Enrolling Eligible Children and Keeping Them Enrolled

Donna Cohen Ross and Ian T. Hill

SUMMARY

Coverage under Medicaid and the State Children’s Health Insurance Program (SCHIP) provides low-income children with a vital link to needed health care, yet a significant proportion of children eligible for these programs remain uninsured. States have found that expanding eligibility and marketing new programs are not enough to increase enrollment of eligible uninsured children in public health programs. States also need to simplify enrollment and renewal procedures to make them more family-friendly. According to survey data, a key reason for underenrollment is that families find enrollment and renewal procedures too complex.

This article details the efforts that states have made to increase enrollment in Medicaid and SCHIP, and it offers recommendations for strengthening these efforts. Although barriers to enrollment and renewal still exist, states are making progress in several ways, such as:

- Simplifying eligibility procedures.
- Using community-based application assistance.
- Eliminating procedural differences between Medicaid and separate SCHIP programs.

The authors recommend that states continue to simplify program requirements and procedures, making it easier for children to enroll in Medicaid and SCHIP, retain coverage for as long as they qualify, and transfer between programs when necessary. In addition, outreach and community-based application assistance will continue to be essential activities, along with developing efforts to enroll children through other public programs, such as the food stamp program.

Donna Cohen Ross is the director of outreach at the Center on Budget and Policy Priorities.

Ian T. Hill, M.P.A., M.S.W., is a senior research associate at the Health Policy Research Center at the Urban Institute.
Health insurance can make a striking difference in the lives of children and their families. It not only can influence whether a child obtains needed health care, but it also can affect a child’s school attendance and ability to fully participate in school activities. In addition, families that lack health insurance are more vulnerable to financial stress than families with health coverage, making it more challenging for them to meet the needs of their children. For the vast majority (84%) of low-income, uninsured children, Medicaid and SCHIP can provide a vital link to health care, improved participation in school, and greater financial stability. Yet, 6.7 million low-income children who qualify for these programs remain uninsured. States’ experiences indicate that expanding eligibility and marketing new programs are not sufficient to reduce the number of uninsured children. To achieve success, a combination of these strategies, supported by ongoing, concerted efforts to facilitate the enrollment of eligible children in health coverage and keep them enrolled, is needed.

Surveys indicate that the complexity of enrollment and renewal procedures has deterred families with eligible children from applying for health coverage. Thus, many children appear to be going without insurance, not because they do not qualify for existing programs, but because their families have difficulty completing forms and assembling the documents that states require them to submit. For example, a national survey found that 67% of low-income families with uninsured children eligible for Medicaid had tried to enroll their children, but only 43% had been successful, largely due to confusion about the process and difficulty producing required documents. Similar procedural barriers impede families from completing the renewal process, causing their children to lose coverage even when they remain eligible.

With the creation of SCHIP in 1997, much attention was focused on the considerable flexibility states had to design new children’s health coverage programs that were free of enrollment obstacles. The surge of state activity that followed led federal officials to emphasize that states could also use this flexibility to remove barriers in their existing Medicaid programs, making it easier to coordinate children’s health coverage and to conduct outreach, as the law requires.

Since the implementation of SCHIP, intensive efforts to publicize the availability of health coverage, simplify enrollment procedures, and provide direct application assistance to families appear to have contributed to a significant reduction in the number of uninsured children. Census data show that the number of uninsured children declined by 1.7 million between 1998 and 2000 (from 15.6% to 13.3%). (See the article by Holahan, Dubay, and Kenney in this journal issue for an analysis of uninsurance trends using recent census data.) One reason for this change was an increase in Medicaid and SCHIP enrollment.

Yet, as children’s health coverage programs evolve, states continue to grapple with the challenges of enrolling eligible children and keeping them enrolled for as long as they remain eligible. In addition, the need for outreach has not diminished. An analysis of data from the 1999 National Survey of America’s Families by the Urban Institute found that although more than 80% of all low-income, uninsured children are now eligible for coverage under Medicaid or SCHIP, the parents of 62% of these children have not heard of the program in their state or do not know that enrollment in welfare is not a precondition for participation. Moreover, the need for outreach is likely to increase further due to increased unemployment, which has caused more children to become eligible for publicly financed health coverage.
This article reviews the strategies states have pursued to achieve strong participation in SCHIP and Medicaid, including simplifying enrollment, reaching out to families, and making it easier for families to renew their children’s health coverage. The article also makes recommendations about how states can strengthen their enrollment and retention efforts. Because rigorous studies evaluating specific outreach strategies are largely unavailable, the discussion relies heavily on case studies and telephone interviews with both state officials and representatives of outreach organizations.

Efforts to Simplify Enrollment

Since the late 1980s, states have taken a number of steps that make it easier for low-income families to enroll their children in public health insurance programs. Simplifying eligibility procedures can remove barriers to coverage and make it more likely that children retain coverage for as long as they qualify, produce administrative savings by reducing the time it takes to process applications, facilitate effective outreach by making it feasible for community organizations to assist families with program applications, and help distinguish public health insurance from the welfare system by eliminating onerous procedural requirements that are a vestige of Medicaid’s link to welfare.

This section provides a brief history of simplification efforts and discusses common approaches that states have taken to simplify health insurance enrollment for children. Key strategies that states have adopted include designing joint application forms for SCHIP and Medicaid; eliminating asset tests and face-to-face interviews; reducing the amount of proof of eligibility that parents must provide; and offering temporary, immediate enrollment for children while their applications are being processed.

