yet despite these advances, policy innovation in the public arena is still too-often inhibited by the persistence of unconnected, outmoded technologies and databases.[xlix] Ultimately, the technological capacity of the health insurance enrollment doorways and of the Medicaid and SCHIP systems at large will determine whether enrollment can be effectively streamlined and the remaining eligible children brought quickly into the system.

Specifically, the enrollment technology needs include:

- Solving the inter-operability challenge to allow privacy-protected data entry and retrieval across agencies, in particular between an enrollment doorway and the health agency;

- Designing a system that links an enrollment doorway directly with Medicaid/SCHIP so that real-time presumptive eligibility determinations can be made;

- Avoiding duplicate enrollment processing through an automated database review of current health program enrollment;

- Allowing *ex parte* inquiry by the health agency into available databases to retrieve missing information and for verification purposes; and

- Installing technological advances like Internet-enabled record sharing at schools, hospitals, and other places that provide doorways to enrollment.

The efficiency and success of the enrollment doorway process depends on meeting as many of these technology needs as possible. If not, manual data entry and paper transfer will sap much of the efficiency from a redesigned process.

9. Maintain employer coverage as a piece of the solution.

This report focuses primarily on the government's role in covering uninsured children. However, reaching as many children as possible also means relying on employers to continue providing affordable dependent coverage. Employers are vital because the public system cannot and should not, at this time, shoulder the financial burden of covering all of the nation's children. Efforts to increase enrollments must therefore make sure that public coverage does not supplant available private coverage while also maintaining the value of that coverage for the family. Enrollment doorways must verify that children are uninsured before helping to enroll them in public coverage.

One way to help the public and private insurance systems work together would be to establish a mechanism through which Medicaid or SCHIP could buy into a parent's dependent coverage, both to expand its scope and also to limit substitution of employer coverage. Many states are already using funds that would otherwise pay for Medicaid or SCHIP to instead buy into, or fund, a family's enrollment in available employer coverage, though efforts need to be made to reduce the administrative complexity of that process if it is to be applied more widely.

10. Provide sufficient federal funding and incentives to states.

In order to capture the remaining six million "eligible but uninsured" children, reliable federal financial assistance is needed for new enrollees, either those that come through the doorways or legal immigrant children whose eligibility for coverage is reinstated. In addition, enhanced support is required for the substantial planning and technological improvements necessary to make a doorway system work. The specific costs of these items are discussed in *Moving Forward*.

A successful doorway system also relies on a state's ability to finance its share of the costs associated with providing coverage to newly enrolled children. Today, however, states are pushed to the limit by their health care expenditures. When SCHIP was introduced, the federal government recognized that enhanced matching (i.e., providing additional federal funds for every state dollar spent) would be necessary if states were going to take advantage of the new authority to bring more children into the public health insurance system. We are at a similar juncture today. States are already pushed to the limit running their Medicaid and SCHIP programs. If our goal is to reach all children, then it is time to consider increasing the federal matching rate for all children covered by public coverage to promote this national agenda.

A CLOSER LOOK AT THE MOST PROMISING ENROLLMENT DOORWAYS

Following is a step-by-step review of how an enrollment doorway system would work.

Enrollment Doorway: Hospitals

Why this is an important doorway: Infants born to women on Medicaid are currently automatically enrolled in the program (usually through a simple form sent from the hospital to the state). Unfortunately, there is no such institutionalized mechanism for checking eligibility on, and enrolling, those low-income infants born to women who are not on Medicaid. A hospital is a logical place to make this happen since much of the information required for Medicaid or SCHIP enrollment may already be collected for hospital admission.

The goal: Every low-income child born in a hospital will have the chance to apply for health insurance coverage before discharge.

How it would work: In the day or two following delivery, hospitals would be required to present new parents with a one-page health insurance enrollment form. The form would ask parents if they have health insurance for the infant or can apply for dependent coverage through an employer. If not, and they indicate gross income below a certain level, the form would then serve as an application for Medicaid and SCHIP. All the information required to presumptively enroll the child would be obtained on this form. The hospital would certify the child's date of birth to establish citizenship for Medicaid or SCHIP.

