

**Bringing uninsured children into Medicaid and SCHIP:
A comparison of enrollment and reenrollment systems in two states**

Capstone Project
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Executive Summary

Among the eight million children in the United States who do not have health insurance, an estimated three of every four are eligible for Medicaid or the State Children's Health Insurance Program but fail to enroll. This group of roughly six million eligible but unenrolled children represents 13 percent of all uninsured people in the United States. The failure to bring these eligible children into public insurance reduces access to health care, threatening quality of care and health outcomes for millions of children.

To begin unraveling the problem, one must begin looking at the various Medicaid/SCHIP programs run by the 50 states. The proportions of eligible children who enroll in public insurance vary widely among the states, from 53 percent in Nevada in 2004 to almost 93 percent in Vermont. Part of the reason for this varied level of success at enrolling children stems from the different administrative tools and procedures that states use to find eligible children, enroll them, and keep them enrolled over time. A sizeable and growing volume of academic research shows that these procedures matter, and that states can pull policy levers to bring more children into coverage. In an effort to better understand these policy levers, this paper examines two states: Maryland, where enrollment rates were lower than all but seven other states in 2004; and Louisiana, where enrollment was higher than most other states.

The research for this paper included an extensive review of peer-reviewed literature, as well as reports gathered by organizations such as The Kaiser Commission on Medicaid and the Uninsured. The research also included interviews with child health advocates and state and local health officials in four states and the District of Columbia. The effort revealed sharp differences, not only in the policies employed by Maryland and Louisiana to enroll families, but also in the culture of the states' enrollment systems. The Louisiana system operates in a proactive manner, with a system that allows state employees to use state databases to reenroll more than half of recipients without ever contacting the families. In Maryland, enrollment specialists continue to rely on outdated computer systems in a largely passive system that local officials say is understaffed.

The paper recommends a number of policy steps that could help Maryland improve its system, including improved information systems and more proactive efforts to prevent families from dropping out of the system. These individual policy levers, however, may not be so important as building a system of policies and practices that is supported by elected officials and taxpayers who must bear the cost of bringing these vulnerable children into the health care system.

I. Introduction

Congress created the State Children's Health Insurance Plan (SCHIP) in 1997 to expand the reach of Medicaid and bring more children from low-income families into health insurance coverage. That mission – insuring poor children – remains the same as the program enters its second decade of existence, having served more than 4.4 million children in 2007.¹ Despite significant accomplishments, however, SCHIP and the states that administer the program continue to struggle against administrative complexities and fragmented program designs that make it more difficult to bring eligible children into the program and keep them enrolled.

One recent analysis concluded that 74 percent of all uninsured children in 2004 were eligible for SCHIP or Medicaid but failed to enroll.² Those eligible-but-unenrolled children account for about *13 percent of all uninsured people in the United States*. This paper is concerned with why so many eligible children do not enroll in public insurance programs, and why some states are more successful than others at bringing these children into the health care system. Specifically, this paper will attempt to explore the causes and determinants of SCHIP enrollment through a qualitative analysis of two states: Maryland, which enrolls a lower proportion of eligible children than most states; and Louisiana, which enrolls a higher proportion of eligible children.

The recent national policy debate over SCHIP has emphasized a political feud between a Democrat-controlled Congress, which wants to make more Americans eligible for SCHIP, and President George W. Bush, who contends that such an expansion would cause some Americans to drop private insurance and move the nation toward a government-dominated health system. This paper does not attempt to address these

philosophical and political divisions. Rather, this paper seeks to examine the policy and management tools that can help states serve children who already are eligible for SCHIP or Medicaid but who remain outside the programs, uninsured, and at risk. By examining two states – Maryland and Louisiana – this paper will attempt to understand and identify policy levers that can help bring children into public insurance programs that are currently underutilized. By doing a better job at enrolling children into public insurance programs, states, communities, and public health professionals can improve the health of thousands of children, while helping to transform the loud, polarizing national debate over expanding SCHIP into a genuine discussion that focuses on improving the health of eight million uninsured children in America.

II. Methods

This paper attempts to link two elements key to understanding the problem of enrolling children into SCHIP: the substantial and impressive volume of peer-reviewed research and grey literature on the topic; and first-hand knowledge and perceptions of people directly engaged in the effort to bring more children into the program. Motivating this effort was a desire to better understand why some states, such as Maryland, do less well than other states at enrolling children. By comparing Maryland to other states, we hope to identify the best policy levers to bring more uninsured children into public health insurance.

The project began with a comprehensive literature review utilizing over a decade of scientific research of SCHIP published in sources such as Health Affairs, Pediatrics, Health Services Research, The Journal of the American Medical Association, and Ambulatory Pediatrics. I also relied extensively on work sponsored by sponsored by

organizations including The Kaiser Commission on Medicaid and the Uninsured, The Commonwealth Fund, The Urban Institute, and The Center on Budget and Policy Priorities.