Historical Overview of Simplification Efforts

In the late 1980s, as states adopted significant Medicaid expansions for pregnant women, infants, and young children, they also began to implement a host of federal options aimed at streamlining enrollment. They designed simpler application forms, stopped counting assets (the value of savings and vehicles) in determining eligibility, and authorized providers to presume low-income pregnant women eligible and directly enroll them in Medicaid. During the early 1990s, as expanded Medicaid eligibility for children was phased in, allowing more children to qualify for Medicaid regardless of their family’s welfare participation, states continued to simplify enrollment for such children. (See the article by Mann, Rowland, and Garfield in this journal issue.)

By July 1997, 36 states had stopped counting assets in determining Medicaid eligibility for children, and 22 states had removed the face-to-face interview requirement. In addition, states were implementing, to varying degrees, the federal law requiring them to allow applications to be filed at outstation locations in certain hospitals and clinics. Overall, however, applying for Medicaid still looked very much like the process of applying for welfare. Most families had to visit a welfare office, complete long, complicated forms, respond to intrusive questions, submit numerous documents to prove the information provided on the application, and periodically file reports to confirm their ongoing eligibility.

As more and more families with children eligible for Medicaid entered the workforce in the 1990s, due to aggressive “welfare-to-work” initiatives and a strong economy, complying with such procedures became even more problematic for many families. In addition, although Medicaid administrative funds could be used to conduct outreach, efforts to publicize the availability of the program and ways to enroll were rare. Thus, as the nation was on the brink of enacting a major new expansion of children’s health coverage under SCHIP, millions of children were eligible for Medicaid but remained uninsured.

Once federal SCHIP funds became available in 1997, most states enthusiastically embraced the new opportunity to provide health coverage to more children. Supported by favorable matching rates and a robust economy, states further expanded eligibility for children’s public health insurance and began to design programs with a full menu of simplified procedures that had advantages for both families and state agencies.

Common Approaches to Simplifying Enrollment

By January 2002, most states had adopted critical simplification strategies, such as allowing families to apply for Medicaid and SCHIP on the same form, disregarding assets in determining eligibility, and eliminating...
As states have simplified Medicaid and SCHIP enrollment procedures, they also have focused attention on reaching out to families and encouraging them to apply.

face-to-face interview requirements. At the same time, several options that could further simplify the application process were not being used to the fullest extent possible. For example, a minority of states had reduced or eliminated application verification rules not required under federal law or adopted presumptive eligibility for children, and efforts to link children to health coverage when they applied for other public benefits were still in the beginning stages.

One simplification strategy that most states chose to adopt was a common application form for SCHIP and Medicaid. Of the 35 states with separate SCHIP programs, 33 have created joint application forms that families can use to apply for either Medicaid or SCHIP. A single application allows families to apply for health coverage for their children by providing information once and leaves it to program administrators to determine the specific program for which a child qualifies. Indiana reports that the use of a simple joint application for its children’s Medicaid and SCHIP program, Hoosier Healthwise, has saved on printing costs and cut in half the time state workers spend verifying information provided by applicants. In addition, the state has realized savings by marketing its Medicaid and separate SCHIP programs as a single, coordinated children’s health insurance program.

Most states—44, including the District of Columbia—also do not count assets (such as the value of savings accounts or vehicles) in determining eligibility for children in both their children’s Medicaid and separate SCHIP programs. Eliminating asset tests removes questions from the application and reduces the amount of verification states require families to provide. Oklahoma officials report a $1.2 million savings as a result of removing the asset test for Medicaid, since the administrative costs of asset verification exceeded the cost of providing health benefits to children who would not have qualified had assets been counted.

In addition, all but four states no longer require a face-to-face interview as a precondition of enrollment in both their children’s Medicaid and separate SCHIP programs. Allowing families to submit application forms by mail, without a face-to-face interview at a government office, can make the process less intimidating and more convenient, particularly for working parents who are hard-pressed to take time off from their jobs to apply and for families with immigrant members who may be reluctant to become involved with a government program. (See the article by Lessard and Ku in this journal issue.)

A growing number of states have taken additional steps to simplify the enrollment process even further. For example, 13 states have eliminated requirements that families provide proof to corroborate the income and eligibility information on their applications (except proof of the immigration status of a noncitizen applying for coverage, which is required under federal law). Generally, these states then verify the income information families provide by cross-checking with data from other government agencies, such as the Social Security Administration and state departments of labor. Such data matching can ensure program integrity while streamlining the enrollment process for families. Other states have reduced the amount of required verification, asking for fewer pay stubs than in the past and not demanding proof of residency or children’s birth certificates. Still, various studies indicate that the difficulties families face in gathering all the required documents that states require them to submit contribute to the delay or denial of coverage to otherwise eligible children.

Some states have adopted another simplification option: presumptive eligibility for children. Nine states allow it in Medicaid, and six states allow it in their separate SCHIP programs. Presumptive eligibility allows “qualified entities” such as health care providers, schools, WIC agencies, Head Start programs, certain emergency food and shelter programs, and agencies that determine eligibility for public benefit programs to immediately enroll children who appear eligible for coverage for a temporary period while the family completes the application process. In the meantime, a child can receive all covered services, and providers can be reimbursed for delivering needed
Enrollment and Retention

Care during the presumptive period, even if the child ultimately is found ineligible for ongoing coverage. (See the article by Klein in this journal issue.)

States can use other strategies to facilitate enrollment in health coverage programs as well. For example, states can explore methods to enroll children in health coverage when they apply for other benefit programs. (See the article by Horner, Lazarus, and Morrow in this journal issue.) More can be done to facilitate development of such approaches and encourage states to implement them.