The form would be sent electronically to the state health agency so a presumptive eligibility determination could be made in real time. The system would check to make sure the newborn wasn't already being added to the public health insurance rolls through another doorway. If the child were found eligible, the parent would be given a temporary, and immediately useable, Medicaid or SCHIP number. The state would later conduct verification of the child's application and send a benefits card for the appropriate program (Medicaid or SCHIP), and, if applicable, the parent would choose a health plan. The families would receive a bill for any required premiums or co-payments.

If a parent indicated that employer coverage was available, states would explore the feasibility of coordinating coverage with the employer as part of the final eligibility process.

Enrollment Doorway: Schools

Why this is an important doorway: Nearly 90% of the nation's children attend public school.[l] Every year, as school is starting, families are asked to submit updated information. Sometimes this includes health insurance information, and often—especially if the family is applying for school lunch or other school-based programs—it includes the same kind of information required for Medicaid or SCHIP enrollment.

The goal: All low-income children will have an opportunity to apply for, or renew, public health insurance when completing their back-to-school paperwork.

How it would work: At the beginning of the school year, parents would be asked whether their child has health insurance or can apply for dependent coverage through an employer. If the family has no coverage for a child, they would be asked to complete an application form which would include the option of providing the child's social security number to verify eligible citizenship or immigration status. This information would be sent to the state, either manually or electronically (just as hospitals, described above, transmit their forms). If a social security number is provided, an eligible child could be enrolled into coverage automatically. If not, the state would follow-up to obtain the child's immigration documentation. In addition, as part of the final eligibility process, the state would explore the feasibility of buy-in if an applicant indicates that employer-based dependent coverage is available.

After all information has been verified, the state would send the child a health benefits card for either Medicaid or SCHIP and seek preferences on health plan options (if applicable). The families would receive a bill for required premiums and co-payments.

Enrollment Doorway: Means-Tested Public Programs

There are a number of means-tested public programs that could serve as enrollment doorways for health insurance coverage. Food stamps, subsidized child care, Head Start, and the Earned Income Tax Credit are all promising choices. In each of these, the enrollment criteria for the program are sufficiently similar to the criteria for Medicaid or SCHIP such that a streamlined application process could be created. For purposes of brevity, a detailed look at how this might work is provided here for only one means-tested public program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Why this is an important doorway: WIC provides nutrition assistance for pregnant, postpartum, and breastfeeding women, and to infants and children up to age 5, if income does not exceed 185% of the federal poverty level. More than 20% of uninsured, low-income children live in families that participate in WIC.[li] As a result, it is an ideal

doorway for reaching these children. Further, the Medicaid program allows eligibility for WIC to serve as proof of eligibility for Medicaid—called adjunctive eligibility. As a result, there is already a system in place for exchanging and verifying information between these two programs.

The goal: Whenever a family applies for WIC, they will be able to simultaneously submit the information to enroll in, or renew coverage for, Medicaid or SCHIP.

How it would work: Applicants for WIC would be asked whether their child has insurance coverage and if not, to authorize use of the information provided for WIC eligibility as a basis for making a health program determination. Those families that are interested would be asked to provide the information required for Medicaid and SCHIP that is not needed for WIC, such as the child's SSN. Medicaid and SCHIP would use the WIC income finding without need for further calculation under their income rules. The WIC agency would electronically send the information to Medicaid or SCHIP so that a presumptive eligibility determination could be made in real time. The system would check to make sure the child is not already enrolled and if not, would provide a temporarily enrollment until a final determination could be made. If a family had access to employer-based coverage, the state would explore the feasibility of buy-in as part of the final eligibility process.

On the back end, the state would conduct verification, collect any necessary follow-up information directly from the family (particularly if a SSN was not provided), finalize the eligibility determination, and send the child a health benefits card. The family would also receive a bill for required premiums and co-payments.