The second step of the research involved one-on-one interviews with county, city and state officials in Maryland and other states who are responsible for enrolling children in SCHIP. These interviews included discussions with the director of eligibility service with the Maryland Department of Health and Mental Hygiene, and officials in county health departments in Maryland. Other sources included child health advocates in Texas, Virginia, and Washington DC. Through the course of these discussions, several participants pointed to Louisiana as an innovator in the effort to enroll children in Medicaid and SCHIP. Louisiana quickly emerged as a relevant comparison state. Information about Louisiana was gathered through reports, state budgets, and conversations and correspondence with state SCHIP director of operations.

The end result of this effort was a comparative analysis of two states with different approaches to enrolling children into public health insurance plans, and varying levels of success. The purpose of this comparison was not simply to rank the states, but rather to learn what works and what does not work, and why.

III. The Origins of SCHIP

Understanding the difficulty of enrolling children must begin with the history of the Medicaid program, as well as the political and legislative compromise that gave birth to SCHIP in 1997.

Medicaid came into existence in 1965, almost as a legislative afterthought to Medicare, the national public insurance system for senior citizens. In the beginning,

Medicaid benefits were tied to other federal social welfare programs for children and low-income families, such as cash assistance and food stamps. Through the decades, Medicaid expanded to cover certain vulnerable groups such as disabled Americans and children in foster care. Eventually, the program was decoupled from traditional welfare cash assistance, allowing states in the 1980s to expand eligibility to higher income thresholds, generally about 100 percent or 130 percent of federal poverty levels.

In 1997, Congress and then President Bill Clinton enacted SCHIP after several years of fierce political battles over the government's role in the nation's health system. Those battles crescendoed in 1993 as Congress rejected a plan proposed by a task force headed by Bill Clinton's wife, Hillary, to provide universal health care. President Clinton returned the political favor after Republicans took power of Congress in 1994 by vetoing a GOP-led effort to convert all of Medicaid into a block grant program that did not guarantee coverage to certain low-income Americans. Underlying this political quarrel was a basic philosophical disagreement over whether the federal government should play a central role in providing health coverage to low-income Americans. This philosophical divide continues to undergird the current political battle over SCHIP and health system reform.

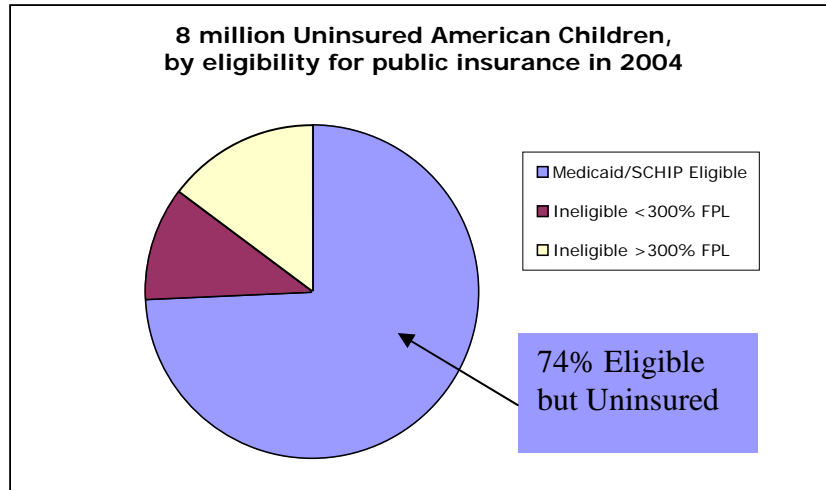
In 1997, this philosophical divide was bridged temporarily as a coalition of the willing, including Clinton and a bipartisan group in Congress, came together to expand health coverage to more low-income children. The compromise was SCHIP. The new program would function beside Medicaid, but without expanding the individual "entitlement" offered by Medicaid to certain low-income families. Instead, SCHIP would provide capped federal payments to states to expand public health insurance to

children and some parents in families with incomes too high to qualify for traditional Medicaid. Generally, traditional Medicaid covers families at or below 100 percent of the federal poverty level. SCHIP, in effect, sits atop Medicaid, allowing states to offer another layer of coverage, for families with incomes from 100 percent up to 250 or 300 percent of federal poverty guidelines.

Over the next decade, the federal government allocated \$40 billion to state-run SCHIP programs.³ Monthly enrollments in SCHIP rose steadily and rapidly, from 897,000 in 1998 to 3.9 million just five years later.⁴ The percentage of children without insurance dropped from 15.6 percent in 1998 to 13.3 percent in 2000, a trend helped along by SCHIP and Medicaid enrollments as well as a rise in private insurance coverage.⁵

IV. The Problem and its Magnitude

Despite these gains, however, many children remain outside the system. By 2005, Dubay and colleagues noted in their 2007 study, the number uninsured Americans had risen to 46.1 million people, roughly 16 percent of the entire U.S. population. Using census data, Dubay and colleagues concluded that 6 million children - nearly three of every four uninsured children in 2004 - were eligible for Medicaid or SCHIP but failed to enroll. An estimated 27 percent of eligible parents failed to enroll and remain uninsured.⁶ Other studies using different data sources provided similar estimates. One study, using the 1996-2005 Medical Expenditure Survey estimated that 5.5 million children were eligible for public insurance but unenrolled in 2005.⁷