Using strategies like these to simplify enrollment procedures can have a marked effect on enrollment. For example, Figure 1 illustrates the increase in Medicaid enrollment in Ohio following implementation of modest eligibility expansions and a host of simplification measures. In addition to adopting modest coverage expansions in 2000, the state reduced verification requirements, revised its family-based application to allow children and parents to apply as a single unit, and improved systems to assure that families leaving welfare did not lose Medicaid coverage inappropriately. Between June 2000 and June 2001, children’s enrollment in the state’s traditional Medicaid program jumped by 22%, and combined regular Medicaid and SCHIP-funded Medicaid enrollment grew by 25%.

Reaching Out to Families

As states have simplified Medicaid and SCHIP enrollment procedures, they also have focused attention on reaching out to families and encouraging them to apply for children’s health insurance. Community-based application assistance has become a common feature of outreach efforts, with a number of states providing financial assistance.

Figure 1

Ohio’s Medicaid Enrollment for Children, Families, and Pregnant Women, 1997 to 2001

During 2000, Ohio:
- Expanded coverage modestly
- Adopted a new family application
- Reduced verification requirements
- Addressed TANF issues

Monthly Enrollmenta (in thousands)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>761</td>
<td>720</td>
<td>728</td>
<td>688</td>
<td>671</td>
<td>684</td>
<td>717</td>
<td>816</td>
<td>877</td>
<td>912</td>
</tr>
</tbody>
</table>

a Reflects enrollment in Ohio’s “regular” Medicaid program, which is coverage under Title XIX of the Social Security Act.

assistance and training to support such activities. A few states also are allowing managed care organizations to participate in enrollment initiatives. Yet, states with separate Medicaid and SCHIP programs still face the challenge of aligning the two programs to make enrollment more consumer-friendly and program administration more efficient. This section describes how states are handling these implementation opportunities and challenges.

Using Community-Based Application Assistance
Using community-based organizations to assist with Medicaid and SCHIP enrollment, providing families with direct help in applying for coverage, can be an important complement to broad outreach and marketing campaigns. Families often have frequent contact and long-standing, trusting relationships with schools, child care providers, faith-based organizations, and health and human services providers. In many communities, staff from these organizations may be the only link to families that are unlikely to apply for coverage on their own, due to a lack of awareness about publicly funded health insurance, difficulties understanding the application process, or a mistrust of government programs. Community organizations may also be in a unique position to reach out to people who do not speak English, have concerns about immigration status, or have work schedules that prevent them from applying at established enrollment sites open only during regular business hours.

Although under federal law only Medicaid agency staff can determine eligibility for Medicaid, staff from community organizations can conduct the initial processing of applications, which includes explaining program rules and benefits and helping families fill out forms, gather required documents, and submit applications. In addition, federal SCHIP regulations allow eligibility determination for separate SCHIP programs to be performed by a wide range of entities, as determined by the state.

States have supported the growth of community-based application assistance with a combination of grants, contracts, and training. Widespread support for community application assistance is evident across the country. Some states, including Illinois, Indiana, and New Mexico, have established enrollment sites in hundreds of locations and in a wide variety of settings, such as health clinics, schools, Head Start programs, recreation centers, and homeless shelters. To enable community groups to conduct aggressive outreach and enrollment activities, other states, including California, Massachusetts, New Jersey, Ohio, and Pennsylvania, offer grants or pay application-assistance fees of $20 to $50 for each application that results in an enrolled child.

In the early years of SCHIP’s implementation, some community organizations found application-assistance efforts too time-consuming to sustain and, as a result, stopped providing such assistance. As states have further simplified application procedures, however, community-based application assistance has become a more effective and popular outreach tool. For example, a project run by the Baltimore City Health Department, which helps enroll children in the Maryland Children’s Health Program, found that application-processing time was significantly reduced after the state implemented a self-declaration-of-income policy. Outreach workers who had previously spent a great deal of time helping families gather necessary documentation were able to spend more time recruiting new families through door-to-door canvassing and identifying eligible children in Head Start programs and schools.

Despite the growth in community-based application assistance, many children’s health insurance applications still are submitted incomplete. For example, in California, state officials reported in mid-2001 that roughly 70% of applications were submitted incomplete, meaning that information, a parent’s signature, or a verification document were missing. A state report indicates that between July 2001 and June 2002, roughly 44% of children’s health coverage applications remained incomplete 20 days after they were submitted. The help provided by community application assistants, however, did appear to make a difference in California: 63% of applicants who received no assistance were approved for enrollment, compared to a 79% approval rate for families who received assistance.

In addition, lessons learned by community-based organizations engaged in outreach and enrollment activities can help inform ongoing simplification efforts. For example, in 1999, initial attempts to reach out and enroll children in Illinois’ KidCare program through a Report Card Pick-Up Day enrollment campaign in the Chicago public schools yielded poor results. Of the 4,600 applications received, only about 1,000 were approved.
from school employees and community groups enlisted to help implement the event revealed that families were daunted by a difficult-to-understand 12-page application. In response, the application was reorganized and shortened to 3 pages, and it was made clear that adults applying for coverage for only their children did not have to provide their own Social Security numbers.

**Involving Health Organizations in Marketing and Enrollment**

Enlisting managed care organizations (MCOs) and individual health plans as partners in outreach and enrollment initiatives offers opportunities, but also raises concerns about potential conflicts of interest. During the 1980s and 1990s, in the early years of Medicaid managed care implementation, states identified instances of abusive marketing practices by MCOs as they sought to attract Medicaid recipients.