MOVING FORWARD

To implement the ten steps laid out in this report, federal authorities must enact key changes to federal law, set out requirements for states, and establish incentives that then push states to implement their part of the policy effectively. States would be given federal financial support to make these changes, such that in the end, program benefits, maintenance of effort provisions, cost sharing, and the primary make-up of Medicaid and the State Children's Health Insurance Program (SCHIP) would be unchanged.

Federal Legislative Changes

States already have the authority to implement a number of the streamlined enrollment procedures that would support an enrollment doorway process. These include the ability to use a shortened application, allow self-certification of income and deductions, and implement presumptive eligibility. In addition, states can already improve technology interfaces, implement some *ex parte* procedures, and build solid systems for verifying eligibility information. Unfortunately, no state has taken all these steps to their fullest potential. Under this proposal, states would be required to make all of these changes. Specific federal-level actions would include revising Title XIX and Title XXI of the Social Security Act to:

- Require states to implement an enrollment system through schools, hospitals, and other public programs, utilizing a shortened one-page doorway application, presumptive eligibility, and self-declaration of income;

- Establish new enrollment incentives, including reliable funding for children enrolling through the doorways, as well as enhanced federal support through technology and assistance grants to states, schools, and other public program entities;

- Extend eligibility to legal immigrant children and approving utilization of the social security number in place of immigration documentation; and

- Allow states to utilize the income determination of another public program for Medicaid and SCHIP, regardless of differences in methodology.[lii]

Financial Considerations
The total cost of an enrollment doorway system would include:

- The cost of providing health care benefits to additional children;

- The cost of financing enrollment assistance; and

- The cost of new technology.

While it is difficult at this juncture to provide an exact final figure—we don't know exactly how many children would enroll each year, or how much technology investment would be required—potential costs can be estimated.

Additional Coverage: If all of the ten steps for a successful enrollment doorway system were implemented, as many as 6.1 million children could be provided with coverage—5.9 million "eligible but uninsured" children[liii] and 170,000 newly eligible legal immigrant children.[liv] Phase-in of enrollment would take a number of years. But assuming a realistic implementation rate of 80% was eventually reached, the federal and state cost would total $8.8 billion a year in current dollars.[lv] If an enhanced match rate were implemented for all children, the federal government share would obviously increase across the board. Contrasted with current annual federal and state government spending on the Medicaid program ($316 billion), or the cost of the annual tax subsidy for private insurance (over $200 billion), this additional investment in children and public health is quite modest.[lvi] And it is important to remember that states and the federal government are already paying to provide health care to some of these uninsured children through less effective, more costly channels. Estimates show that public and private sectors spend $5.4 billion each year to pay medical costs incurred by hospitals, offices, and clinics for uninsured children, not including the out-of-pocket costs paid by the insured themselves.[lvii] Despite this expenditure, most uninsured are receiving no continual care. Providing coverage to the children brought in by the enrollment doorways would significantly reduce this current spending while helping set children up with timely, beneficial, cost effective access to services.

Enrollment Assistance: Experience to date clearly shows that enrollment doorway programs will not be able to add Medicaid/SCHIP enrollment to their systems without additional financial support. For schools and public programs in particular, the new enrollment efforts would be outside the scope of normal services. These institutions are already stretched thin, and they certainly do not have the resources to support the initial technology development that would be needed. By contrast, hospitals are better positioned to easily incorporate health insurance enrollment into their existing protocols.

Funding enrollment assistance could be accomplished by paying the doorway organization a small fee of, for example, $25 for each applicant whose paperwork is properly submitted. If 80% of 6.1 million uninsured children were successfully enrolled through a doorway, the cost for enrollment assistance would be $122 million. This cost would decrease over time as children are simply having their information updated for renewal. Policies to provide compensation for renewal activities through the doorways should also be pursued.

In the alternative, enrollment assistance could be funded through a volume-based system of grants as it is in the Title I program. Title I funding for schools is tagged to successful enrollment of children in school lunch, among other markers. Success in health insurance enrollment could provide doorway institutions with enhanced federal funds useable for other purposes. Most likely, this would need to be funded at about the same level as the stipends proposed above.