Source: Dubay, Holahan and Cook, 2007

The data used by Dubay and colleagues also show that enrollment levels vary widely among the states.⁸ In 2004, the percentage of eligible children enrolled in SCHIP or Medicaid varied from roughly 60 percent in Texas to 92 percent in Vermont. The enrollment rate in Maryland was 69.2 percent in 2004, less than the national average of 75 percent and below enrollment rates of nearby states such as Virginia (72.3%), West Virginia (80.6%), Pennsylvania (71.7%), North Carolina (73.9%) and New York (82.6%). These differences may fail to resonate without some context. Consider, for instance, that if Maryland had boosted its enrollment rate in 2004 to the national average of 75 percent, the state would have added roughly 23,000 children to the ranks of the insured. If Maryland had matched Louisiana's enrollment rate of 84.3 percent, more than 58,000 children would have been brought into the health system, enough to exceed the capacity of Oriole Park at Camden Yard.

The point of these state-by-state enrollment figures should not be simply to rank states on a scale of best to worst performers. Comparisons must be drawn carefully because each state faces different fiscal challenges, varying demographics, and a wide

range of economic circumstances. Perhaps most importantly, each state has implemented SCHIP in its own way, giving rise to 51 distinct programs with varying eligibility requirements, and enrollment procedures and rules. The states also receive varying degrees of federal financial support from federal coffers, with federal match rates for SCHIP that vary from 65 percent to 85 percent.

This analysis attempts to look behind the simple rankings of the states to find causes and correlates for enrollment successes and failures among the states. The fact that each state has its own distinct program creates problems for those trying to compare the programs. But those differences also provide an opportunity for 51 case studies into what works and what does not.

Finally, it is imperative to remember that enrollment in any insurance program is only an intermediate outcome, a way station in a long march to improve health outcomes. Having insurance by no means guarantees improved health. However, there is a sizeable, consistent, and growing body of research demonstrating that enrolling children in public insurance improves access to health care⁹, decreases unmet medical needs and improves both the quality and utilization of care.¹⁰ Children enrolled in SCHIP are more likely than uninsured children to receive preventative care,¹¹ dental care,¹² and immunizations.¹³ Growing evidence also points to health gains for children with specific chronic conditions such as asthma¹⁴, and decreased unmet needs and rising continuity of care for children with special health care needs.¹⁵ So perhaps we should view health insurance not as a necessary way station on the march to better health outcomes, but rather as a critical gateway to delivering better care and improved health to this nation's most vulnerable children.

V. Causes and determinants: Why don't eligible families enroll?

“If you were raised in a violent home, and you’ve got a kid, and you are functionally illiterate, and you live five miles up a hollow and your daddy kicks the hell out of you, how in God’s name are you going to enroll in Medicaid?”

- A Medicaid enrollment specialist in West Virginia

Why don't eligible families enroll children into free or heavily subsidized public insurance? Who are these families? Do they share common characteristics and communities? How can we get them enrolled, and keep them enrolled? What are the causes and determinants that keep families from enrolling?

These are the central questions facing Medicaid and SCHIP enrollment personnel in all 50 states and the District of Columbia. And as evidenced by the quotation at the beginning of this section, the answers to these questions are rarely simple, and almost always vary widely among the states.

Focus groups and surveys of low-income uninsured parents have shown that a large majority of parents value health insurance and would enroll their children if eligible. In a 2001 report mandated by Congress, over 80 percent of low-income parents said they would sign up for public insurance if eligible, but fewer than half (48%) said they believed their children were eligible. Among parents interviewed, 25 percent reported insufficient knowledge of the programs, while 20 percent reported problems with the enrollment system.¹⁶

Information gleaned from a household survey conducted by The Urban Institute in 1999 provided evidence that lack of knowledge and administrative red tape posed big obstacles to enrollment. Of nearly 2,500 low-income parents surveyed, about 10 percent cited administrative hassles as the reason why, while 17.7 percent said they didn't believe

their child was eligible, and 12 percent had never heard of the programs. Nearly 18 percent had been enrolled in the past year but had lost enrollment, while 22 percent said they didn't want to enroll. Clearly, administration, outreach, and process matter when enrolling low-income children into public insurance.¹⁷

In a 2006 report entitled "Which Children are Uninsured and Why?" Holahan and colleagues set out four categories of factors that influence participation¹⁸:

- **Program Characteristics:** These factors encompass the processes that governments use to enroll people in SCHIP and keep them enrolled. They include factors such as community outreach, eligibility rules, the length of time before families must re-enroll, income and asset verification procedures, and application processing. Program characteristics are the most malleable factors of the enrollment process, and as such will be the focus of this paper.
- **Children's Characteristics:** The factors include demographic and socio-economic factor such as income, ethnicity, citizenship/immigration status, and family composition.
- **Connection to Welfare:** Holahan and colleagues found that children from families with previous connections to government welfare programs were more likely to enroll in SCHIP. This category also encompasses perceptions of government programs for the needy, and willingness to use those programs.
- **Geographic Location:** Families living in urban areas tend to enroll in public insurance at higher rates than rural families, according to Holahan and colleagues. Southern and Midwestern states had the lowest participation rates at roughly 66%, while states in the Northeast enrolled nearly 80% of eligible children.