To prevent abuses, states have adopted practices designed to carefully regulate these organizations’ activities. For example, to protect beneficiaries’ access to information and their freedom of choice in selecting a health plan, states commonly prohibit organizations from conducting door-to-door marketing, using enrollment gifts or incentives, marketing in food stamp and welfare offices, and providing inaccurate information to potential enrollees. In addition, many states have hired “enrollment brokers” to oversee the fair and systematic enrollment of Medicaid eligibles into managed care.38,39

Yet, the prospect of using MCOs’ marketing skills and resources to help children enroll in public health insurance programs is attractive to some states, and several have enlisted the assistance of MCOs and health plans in SCHIP and Medicaid outreach and enrollment efforts. Case studies of 10 states conducted in 2001 and 2002 found that one-half of the states permit health plans to produce and disseminate advertisements for SCHIP and Medicaid that identify these plans as participating providers. All television, radio, and printed marketing materials, however, must be submitted to the state for review and approval. In two of these five states, California and New York, health plan staff are permitted to provide application assistance to prospective enrollees40 (see Box 1).

**Aligning Enrollment Procedures in Dual-Program States**

States that created separate SCHIP programs designed their new systems with a wide range of simplified procedures, such as eliminating face-to-face interviews, asset tests, and family income verification. These strategies are also allowed under federal Medicaid law; however, states have not always simplified the process for children in Medicaid to the same extent as in SCHIP.41 Given that more than two-thirds of uninsured, low-income children

---

**Box 1**

**Partnering with Managed Care Organizations in Marketing and Enrollment Efforts in New York**

Managed care plans are key partners in New York’s marketing and enrollment strategies. This approach began in the early 1990s when the state-funded Child Health Plus program relied exclusively on managed care plans to enroll eligible children, and was continued when the program began receiving federal matching funds under SCHIP. As of 2002, virtually all participating health plans had contracts with the state to serve as “facilitated enrollers.” Health plan staff can assist families in completing the Child Health Plus application form, and must screen children for both SCHIP and Medicaid eligibility, referring applications of those children who appear Medicaid eligible to the appropriate county social services agency.

are eligible for “regular” Medicaid, not SCHIP, simplifying the Medicaid program needs further attention.\(^4\)

Aligning the two programs makes enrollment easier for families and for states and can help some families overcome their concerns about participating.

**Making Enrollment Easier**

In states where the enrollment procedures for Medicaid and SCHIP are not aligned, families face added barriers to gaining coverage, with the larger burden often falling on families with children eligible for Medicaid. Families applying for the SCHIP program whose children turn out to be eligible for Medicaid may be asked to submit additional paperwork and undergo greater scrutiny to complete the Medicaid eligibility process. In addition, in states where Medicaid income-eligibility limits vary by the age of the child,\(^4\) children in the same family may be eligible for different programs. In such situations, families may have to navigate two sets of program rules and procedures to obtain coverage for all their children, a complication that can override the advantages of a joint application. Once enrolled, families may have to abide by two sets of reporting requirements and respond to correspondence from two different agencies regarding different enrollment periods and renewal schedules. Bringing all children in a family into the same health insurance program could help prevent such complications and could substantially improve the degree to which children in the family receive uninterrupted health care.

States can use their broad flexibility to create Medicaid programs that feature the same simple, streamlined procedures used in separate SCHIP programs. Moreover, states can assure that all children are covered under the same program by using the authority they have under Medicaid law or by using SCHIP funds to expand Medicaid beyond the minimum thresholds to establish a uniform Medicaid income-eligibility limit for all children through age 18.

Abolishing procedural differences between Medicaid and separate SCHIP programs also makes it easier for states to administer the programs and allows them to more effectively meet their responsibility to determine the appropriate program for children applying for benefits. Under federal law, states are required to screen all children who apply for coverage under the separate SCHIP program to identify those who appear to qualify for Medicaid, and children found eligible must be enrolled in Medicaid.\(^4\) This rule has become known as the “screen and enroll” requirement. (Federal SCHIP regulations also require state Medicaid agencies to adopt a process that facilitates enrollment in the state’s separate SCHIP program when a child is found ineligible for Medicaid at initial application or redetermination.\(^4\)) Effective screen and enroll procedures help prevent children from losing out on coverage if a parent applies to the “wrong” program and also ensure that children eligible for Medicaid are able to receive the full benefits and cost-sharing protections that the program provides. The procedures also permit the smooth transfer of children from one program to the other if their family circumstances change.

A number of states with separate SCHIP programs, including Indiana, Kentucky, Massachusetts, and North Carolina, have taken steps to align their SCHIP and Medicaid programs. They use similar methods to count income in determining Medicaid and SCHIP eligibility, have similar enrollment procedures, and allow eligibility workers to determine eligibility for either program.\(^4\)

Other states have improved coordination by screening applications for Medicaid at a central location and then forwarding them to the proper place for final eligibility determination. In Florida and Texas, the transfer occurs
electronically; in Kansas and New Jersey, applications that appear eligible for Medicaid are transferred to colocated Medicaid eligibility workers for a final determination. 47

Some Families’ Concerns about Participating
Concerns have been raised that some families’ resistance to enrolling their children in Medicaid could adversely influence the effectiveness of the SCHIP screen and enroll process. This resistance may stem from a number of concerns, including the belief that the Medicaid enrollment process is difficult to complete or intrusive, fears on the part of families with immigrant members that enrolling in Medicaid will jeopardize their immigration status, worries about the availability of providers or that providers will give substandard treatment, or the belief that Medicaid participants are not treated with respect, generally referred to as “stigma.” 48 In key informant interviews conducted as part of SCHIP evaluations, outreach staff and family advocates report that some parents feel intimidated or encounter rude treatment by local social services staff. In addition, fears about being a “public charge,” and the misconception that participation in Medicaid or SCHIP will hurt applications for citizenship, may be more pronounced in states with large immigrant populations. 49 However, a study of community health center patients in 10 states found that, among these barriers, the most significant in terms of deterring families from applying for Medicaid were those associated with the application process or confusion about Medicaid eligibility. 50