Technology: In addition to the costs associated with increased enrollment and support for the enrollment entities, an enrollment doorway system will require investment in the technology that is necessary to make it really work. In part, this effort can be linked to the current health information technology revolution seen in the wide deployment of on-line application systems, development of electronic health records capacity, and substantial upgrade of the information technology used by public agencies. However, based on GAO cost estimates for implementing welfare database improvements required by welfare reform,[lviii] it is safe to assume that over $1 billion in grants to states would be required to create and deploy some of the technology needed for this new way of operating. Balanced against this expense is the strong likelihood that each dollar invested in improving technology would result in substantial administrative savings. An audit of potential savings from technology that would result from integrated eligibility and screening systems in Texas found that a single program could save 12% of its budget (or $38 million per year) through improved centralization and efficiency.[lix] Given the ultimate savings, it makes financial sense for the federal government to provide enhanced matching for the cost of overhauling enrollment technology, along the lines currently provided for other information technology efforts.

By the estimates provided, implementing the ten steps means a financial investment of close to $10 billion, $8.8 billion of which would be a yearly state and federal cost to pay for health benefits. However, these costs would be phased-in over time as new children are enrolled, and eventually the technology and enrollment assistance grants would not be required. Substantial savings would also flow out of this investment, in reduced administrative costs as well as reductions in costs from "churning" (children entering and exiting the system repeatedly) and uncompensated care.

Phases of Work

States can begin taking steps toward an effective enrollment doorway system by first enacting all existing opportunities to simplify and streamline their enrollment systems, such as self-declaration of income, and presumptive eligibility.

At the same time, the success of this systematic doorway approach depends on the use of new technology systems. States should avail themselves of existing enhanced matching opportunities and any available grant funds, both public and private, to assist them in automating and reconfiguring their systems to create the necessary interfaces.

Further, states should ready the doorways to provide children with an effective pathway to access health coverage. As each improvement is made to the enrollment system, the state should make sure that it improves its capacity for the enrollment doorway approach. This is particularly important in the technology design, which must anticipate its ultimate use for an enrollment doorway system from its inception, to really be feasible.

Finally, at the federal level, Congress and the Centers for Medicare and Medicaid Services will need to revise the rules as outlined in this report that impede true streamlining and stand in the way of greater efficiency and enrollment of all eligible children.

CONCLUSION

We are standing at an important public policy threshold: if we can provide subsidized health insurance to the six million children who are currently eligible but uninsured, 95% of America's children will be covered. The programs that can accomplish this (Medicaid and SCHIP) already exist, and states have the knowledge gained through nearly ten years of innovative outreach and enrollment efforts. Public, bi-partisan support for children's health is on the rise—some states have recently expanded their children's health programs even in the face of tight budgets, and President Bush has promised to enroll eligible but uninsured children.

While covering these children does come with a price tag, every dollar spent is an investment with a high pay-off. Health insurance coverage is a proven avenue to increasing the health and educational achievement of our nation's children. Further, the changes contemplated here will establish a modernized enrollment system that guarantees every dollar is spent wisely. If we do nothing, we pay a much higher price.

This report provides a blueprint to make sure we do not pay the price of doing nothing. It offers a concrete strategy for implementing smart and efficient public health insurance enrollment doorways. We hope it will both motivate federal and state leaders to take action and assist them in doing what needs to be done.