This paper will focus primarily on program characteristics because they are the most mutable, and because the growing volume of research is beginning to yield important clues about which program characteristics help boost enrollment. But to place these factors in context, one should first examine the complexity and variability of SCHIP and Medicaid processes in the states.

Let us look at the American public health insurance system for children as a gigantic pond filled with lily pads. An uninsured parent has been forced off safe ground, into the pool of 47 million uninsured Americans. In order to regain insurance for her child, the parent must clamber and jump from lily pad to lily pad. The first leap: knowing that programs exist and that their children might be eligible. Next, the parent must apply for enrollment, meet changing eligibility requirements, and supply varying degrees of proof of citizenship, income levels, and in some cases, assets. Every step provides an opportunity to fall back into the pool of the uninsured. Eligibility requirements vary from state to state, by the age of the child, by income level, and family size. Once these eligibility conditions are met, the child will sit safely on a lily pad, but only for a short time. After 12 months, or six months in some states, the family must renew eligibility. It is at this point that many children slip back into the pond of the uninsured.

This process of enrollment, drop out, and reenrollment – called “churning” by many health researchers – is critical to the problem. One recent study from Harvard University calculated one of every eight children in Medicaid and SCHIP drop out over the course of one year, accounting for approximately 3 million uninsured children.¹⁹ The author of that study, Dr. Benjamin D. Sommers, concluded that by keeping all children enrolled for one year “the number of uninsured U.S. children would fall by one-third.”

“The implication is clear,” Sommers wrote, “Policymakers do not have to find eligible children to keep them enrolled. Rather, for many of these children, public insurance programs simply need to keep them enrolled.”

Reenrollment, however, is complicated. As mentioned above, families can move in and out of eligibility depending on their income levels, the age and number of children, and number of parents in the home. Significant changes in any of these factors can cause the lilyypad of health coverage to sink, sending families back into the pond and clambering to scramble back into insurance.

The rates of disenrollment seem to vary widely by state. A recent study of Medicaid enrollment among children in five states showed that 16 percent of children enrolled in Medicaid in Pennsylvania at the end of 2003 had at least one gap in coverage between 2000 and 2003, compared to 41 percent of children in Oregon, 40 percent in Michigan, 23 percent in Ohio, and 18 percent in California.²⁰ The length of disenrollment also varied among the states, from a mean of 4.49 months in Michigan to 6.13 months in Oregon. And while the authors did not seek specific reasons for this variation, they noted that Oregon, the state with the highest rate of disenrollment and longest average period of disenrollment, was also the only state of the five that required families to re-enroll every six months rather than 12 months.

If we accept that enrollment and reenrollment are both crucial factors, we can then move onto more specific policy levers being used by states to enroll more children and keep them in the program. In its 50-state update on eligibility rules and procedures, the Kaiser Commission on Medicaid and the Uninsured identified several policies that affect enrollment²¹:

- **Renewal Period:** This refers to the length of time that a child is allowed to remain in SCHIP or Medicaid before the state requires families to re-enroll and prove that they meet eligibility criteria. As of 2006, 44 states required renewal every 12 months, with the remainder requiring six-month renewals.

- **Continuous Eligibility:** Sixteen states allow children to remain enrolled for 12 months regardless of changes to income, family size, or other events. This feature, called continuous eligibility, is designed to keep children enrolled for longer periods.
- **Presumptive Eligibility:** Nine states have instituted presumptive eligibility, which allows states to enroll children into public programs immediately so long as they appear to meet eligibility requirements. This allows families to avoid waits for eligibility verification. The obvious concern here is that ineligible families would enter the program.
- **In-person interviews:** As of 2006, only four states required an in-person interview for all Medicaid recipients. In Maryland, an interview is required for families who are eligible for certain other welfare programs, such as cash assistance or food stamps.
- **Assets tests:** Nearly all states have dropped assets tests from eligibility criteria.
- **Income verification:** States require varying degrees of documentation to prove income levels. Some states, including Louisiana, use “ex parte” verification, utilizing state databases to verify income levels and other eligibility requirements.
- **Premiums:** Some states require SCHIP recipients to pay premiums at higher income levels.
- **Waiting periods:** Some states require applicants to be uninsured for a set period of time before joining public insurance programs. These waiting periods are designed, ostensibly, to prevent families from dropping private insurance to enroll in Medicaid or SCHIP, a trend called “crowding out” of private insurance.
- **Parental enrollment:** States use SCHIP and Medicaid dollars to varying degrees to provide insurance to parents of children. A growing body of research suggests that covering parents improves the chances that a child will join the program and remain enrolled. In one 2003 study, participation rates were 20 percentage points higher in states where public health insurance was offered to parents.²² A more recent study suggests that public insurance coverage rates are lower among children of parents who have recently lost coverage.²³