While some of these concerns may prompt potential beneficiaries to indicate they do not wish to enroll their children in a program, when families are given a better understanding of the program and application process, they often reconsider and go forward with their applications. In California, for example, where the joint Medicaid/SCHIP application contains a check box (sometimes called an “opt-out box”) for families to indicate if they do not want their applications forwarded to Medicaid or Healthy Families (the state’s separate SCHIP program), between June 2001 and June 2002, about 30% of families indicated they did not wish to have their applications forwarded to Medicaid. 51 Community-based application assistants report that they are often successful in allaying parents’ fears about Medicaid, dispelling misconceptions about the program, and persuading parents to enroll their children. Most often, the factors that help persuade parents to follow through with Medicaid enrollment are that they do not need to go to a county social services office to apply (but instead can complete the process by mail) and that they do not necessarily need to change doctors as a result of enrolling in Medicaid. 52

In Georgia, where the joint Medicaid/SCHIP application formerly contained an opt-out box, families with children who appeared to be eligible for Medicaid, but had opted out, received a personal call from a Right from the Start Medicaid (RSM) eligibility worker, who explained the benefits of Medicaid. According to RSM, between March 2000 and July 2000, only 460 families out of 7,425 applying for PeachCare—about 1 in 17—checked the Medicaid opt-out box. After a call from an RSM worker, 260 of these families decided to complete the application process. 53 Responding to concerns that opt-out boxes may communicate misleading messages about coverage programs (for example, possibly implying incorrectly that Medicaid and SCHIP have the same benefits), all but one of the five states that initially had opt-out boxes eliminated them.

Despite the concerns expressed about participating, research also indicates that families with eligible children consider Medicaid to be a good program and would like to enroll their children. For example, a national survey of low-income parents found that the vast majority of parents of both Medicaid-enrolled and -eligible uninsured children agreed that Medicaid is a good program (94% and 81%, respectively). 54 In addition, more than 9 in 10 parents of eligible uninsured children (93%) appeared willing to enroll their children in Medicaid. Another study conducted in California found that 70% of English-speaking Latino parents and 63% of Spanish-speaking Latino parents said they would enroll their children in Medi-Cal (the state’s Medicaid program) if the children were found eligible. 55

Many states tell much the same story in analyzing their experiences with SCHIP, reporting that the steps they have taken to improve Medicaid’s processes, marketing, and coverage strongly contributed to their enrollment gains. 56 Given the research demonstrating that the barriers to enrollment are largely related to process and are not inherent to the program itself, states could use their broad flexibility to re-create Medicaid programs that feature the same simple, streamlined procedures used in sep-
arate SCHIP programs. In doing so, they could allay many of the fears expressed by families who may be reluctant to apply. Moreover, community outreach efforts can be instrumental in helping families—particularly those that have had difficulty applying for Medicaid in the past or those with particular concerns, such as immigrants—understand new, improved procedures.

Addressing Eligibility Renewal

Enrolling children in SCHIP and Medicaid is only the first step in giving them access to health care. Policymakers also must ensure that eligible children do not lose coverage because of difficulties in renewing their health insurance. States have adopted a number of strategies for easing eligibility renewals, but despite these steps, significant barriers keep many families from renewing their children’s health coverage.

Keeping Children Enrolled: A Continuing Challenge

Typically, states’ eligibility redetermination processes under SCHIP and Medicaid work as follows: Between 60 to 90 days before the renewal date, computerized eligibility systems send notices to parents, informing them that their children need to reestablish eligibility. These notices also may instruct parents that they must complete a renewal form, usually enclosed with the notice, and attach income verification. This initial contact may be followed up by one or more reminder notices or postcards; a few states make personal or telephone contacts. If the family’s renewal form and documentation are not received, its children are automatically disenrolled at the termination date.

The problem of “churning” among children on Medicaid—that is, when children are disenrolled when the renewal process is not completed, only to be reenrolled when parents learn of the disenrollment or when the children next need health care—has been well documented. Nevertheless, state officials did not fully anticipate potential retention problems when designing their SCHIP programs, placing more emphasis on designing streamlined enrollment policies than on designing simple eligibility redetermination processes. As a result, SCHIP programs also experienced considerable churning during the early phases of implementation.

As early as mid-1999, when children in many states were reaching the end of their first annual SCHIP eligibility cycle, anecdotal reports from states indicated that large proportions of children were losing their eligibility or disenrolling. Research has since confirmed the extent of the problem. One study found that four of the five states examined were retaining less than 50% of children who were up for renewal, often because parents were unable to complete the redetermination process or did not respond to state renewal notices.

At the same time, state officials have struggled with the question of what a reasonable rate of retention under SCHIP should be. Because the program is explicitly designed to serve children of low-income workers, whose hours and employment status fluctuate, many enrollees may lose eligibility when their parents obtain new jobs that provide health benefits, or when their parents lose income, thus making the children eligible for Medicaid.

More recent evidence indicating high rates of disenrollment, however, has raised concerns. For example, a study found disenrollment rates of about 50% or higher at renewal time in three of the four states studied, noting further that roughly 25% of disenrolled children reenrolled within two months. The finding that many families obtained coverage again so soon after disenrollment suggests that their children were probably dropped even though they remained eligible. Still unknown is how many of the children in families that did not attempt to reenroll also may have been eligible at the point of disenrollment. Concerns that many eligible children may be losing coverage at the point of renewal has made SCHIP and Medicaid retention a high priority for federal and state policymakers, as well as advocates and community-based organizations.