ENDNOTES

[i] Marc L. Berk, et al., "Americans' Views About The Adequacy Of Health Care For Children And The Elderly," *Health Affairs* Web Exclusive, 14 Sept. 2004.
[ii] President Bush pledged support to enroll all "eligible but uninsured" children. Leaders from Senate Majority Leader Bill Frist and Senator Richard Lugar to Senators Ted Kennedy, John Kerry and Jeff Bingaman, have made similar commitments.
[iii] State Health Access Data Assistance Center and Urban Institute, *Going Without: America's Uninsured Children* (Columbia, S.C.: Covering Kids & Families, Aug. 2005) 4. This figure is based on the U.S. Census Bureau 2004 Current Population Survey (CPS) and is limited to children under age 18. We use this figure, rather than one for ages 0-18, because it allows for the most up-to-date analysis of the number of eligible but uninsured. However, by excluding children age 18, the figure somewhat undercounts children who might be eligible for Medicaid and SCHIP. The Kaiser Commission on Medicaid and the Uninsured, based on March 2004 and 2005 CPS, puts the number of uninsured children at over 9 million, which includes 18 year olds. (http://www.statehealthfacts.kff.org).
[iv] Ibid.
[v] Vernon Smith, Health Management Associates, "Medicaid in 2005: Current Trends, Key Issues and Outlook for the Future," 6 June 2005. This figure presumes an 80% take up rate as its goal, which would mean that 4.9 million children would ultimately obtain coverage, and uses the most recent estimate of $1,800 as the average cost of Medicaid per child in 2005, as per Health Management Associates, based on CBO March 2005 Baseline.
[vi] Ibid; Leonard E. Burman, Statement before the U.S. Senate Committee on Finance, "Taking a Checkup on the Nation's Health Care Tax Policy: A Prognosis" (Washington, D.C. Urban Institute, March 8, 2006).
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[ix] Centers for Disease Control and Prevention, "Vaccination Coverage Among Children Entering School – United States, 2003-04 School Year," *MMWR Weekly* (Atlanta, GA: 12 Nov. 2004) 1041-1044.
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[xi] Mary Sue Coleman, et al., *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: Institute of Medicine of the National Academy of Sciences, 2002).
[xii] G. Melnick, et al., *Evaluation of the Los Angeles CalKids Program: Full Report* (Los Angeles, CA: University of Southern California School of Policy, Planning and Development, Center for Health Financing, Policy and Management, Feb. 2002) 35-36.
[xiii] Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update 2004* (Washington, D.C.: KCMU, May 2004) 7, Table 1.
[xiv] Ibid. 3.
[xv] Families USA, *Paying A Premium: The Added Cost of Care for the Uninsured* (Washington, D.C.: Families USA, June 2005) 2.

[xvi] Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Washington, D.C.: KCMU, June 2002).
[xvii] General Accounting Office, *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, Benefits,* (Washington, D.C.: GAO/HEHS-00-86, April 2000) 14-15.
[xviii] See http://coveringkidsandfamilies.org/about.
[xix] Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Low-Income Children* (Washington, D.C.: KCMU, September 2004).
[xx] op. cit.(3).
[xxi] op. cit. (7).
[xxii] Ibid, 8-9.
[xxiii] Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families* (Washington, D.C.: KCMU, Oct. 2004) 16.
[xxiv] Gerry Fairbrother, et al., "Costs of Enrolling Children in Medicaid and SCHIP," *Health Affairs*, Vol. 23, No. 1 (2004) 241.
[xxv] op. cit. (16) 3.
[xxvi] Lake, Snell, Perry and Associates, *How and Why Eligible Children Lose or Leave SCHIP/Healthy Families* (Washington, D.C.: June 2002).
[xxvii] Carol Irvin, et al., *Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children* (Cambridge, MA: Mathematica Policy Research, Inc., 2001).
[xxviii] Gerry Fairbrother, *How Much Does Churning in Medi-Cal Cost?* (Sacramento, CA: Cover California's Kids, April 2005).
[xxix] op. cit. (23).
[xxx] Vernon K. Smith and David M. Rousseau, *State Enrollment in 50 States: December 2004 Data Update* (Washington, D.C.: KCMU, Sept. 2005) 1.
[xxxi] National Center for Education Statistics, "Enrollment trends, public & private schools," *NCES Fast Facts* (http://nces.ed.gov/fastfacts/FAQTopics.asp?type=1).
[xxxii] Stan Dorn and Genevieve Kenney, Economic and Social Research Institute, *Automatically Enrolling Eligible, Low-Income Children and Adults into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Policy Makers* (Washington, D.C.: Upcoming Release).
[xxxiii] Food Research and Action Center, *State of the States 2005* (Washington, D.C.: 2005) 24.
[xxxiv] Donna Cohen Ross and Ian T. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *The Future of Children*, Vol. 13, No. 1 (2003) 81-97.
[xxxv] Peggy Papsdorf and Vivian Horn, Washington Campaign for Kids, *Linking School Lunch Programs to Medicaid Enrollment in Washington State* (Seattle, WA: July 2002) 7.
[xxxvi] Kathleen Widdoes, Health Benefits Manager, EDS Newark, DE, Interview by author, 25 July 2005. Data refers to the period between January 2004 and January 2005. To make the picture even worse, in early data from the first few months of the program, EDS reported that 20% of those who returned their application package left something out.
[xxxvii] Kaiser Family Foundation (KFF), Statehealthfacts.org, "Presumptive Eligibility for Medicaid and SCHIP, 2005" (http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi).
[xxxviii] KFF, Statehealthfacts.org, "Allows Self-Declaration of Income Under Medicaid and SCHIP, 2005" (http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi); Danielle Holahan and Elise Hubert, *Lessons from States with Self-Declaration of Income Policies* (New York, N.Y.: United Hospital Fund, 2004).
[xxxix] Due to the fact that these various public programs utilize different methodologies to calculate income, including different income counting rules, it is currently not feasible for Medicaid and SCHIP agencies to rely upon another public program's income finding without recalculating income under their own rules.