Considering the number and variation of these potential determinants of enrollment, one can begin to glimpse the complexity and difficulty of comparing one state to another. Below this layer of administrative complexity lay more basic variations

in program structure. Some states operate SCHIP as a stand-alone program set up beside Medicaid, while other states used SCHIP dollars to expand their existing Medicaid program, and still others have mixed the two approaches. States also deliver services differently. Some, such as Maryland, use managed care insurers to administer benefits. Others, including Louisiana, pay doctors and providers on a fee-for-service basis. All of these variables could affect enrollment patterns and the usefulness of the policy levers listed above. One final layer of complexity is added when one considers the differences in state demographics, relative wealth, and geography.

It is with this complexity and variation in mind that one begins to see the value of looking behind the enrollment statistics to compare states in a more qualitative fashion. For the purposes of this paper, we will focus on two states – Maryland and Louisiana – with similarities and stark differences. Both states have sizeable rural populations, anchored by a large port city with relatively high poverty and significant crime levels. Maryland’s population stood at about 5.6 million in 2006, compared to 4.2 million in Louisiana, with about 65 percent of residents classifying themselves as white and 30 percent as African American in both states.²⁴

The states also have important differences. Maryland is wealthier and better educated, with a median household income of \$57,000 in 2006, more than 60 percent higher than Louisiana. Nearly one-third of Maryland residents have a bachelor’s degree, compared to 19 percent in Louisiana. A higher proportion of Maryland’s population (9.8 percent) was foreign born, while only 2.6 percent of Louisianans were born abroad. Finally, 19.2 percent of Louisiana households reported income below the federal poverty guideline, a rate 10 percentage points greater than Maryland.

The most salient reason for comparing these two states, however, is the disparity in enrolling children in Medicaid and SCHIP. While Maryland continues to grapple with legislative and procedural changes to help bring more children into these programs, Louisiana seems to have found a formula for success. In 2004, Louisiana enrolled an estimated 84.3 percent of eligible children into Medicaid or SCHIP, well above the national average. Maryland enrolled 69.2 percent, an enrollment rate exceeded by all but seven other states. Louisiana also stood out for another reason. During interviews, a number of child health advocates around the nation pointed to Louisiana as an example of a state that has successfully enrolled and re-enrolled children into Medicaid and SCHIP.

VI. Louisiana: A Case Study

“It is our responsibility to connect these families and put their children into the programs.”

- An eligibility specialist with Louisiana’s SCHIP Program

Despite demographic and wealth disadvantages, Louisiana enrolls a higher percentage of eligible children in Medicaid and SCHIP than most other states. Anne Dunkelberg, a children’s health advocate in Texas, admires the reenrollment system in Louisiana. As associate director of the Center for Public Policy Priorities, a non-partisan, non-profit policy research group in Texas, Dunkelberg has advocated for years to simplify enrollment procedures, increase the length of eligibility to 12 months, and end required assets tests and waiting periods for children trying to enroll in SCHIP. Dunkelberg says Louisiana long ago adopted these measures, and a “culture” of enrollment that brings children into the system.

For families applying for Medicaid or SCHIP for the first time, Louisiana does not require an assets test, in-person interviews, or waiting periods. Families may apply using

a paper application, or by using the state's internet-based electronic application system. The state has also granted enrollment officials the authority to grant presumptive eligibility, allowing children who appear to meet eligibility criteria to enroll immediately. In states that practice presumptive eligibility, state officials verify eligibility criteria after a child is enrolled, allowing families immediate access to health care. While Louisiana state legislators have Medicaid officials the authority to use presumptive eligibility, Louisiana has yet to implement the idea, in part, because officials feel they don't need it. Most applications are processed within seven to 10 days, Viator said, allowing children to move relatively quickly into the program without presumptive eligibility.

Kyle Viator, Director of Operation for Louisiana's SCHIP system (called LaCHIP), said Louisiana made one of its most consequential changes in 2001. That's when state enrollment officials began using state databases and information systems to verify that SCHIP and Medicaid recipients were eligible for reenrollment in the programs. Through these "ex parte" renewals, the state is able to re-enroll children without ever contacting families, or even sending out a renewal form. In effect, the state uses the information within its own systems to verify eligibility.

Typically it works this way: As a child is nearing the end of her 12 months of eligibility, a state enrollment employee begins using state databases to confirm income and residency requirements. This process is successful in more than 50 percent of renewals, allowing the child to be re-enrolled without any contact with the family. If the eligibility cannot be determined, enrollment workers telephone the family to confirm that they still meet eligibility requirements. Usually, Viator said, this can be accomplished with a single, simple conversation. No signatures, forms, or documents are required.