State Strategies for Simplifying Renewal Policies and Procedures

The attention focused on problems with retention, coupled with guidance from the federal level on facilitating renewal procedures, has spurred an increasing number of states to simplify their eligibility renewal processes. State efforts to simplify renewal policies and procedures vary widely. Some of the more promising approaches are described below.
Less Frequent and “Off-Cycle” Renewal
A national survey of enrollment and renewal procedures in children’s health coverage programs found that 42 states, including the District of Columbia, allow families to renew coverage for their children under Medicaid and separate SCHIP programs every 12 months, as opposed to requiring families to renew children’s health coverage more frequently.63 At least one state, Massachusetts, allows parents to renew children’s coverage early, or “off cycle,” when it is more convenient to do so (see Box 2). Seventeen states also have adopted 12-month continuous eligibility, which guarantees a full year of coverage regardless of fluctuations in family income or other circumstances, for children in Medicaid and separate SCHIP programs.

No Face-to-Face Interview
In addition, the survey found that almost all states—48, including the District of Columbia—no longer require a face-to-face interview with an eligibility worker when parents renew children’s public health coverage.64 As with initial applications, mail-in renewal applications are more convenient and desirable for parents who work or who might be uncomfortable visiting a county welfare or Medicaid eligibility office.

Joint Renewal Forms
The lack of coordination between SCHIP and Medicaid eligibility renewal processes can create significant problems for families. Many states are applying their successes with joint SCHIP and Medicaid application forms to the renewal process. Of the 35 separate SCHIP programs, 21 allow families to use a joint form to renew coverage in both SCHIP and Medicaid.65 Joint renewal forms save families from having to submit multiple renewal applications if changes in income or other circumstances require a shift in coverage from SCHIP to Medicaid, or vice versa, or if families have children in different programs.

Less Onerous Verification Requirements
Some states have reduced the amount of verification they require at renewal, often requesting only documentation of current income, or allowing families to self-declare

---

Box 2

“Member Express Renewal” Helps Families Retain Coverage in Massachusetts

Massachusetts has supported intensive efforts on the part of community organizations to help get children enrolled in the state’s Medicaid and SCHIP programs, collectively known as MassHealth. Considering the investment in outreach, state officials and advocates were disappointed to learn that a large proportion of families—about 20%—were not responding to renewal notices at the end of the 12-month coverage period. As a result, large numbers of children were losing coverage even though they were likely to still qualify.

In response, health care administrators in Massachusetts decided to apply the advances of community-based assistance to the renewal process. With funding from the federal Centers for Medicare and Medicaid Services, a procedure termed “Member Express Renewal” was developed in which some families can opt to renew their coverage “off cycle,” that is, before their scheduled redetermination date, when they visit a community clinic or other community location. For example, if a child were determined eligible on January 1, 2002, he or she would not be due to renew coverage until January 1, 2003. But, if the child were scheduled for a pediatric care visit in September 2002, the parent could fill out a simple form in the clinic waiting room and the child’s eligibility could be extended until September of the following year.

To date, the results have been encouraging. Recent data show that of the families permitted to renew via the “Member Express” process (some beneficiaries, such as those also on food stamps, are not permitted to do so), 100% received continued coverage.

Source: Correspondence with Joshua Greenberg, Health Care for All, Boston, MA, February 6, 2002.
Many states still require families to resubmit extensive information and documentation to renew their children’s health insurance. their income. In addition, some states have begun to preprint their renewal forms, for SCHIP in particular, with some or all applicant information collected during the initial application. Families are required to update only existing information that has changed.

**Automatic or “Passive” Renewal**

Changing the “default” action to continued coverage, rather than disenrollment, for families that do not respond to renewal notices offers an even simpler approach to eligibility renewal. For example, Florida conducts what it calls “passive renewal” under SCHIP. The state’s data system generates a preprinted renewal form, which families are required to return only if any information has changed. A “nonresponse” is presumed to indicate that nothing on the application has changed, and therefore the child remains eligible. It is important to note that Florida’s SCHIP program requires the payment of monthly premiums as a condition of ongoing eligibility. Therefore, state officials assume that if parents are contributing to the cost of their coverage on a monthly basis, they must be living in the state and participating in the program.

Recent research has demonstrated the benefits of Florida’s policy. While large drops in enrollment—about 30% to 50%—were found in three states with more traditional renewal procedures, in Florida, disenrollment at renewal was only 5%. Thus, the passive renewal procedure can sharply reduce disenrollment. South Carolina has introduced a similar process in its Medicaid program.

**Addressing Barriers to Renewal: Areas for Improvement**

Although the state experiences presented here demonstrate that efforts to facilitate ongoing coverage and simplify eligibility renewal appear to be working, case studies and discussion with state and local officials indicate that barriers to reenrollment still need to be addressed. (See Box 3.)

**Relying on a Mail-Based System**

Most states send families notices and postcards reminding them to renew eligibility. These notices often use confusing bureaucratic language, and many state and local officials suspect that such language often results in nonresponses that lead to disenrollment. Many officials believe that following up by phone or with in-person reminders might yield a better response rate. For example, county offices in North Carolina follow up with personal phone calls to remind families about their renewal deadlines, and in New York, the Bronx Health Plan (which participates in the state’s SCHIP program, Child Health Plus) makes home visits to remind families of the need to renew eligibility. In both of these states, these follow-up strategies have reportedly reduced rates of disenrollment. In addition, state and local officials interviewed during case studies as part of national evaluations of SCHIP have speculated that grace periods might allow children to retain eligibility while enrollment entities conduct follow-up with nonresponding families.