Legislation currently in Congress would authorize states to use another program's income finding (Section 3 of S. 1049, The Covering Kids Act of 2005, introduced by Senators Frist and Bingaman).

[xl] op. cit. (38).

[xli] Shawn Fremstad and Laura Cox, Center on Budget and Policy Priorities, *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance* (Washington, D.C.: KCMU, Nov. 2004) 1. There is one exception to this rule: certain "lawfully present" or PRUCOL immigrants are ineligible for Medicaid and SCHIP regardless of their length of residency in the U.S.

[xlii] Ibid, 16-17.

[xliii] Congressional Budget Office, Cost Estimate for HR 4737, section 402, 18 July 2002, 15-17. This figure includes legal immigrant children (90%) as well as U.S. citizen children of immigrant parents, who would be expected to enter the program in larger numbers, following 10 years of implementation. The approximate cost was calculated using the most recent Health Management Associates estimate of $1,800 for the average per-child Medicaid cost in 2005.

[xliv] S. 1104 in 2005.

[xlv] There are three types of social security numbers: unrestricted, limited (valid for work only with authorization), and nonwork restricted.

[xlvi] op. cit. (41) 2.

[xlvii] Leighton Ku and Matt Broaddus, Center on Budget and Policy Priorities, *New Requirement for Birth Certificates or Passports Could Threaten Medicaid Coverage for Vulnerable Beneficiaries: A State-by-State Analysis* (Washington, D.C., 5 Jan. 2006).

[xlviii] Some legal immigrants or their children will experience a delay in obtaining SSNs, such as PRUCOL aliens or asylees.

[xlix] General Accounting Office, *Welfare Reform: Improving State Automated Systems Requires Coordinated Federal Effort* (Washington, D.C.: GAO/HEHS-00-48, April 2000).

[l] op. cit. (31).

[li] op. cit (32) 3.

[lii] This provision is currently in S. 1049 Covering Kids Act of 2005 sponsored by Senators Frist and Bingaman.

[liii] op. cit. (3).

[liv] op. cit. (43). Note that while the CBO estimate does not include the number of children who will enroll in SCHIP, it is still the best figure available. In order to adjust for this factor, we have elected to use the 170,000 figure that CBO estimated as the ultimate enrollment of newly eligible legal immigrant children following 10 years of implementation instead of their estimate of 155,000 children who would enroll in the first year.

[lv] op. cit. (5).

[lvi] op. cit. (5) and (6).