By 2005, Louisiana officials were using ex parte renewals for 53 percent of children who re-enrolled in the programs. Another 9 percent were re-enrolled through a telephone conversation. A Commonwealth Fund report on Louisiana's system noted that in the four years after ex parte renewals were introduced, the proportion of children who successfully renewed eligibility jumped from 72 percent to 92 percent. And the percentage of kids losing eligibility due to paperwork or procedural problems dropped from 17 percent to 2 percent.²⁵

Viator said the state tracks reenrollment rates each month in each of nine regions. In some regions, he said, the percentage of children who lost coverage due to procedural problems dropped from over 30 percent five years ago to one or two percent today. These rates of reenrollment are tracked in all nine regions of the states, Viator said, and enrollment offices are held accountable. "When outreach is not being done, we know it," he said.

Louisiana is one of 16 states in the nation that practices 12-month continuous eligibility²⁶, allowing children who enroll in Medicaid or SCHIP to remain in the system regardless of changing family circumstances. Most other states enroll children for 12 month but require families to report increases in income or family change that might cause them to lose eligibility during the year. Maryland operates a dual system in which most children are enrolled for 12 months, while some extremely low income families that receive food stamps or cash assistance are required to renew eligibility for all programs every for three to six months.

Viator said the main determinant in Louisiana's rising enrollment rate is a mindset on the part of state officials to go out and ensure that children are enrolled and re-

enrolled. He noted that Ruth Kennedy, deputy director of Louisiana's Medicaid program, is a former eligibility worker, and that state lawmakers are receptive to granting authority for ideas such as presumptive eligibility.

State officials say these policy levers matter. Across the border in Texas, Anne Dunkelberg says policymakers have been slower to adopt the practices that seem to be working in Louisiana. Late in 2007, Texas followed the lead of Louisiana and most other states in lengthening its renewal period for SCHIP recipients from six months to 12 months. The impact was dramatic. In March of 2008, the first cohort of children who was enrolled under the new rule hit the six-month mark in the program. Because of the new 12-month rule, those children did not have to renew their eligibility. As a result, the number of children enrolled in SCHIP in Texas spiked, rising by 24,000 children in one month.²⁷ State officials told Texas newspapers that SCHIP enrollment in March hit 382,000, the highest level in three years.

Dunkelberg said the 12-month renewal period effectively halved the number of opportunities for families to drop out of the program due to paperwork tangles or administrative problems. The six-month rule, she said, siphoned children out of the program.

"It's like opening a drain on the bathtub without turning on the tap," Dunkelberg said. "We really lost enrollment every month."

VII. Maryland: A Case Study

Relative to Louisiana, Maryland's system for enrolling children into public health insurance seems complicated and cumbersome.

The Maryland system relies entirely on paper applications that are processed by county health departments, or in some cases county social services offices. There is no electronic application available online, other than PDF files that can be downloaded, printed by the applicant, and mailed out for processing. Depending on their income level and eligibility for other programs, families apply through one of two state agencies: the Department of Health & Mental Hygiene (DHMH), or the Department of Human Resources. Each agency uses different application procedures.

Most families enter the program through local county health departments, which have been tasked by the state to carry out community outreach, process applications, and verify eligibility for the Maryland Children's Health Insurance Program, also known as MCHIP. Most enrollment positions in the county offices are funded by the state, through DHMH. (The MCHIP program combines families who qualify under expanded SCHIP standards as well as children who qualify under the traditional Medicaid program. State officials consider all of these children MCHIP recipients.)

Maryland's system is complicated because a significant number of children enter the MCHIP program through the Department of Human Resources (DHR) and local social services offices. These applicants – often, pregnant women and parents with extremely low incomes – apply for MCHIP as part of a package of services that may also include direct cash assistance or food stamps. Unlike other MCHIP applicants, families applying for this expanded bundle of programs must attend a face-to-face interview and prove that their assets do not exceed a threshold specified by state, usually \$2,000. Once enrolled, recipients of the bundle of services that includes cash assistant usually must renew eligibility every three to six months, creating opportunities for eligible families to

lose coverage. These stricter enrollment procedures are a vestige of the days when Medicaid was tied to cash assistance and other federal welfare programs. It is no surprise that assets tests, in-person interviews and the complexities and confusion attendant to this sort of bifurcated application process have negative effects on enrollment.²⁸

In the city of Baltimore, the local health department has turned to a non-profit organization called Baltimore HealthCare Access Inc. to enroll children into MCHIP. Kathy Westcoat, President of HealthCare Access, said her organization handles about half of MCHIP enrollments in the city, with the others flowing through the Department of Social Services. The result, Westcoat said, is that Baltimore's poorest families – the ones that are eligible for cash assistance and food stamps – are the same families that are forced to navigate the stricter enrollment procedures.

Like many child health advocates in Maryland, Westcoat and Baltimore Health Commissioner Joshua Sharfstein support proposed legislation to create 12-month continuous eligibility in Maryland. The Maryland Legislature recently ended its session without passing a bill that would have provided continuous eligibility to guarantee 12 months of coverage for every child enrolled in MCHIP. Advocates say opposition to the proposal, offered by Del. Heather Mizeur, stemmed mostly from concerns over how much it would cost to cover more children.