**Requiring Families to Resubmit Information and Documentation**

Many states still require families to resubmit extensive information and documentation to renew their children’s health insurance, even though federal guidance issued in August 2001 emphasized that states have the options of using preprinted renewal forms and reducing verification requirements. The federal government also requires states to conduct reviews of ongoing eligibility using information that is already available to the state to the extent possible (“ex parte eligibility reviews”). By conducting such ex parte reviews, using program records from food stamps, TANF, subsidized child care, or wage-reporting databases, states can simplify administration and reduce the risk that a family with an eligible child will not complete the renewal process and thus be inappropriately denied coverage. (See Box 4.) Currently, however, no national data are available on the extent to which states conduct ex parte reviews.

**Charging Premiums**

Most states with separate SCHIP programs charge premiums, which may make parents less likely to renew their children’s coverage. Imposing premiums has been shown to have a negative effect on enrollment in subsidized health insurance programs, but less is known about the extent to which premiums affect rates of
Enrollment and Retention

retention and families’ decisions regarding whether or not to continue children’s coverage. One study found that failure to pay premiums accounted for no more than 2% of all renewal outcomes among five states studied. On the other hand, a study by the U.S. General Accounting Office found that up to 10% of children enrolled in SCHIP lost coverage due to their parents’ failure to pay premiums. In addition, a case study of New York found that children in the premium-paying categories under Child Health Plus churn more regularly than children whose parents do not pay premiums. Some health plan officials believe that many premium-paying parents allow their children’s coverage to lapse when children are healthy and then reenroll them when medical care is needed. In most states, however, data do not permit officials to conclude whether disenrollment for nonpayment of premiums is due to the affordability of those premiums or to some other reason, such as a family moving out of state or a parent getting a new job with health benefits.

More generally, current data systems limit the ability to accurately measure retention and thus understand the factors that may contribute to retention problems. Recent research has found that SCHIP and Medicaid data systems are highly variable, and often quite limited, in their capacity to report on outcomes of the eligibility renewal process. Some states do not collect data on eligibility redeterminations per se; rather, these states maintain broader “case closure” databases that compile information on all closures, whether or not they occur at renewal. Even among those states that do maintain records specific to redetermination, the codes, definitions, and classifications of various data elements vary dramatically, thereby making aggregation and cross-state comparisons very difficult, if not impossible.

Considerations for the Future

The current environment is challenging for children’s health insurance programs. Because of an economic downturn that began in 2001, states have come under...
serious pressure to curb spending, and many are considering a range of measures to limit enrollment in their Medicaid and SCHIP programs, including retracting eligibility, freezing enrollment, and curtailing high-profile media campaigns. Some states already have begun such actions. At the same time, the need for public insurance programs likely has increased. Many working families have lost jobs or have had work hours cut back and, as a result, may have lost their employer-based coverage or their ability to pay out-of-pocket costs associated with health coverage. Parents whose children now qualify for coverage under SCHIP or Medicaid will need to obtain health coverage for their children without delay.

Prompt enrollment in Medicaid or SCHIP ensures continuity of care for a child with current medical needs and protects families from financial exposure should a medical need arise. Preserving simplified procedures and outreach efforts will help eligible children gain access to existing health coverage programs and help reduce the degree to which elevated unemployment causes an increase in the number of uninsured individuals.

Some specific simplification steps are of particular importance. For example, states can take steps to:

- **Ease transfers between Medicaid and SCHIP.** State procedures should allow children to transfer smoothly from the state’s separate SCHIP program into Medicaid if financial hardship warrants the change. A shift into Medicaid would relieve eligible families of any cost-sharing requirements imposed by the SCHIP program and would ensure families the benefit package and other protections the Medicaid program provides. Families should be apprised that such a transfer is possible when the need arises, even if a child is in the midst of the SCHIP enrollment period, and families should not have to submit a new application, although documentation of their new income may be requested.

- **Eliminate waiting periods.** Although federal regulations do not require it, many states impose waiting periods in their children’s health coverage programs in an effort to discourage “crowd-out,” or the substitution of public coverage for private insurance. In states that have waiting periods, children are required to be uninsured for the duration of the waiting period before they are allowed to apply for public coverage. While states with waiting periods generally exempt children whose parents have lost employer coverage through no fault of their own, this protection does not usually extend to families who find the premiums charged by private plans to be unaffordable. Children subject to

---

**Box 4**

**Using Information from Food Stamp Reviews to Automatically Renew Medicaid in Washington**

In Washington State, county community service offices (CSOs) automatically renew health coverage for children in families that have an open case for other benefits such as food stamps, using the latest information the family has supplied to the food stamp program. When the family comes in for a food stamp eligibility review, the caseworker automatically performs a Medicaid review at the same time. If eligible, the child is certified for 12 months of coverage and does not have to go through the Medicaid renewal process at the original 12-month mark. The next Medicaid renewal date would be scheduled 12 months from the food stamp review, extending coverage for the child and reducing administrative burdens on the family and the state agency. After this policy and others were implemented, Washington’s Medicaid retention rate for children who also had food stamps improved dramatically.

Source: Conversation with David Hanig, Washington Department of Social and Health Services, February 2002.
waiting periods may experience harmful gaps in coverage that can be particularly problematic for children with urgent or chronic medical conditions.

To reduce the potential dangers of coverage gaps, states can eliminate waiting periods or shorten their duration. Alternatively, following the lead of states like California, Colorado, Connecticut, Michigan, New Jersey, Texas, and Washington, states may exempt from waiting periods families whose children are covered by costly individual policies or whose premiums are considered unaffordable. Or, like North Carolina, states may opt to exempt children with special health care needs from waiting periods. Presumptive eligibility can also speed the enrollment of children who appear to qualify for SCHIP or Medicaid, allowing their parents time to gather documents the state requires before children can be enrolled.