[lvii] Ibid, 3.

[lviii] op. cit. (49) 21.

[lix] Texas Health and Human Services Commission, *Integrated Eligibility Determination: Discovery Report* (Austin, TX, Feb. 2004) 30. The program referred to is Food Stamps. In total, the cost of eligibility and screening for Medicaid, SCHIP, and multiple other human services in Texas is $700 million per year.

APPENDIX: FEDERAL MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) RULES

Administration	Medicaid and SCHIP are administered at the state level under broad federal guidelines. States have some latitude on how to run their programs, e.g., the name, application and enrollment procedures, etc. Some states have combined Medicaid and SCHIP (either by creating one Medicaid program or administratively combining the programs under one name). Most maintain two separate programs (sometimes administered by different agencies). Federal law requires that a state determine eligibility for a child for Medicaid before screening for SCHIP, to ensure the child is appropriately placed.
Funding	Medicaid and SCHIP are funded with federal and state dollars. State dollars are matched with federal funds, with states receiving a higher matching rate for SCHIP expenditures than Medicaid. The Medicaid program is an entitlement program, meaning that a state is required to provide, and will receive a federal match for, services to all qualifying children that enroll in Medicaid. SCHIP is a block grant program in which the federal government allocates a set amount of money to a state for matching purposes.
Income Thresholds	Income rules vary by state, but states are required to enroll newborns through age 5 with family incomes up to 133% of the federal poverty level (FPL), or $26,600 for a family of four in 2006, and ages 6 to 19 up to 100% FPL (or $20,000). Effectively, federal law imposes no upper income limit since a state can elect to disregard some income above that level States are allowed to use SCHIP to reach "targeted low-income children" whose income is above Medicaid thresholds. Most states make coverage available to children in families with incomes at 200% FPL or higher.

Income Counting	The type of income that is counted toward eligibility thresholds varies from state to state, with substantial federal guidance. Families can also claim certain deductions, such as childcare expenses, to lower countable income. The wage earner's familial relationship to the applicant is what determines whether the income is counted. For Medicaid, income and assets are counted for related persons living in the same home who have financial responsibility for health care for the applicant (spouse for spouse, parent for child). This determination is at state discretion for SCHIP.
Allowable Resources	States have the option to require an assets test for low-income children. This test limits the amount of resources (e.g., a car or house) that a family can own.
Cost-Sharing	Federal law generally protects low-income children enrolled in Medicaid from cost-sharing requirements and allows limited premiums or co-pays for children covered by an expansion of Medicaid to higher income levels. SCHIP cost-sharing is limited by federal law to five percent of family income. New rules in the Deficit Reduction Act of 2005 give significantly more flexibility to states to impose premiums and cost-sharing in Medicaid for children.
Immigration	Federal law limits Medicaid and SCHIP eligibility to U.S. citizens and most categories of legal immigrants who have resided in the U.S. for more than five years. Most legal immigrants who entered the U.S. on or after August 22, 1996 are ineligible for Medicaid and SCHIP during their first five years of residency, unless a state has decided to use state funds to provide coverage. Legal immigrants must provide documentation of their status as part of their Medicaid and SCHIP application. Undocumented immigrants and those subject to the five-year ban can only qualify for emergency medical care.

Documentation	A state is required to obtain documentation of immigration status of non-citizens. The Deficit Reduction Act of 2005 imposes a new requirement on states to collect documentation of U.S. citizenship and nationality, as well. On all other matters, such as income or resources, self-verification is allowed.
Social Security Number	Medicaid applicants must provide a social security number. States have discretion as to whether to require a social security number for SCHIP applicants.
Verification	States must have an income and eligibility verification system (IEVS) in place for verifying the family income of children who are found eligible for Medicaid. States accomplish this verification by requesting wage, income, and other information from state and federal agencies, including the Social Security Administration and/or Internal Revenue Service. States are not required to conduct such verification for SCHIP, although most states do so.
Renewal	Federal law requires states to re-determine eligibility at least once every 12 months.

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