Like many states, Maryland's enrollment process is further complicated because eligibility thresholds are different depending on the age of children, income levels, family size, and whether a mother is pregnant. Pregnant women are allowed higher income limits than parents who are not pregnant. Foster children and the disabled fall into their own specific eligibility criteria. Some Maryland recipients making more than 200

percent of federal poverty levels must pay Medicaid premiums, a burden that has been shown to reduce enrollment in other states.²⁹

The result is a set of eligibility rules that is difficult to navigate for trained public health professionals, and potentially impassable for some mothers and fathers struggling to raise children at or near the federal poverty line. A “quick reference” guide used by eligibility specialists in Maryland contains 25 separate categories of eligibility for children, each with its own set of requirements. This does not include the additional dozens of categories of eligibility for disabled recipients, refugees, or children in long-term care.

The job of disentangling these eligibility requirements falls mostly to county and local health departments, where staffing has been suppressed by recent state hiring freezes and budget reductions. Managers at local health departments in Maryland say the computer system used to verify enrollments borders on antiquated. To process one application, enrollment workers must enter at least three separate state databases, each run using outdated DOS operating systems. “It is the most ridiculous thing you have seen in your entire life,” said one county manager.

Reenrollment procedures in Maryland also differ from Louisiana’s system of *ex parte* renewal and aggressive outreach. In Maryland, all families enrolled in MCHIP receive a pre-printed renewal application 60 to 90 days before their 12-month renewal deadline. If the family does not respond, the state sends out a second notice, about 15 days before the deadline. The next contact with the family is a written notice of disenrollment from MCHIP, along with notice of a 30-day grace period for reenrollment if the family wishes to stay in the program. Maryland does not operate a large-scale

system of phone calls and outreach to re-enroll families who are eligible for MCHIP and at risk of dropping out of the system into the pool of the uninsured.

None of these problems have gone without notice among Maryland Medicaid officials. On July 1, officials with MCHIP say they will effectively end the requirements for face-to-face interviews, assets tests, and stricter income verification for those recipients who also receive cash assistance and food stamps. The state will allow all recipients to apply, enroll, and reenroll through local health departments, rather than forcing some to use social services offices. “We’re going to operate on the philosophy that if you want Medicaid, you can go to any door and apply,” said Cheryl Camillo, executive director of the Office of Eligibility Services with the Maryland Department of Health and Mental Hygiene.

The state also plans soon to expand MCHIP eligibility to more parents, raising income limits from 30 percent of federal poverty guidelines to 116 percent. There is significant evidence that extending eligibility to parents increases the likelihood that children will be enrolled in public health insurance programs.³⁰

Policymakers in Annapolis have also made progress, passing legislation that would require parents to report on state tax returns whether their children have health insurance. The new law requires the state comptroller, in cooperation with MCHIP administrators, to use these tax returns to identify families that do not have insurance and that appear to fall within MCHIP income eligibility limits. The state will then send out enrollment packets and letters to these families. This effort could be an important first step in Maryland in moving toward a more proactive system of enrollment and reenrollment.

VIII. Proposals for the Future: A Path to Enrolling More Children

The first step toward improving Maryland’s enrollment system should include improvement in the state’s information management system to track MCHIP recipients. Such an effort would allow the state to better track not only enrollment, but also the numbers of children dropping out of public insurance even though they are still eligible. Understanding this last figure – the numbers of eligible children who reenroll or leave the program – is not regularly tracked in Maryland or many other states. Measuring “retention” in MCHIP should be a first step toward keeping eligible children in the program.

Maryland could continue to improve MCHIP enrollment by adopting Louisiana’s system of ex parte renewal. This would likely require a culture shift, as well as substantial investment in information systems, staffing, and management. This will be complicated by state budget limitations. Despite these administrative costs, however, Louisiana’s experience provides strong evidence that an aggressive, proactive effort to reenroll families through an ex parte process would keep more children in the health system for longer periods, while also decreasing the number of uninsured Marylanders and improving health access, quality, and outcomes.

The state’s planned elimination of asset tests and in-person interviews for all MCHIP recipients are also steps in the right direction. Evidence from studies that attempt to measure the effects of various policy levers indicates that states that require these sorts of added eligibility hoops have lower enrollment rates.³¹ Maryland could continue moving down the road to better enrollment by creating an on-line application

process, providing another route of entry into the MCHIP system at a relatively low cost. Maryland's plan to extend MCHIP to cover more parents is also a positive step, considering the emerging evidence that parental coverage has a carryover benefit of keeping more children enrolled.³²

There is also a compelling case to institute continuous eligibility and presumptive eligibility in Maryland, though these issues are more complex. One recent study (Kronebusch and Eibel, 2004, see note 27), found that the probability of enrollment was 6.4 percentage points higher in a system with presumptive eligibility compared to one without. The same study found no statistically significant correlation between enrollment and continuous eligibility. A more recent study (Espeseth and Riportella, 2006, see note 28) concluded that both continuous and presumptive eligibility are associated with better enrollment.