Enroll children through other benefit programs. Because most of the information needed to make a health coverage eligibility determination is collected when a family applies for other programs, states need to take affirmative steps to ensure that children are linked to Medicaid and SCHIP when their families seek other assistance. Families affected by increased unemployment are likely to rely on public benefits to help them weather hard times. From October 2000 to October 2001, for example, the number of food stamp participants increased by 1.4 million, and approximately three-quarters of food stamp households include children. Thus, procedures to enroll children in Medicaid or SCHIP when their families apply for food stamps could help ensure that children’s health needs are met when their families are under financial stress.

Implement easy renewal procedures. During an economic downturn, it is particularly important to help families retain Medicaid and SCHIP coverage for as long as they are eligible, since they are less likely to be leaving the program because they have found private coverage through an employer. Families should be able to complete the renewal process easily, by mail, and without having to produce information that has not changed since the initial application.

Continue outreach and public information. Although states may be under pressure to dispense with the health insurance public education and media campaigns that have been popular over the past several years, outreach will continue to be crucial during hard economic times. A national survey by the Urban Institute found that, in 1999, almost two-thirds (62%) of parents of low-income, uninsured children were either not aware of any child health insurance program in their state or did not know that enrollment in welfare was not a precondition for participation. Although extensive outreach in recent years has presumably increased families’ awareness of both Medicaid and SCHIP, it is likely that many newly unemployed families with long-standing stable work histories or employer-based coverage will need information about available public coverage. Outreach messages can be crafted especially for this new audience, alerting them to the availability of Medicaid and SCHIP for their children and to the possibility of obtaining coverage for parents.

Over the past five years, states have made substantial gains in making health coverage available to uninsured children and facilitating their enrollment. Yet, continued efforts to simplify enrollment and renewal procedures and to align Medicaid and SCHIP rules are needed to ensure that the programs reach their full potential. A weakening economy could lead states to enact eligibility cuts or procedural changes that could undermine the progress achieved in reducing the numbers of uninsured children. The challenge now is to sustain the progress that has been achieved and to continue to advance efforts to ensure that eligible children and parents are aware of and able to obtain available health coverage.
ENDNOTES


6. See note 5, Perry, et al.


13. See note 11, Smith and Ellis.

14. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) required the phase-in (by 2002) of Medicaid coverage for children ages 6 through 19 in families with incomes at or below 100% of the federal poverty level.

15. See note 12, Cohen Ross and Cox.


18. A recent national survey of eligibility rules and enrollment procedures in children’s health coverage programs, conducted for the Kaiser Commission on Medicaid and the Uninsured; see note 10, Cohen Ross and Cox.

19. See the article by Klein in this journal issue; also see note 10, Cohen Ross and Cox.

20. See the article by Horner, Lazarus, and Morrow in this journal issue.


22. Interview with Nancy Cobb, director, Children’s Health Insurance Program; see note 12, Cohen Ross and Cox.

23. See note 11, Smith and Ellis.

24. Cox, L. Allowing families to self-report income: A promising strategy for simplifying enrollment in children’s health coverage programs. Washington, DC: Center on Budget and Policy Priorities, December 2001. States implementing self-declaration policies have found that their procedures result in accurate and efficient eligibility determinations. For example, between December 1999 and December 2000, a review of 543 approved children’s Medicaid cases in Idaho reflected an accuracy rate of more than 99%. In addition, an ongoing monthly audit of the income reported on children’s health insurance applications in Michigan has shown that self-declaration has not led to high error rates in children’s Medicaid and SCHIP, and the state saw the proportion of applications placed in the “pending” category, due in large part to missing verification, decline from 75% to less than 20%.


28. 42 CFR § 43.5.904 (d) (2). Social Security Act.


31. See note 30, Hill, et al.


33. See note 24, Cox.

34. Conversation with Irma Michel, California Managed Risk Med-
37. See note 12, Cohen Ross and Cox.
40. See note 30, Hill, et al.
41. See note 10, Cohen Ross and Cox.
42. See note 3, Dubay, et al.
43. Age-based eligibility for Medicaid still exists in the majority of states; as of September 2002, only 20 states had removed the age-based standards.
45. See note 44. Federal SCHIP regulations also require state Medicaid agencies to adopt a process that facilitates enrollment in a separate SCHIP program when a child is determined ineligible for Medicaid at the initial application or redetermination.
46. See note 12, Cohen Ross and Cox.
47. See note 12, Cohen Ross and Cox.
49. See note 30, Hill, et al.
50. See note 48, Stuber, et al.
52. See note 30, Hill, et al.
53. Conversation with Georgia state officials; see note 12, Cohen Ross and Cox.
54. See note 5, Perry, et al.
56. See note 27, Mann.
60. See note 58, Hill and Westpfahl-Lutzky.
61. See note 25, Dick, et al.
62. See note 8, Centers for Medicare and Medicaid Services.
63. See note 10, Cohen Ross and Cox.
64. See note 10, Cohen Ross and Cox.
65. See note 10, Cohen Ross and Cox.
67. See note 25, Dick, et al.
68. See note 58, Hill and Westpfahl-Lutzky.
69. See note 58, Hill and Westpfahl-Lutzky.
71. Regulations provide that the scope of eligibility reviews must be limited to information that is necessary to determine ongoing eligibility and is related to circumstances that are subject to change. States may not require families to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change, such as documentation of the date of birth of a child.
74. See note 58, Hill and Westpfahl-Lutzky.
77. See note 76, Hill and Hawkes.
78. See note 58, Hill and Westpfahl-Lutzky.
79. See note 58, Hill and Westpfahl-Lutzky.
83. See note 9, Kenney, et al.