The impact of these individual policy levers may not be so important as the package of techniques that states use in enrolling children. This can be seen clearly in the study by Barbara Wolfe and Scott Scrivner, which measured the effects of several policy levers, including face-to-face interviews, presumptive and continuous eligibility, the presence of premium payments, and 12-month renewal periods. In part of their analysis of these multiple variable, Wolfe and Scrivner used census data and statistical modeling to calculate expected enrollment rates in two hypothetical states. The first state charged no premiums, required no face-to-face interview, waiting periods or assets test, and allowed children to enroll using presumptive eligibility. The second state had a one-year waiting period, did not cover parents, and required face-to-face interviews. The researchers concluded children in the state with the more inclusive enrollment package

would have a 75 percent probability of enrolling, compared to 61 percent probability in the more restrictive state.³³

One lesson to be drawn from these results is that it is the system that matters as much as the specific policy techniques. “It’s not just policy,” said a manager in one Maryland county health department. “It is policy and process.”

Another lesson to draw from the literature is that not all policy solutions work the same in every state. Fourteen states, for instance, allow Medicaid officials to enroll children by using presumptive eligibility. The state immediately covers children who appear to meet eligibility requirements, allowing immediate access to care. Such a system could be problematic in Maryland, however, because the state’s Medicaid system is run almost entirely through managed care health plans. The state pays managed care companies and organizations through capitated payments, not through fee-for-service payments as in Louisiana. This difference in payment systems could make it more expensive for Maryland to enroll children through presumptive eligibility.

IX. Discussion and Policy Implications

In regards to enrolling more children in MCHIP, Maryland will not find step-by-step cookbook recipes in the academic literature or the practices of Louisiana and others states. The issue is far too complex for simple, formulaic solutions. The 50 states serve vastly different populations, with different health care systems, different Medicaid designs, and varying political and economic realities. The academic literature, while plentiful and substantial, cannot offer canned solutions for 51 separate and distinct jurisdictions.

As noted above, one other major weakness to state-to-state comparisons is that states differ in a wide array of ways. In Louisiana, for instance, the federal government pays 85 percent of the health care costs for LaCHIP enrollees. In Maryland, with a relatively wealthier population, the federal government pays 65 percent. That difference – the 85% federal match in Louisiana vs. 65% in Maryland – underscores one other fundamental aspect of enrollment: money.

It is a fact that states have a financial disincentive for enrolling children in Medicaid. For every child enrolled, the state will pay a portion of his or her health care expenses. In Louisiana the state pays 15 cents of every health care dollar. In Maryland, the state pays 35 cents of every dollar. States may react to this disincentive in varying ways. In Louisiana, the state seems to have overcome the problem of enrolling eligible children and has taken the lead in pushing policy levers that have been shown to bring children into public health insurance programs. Child health advocates and state officials describe a “culture” of enrollment that is driven by state Medicaid officials, carried out by front line enrollment employees, and supported by the legislature and governor. In Maryland, by contrast, legislative efforts to provide presumptive eligibility and 12-month continuous enrollment have stalled. Proponents say the main reason for the legislative inaction is not partisanship, but rather a lack of funding to cover additional children who enter the program. At the local level, county health officials say they are constrained by staff shortages and budget constraints.

So, while we can and should debate the specific policy levers to bring more uninsured children into public insurance, changing the system of enrollment will also

require commitment and resources from all levels, including the governor and the state legislature.

Medicaid was born decades ago as an effort to provide the nation's poorest and most vulnerable children with health insurance. The program has grown through the years as the American people sought to serve needy children. The decision to provide this care was made in bills passed by Congress and signed by presidents, through regulations enacted by state legislatures and signed by governors. Yet still, an estimated 75 percent of all uninsured children are eligible for these programs are not enrolled. This can be changed.

In Maryland, this change has begun with plans to cover more parents under MCHIP and to eliminate enrollment requirement for such as assets testing and in-person interviews. The process should continue with a more robust investment into information systems in county and state health offices, and an on-line application system. These improved tools should serve as the undercarriage of an improved enrollment system that uses ex parte renewal techniques to keep more eligible children enrolled for longer periods of time. Finally, the state should begin county-by-county tracking of enrollment rates, disenrollment rates, and the numbers of children who leave the system even though they are eligible for public insurance. The state cannot improve what it does not measure.

Finally, Maryland should begin working with managed care companies to determine the possible benefits and drawbacks of methods such as presumptive eligibility and continuous eligibility. The state has already begun to take steps to bring more

children and parents into the system. Success will require more resources from the state, better outreach by local officials, and public pressure to continue pressing the effort.

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² Dubay L, Holahan J, Cook A. *The Uninsured and the Affordability of Health Insurance Coverage*. Health Affairs. 2007 Jan-Feb;26(1):w22-30. Epub 2006 Nov 30.

³ Spending figures drawn from Congressional Research Service report to Congress, updated March 12, 2008. *State Children Health Insurance Program: A Brief Review*.

⁴ See note 1, Smith, et al

⁵ Holahan J, Dubay L, Kenney G. *Which Children are Uninsured and Why?* FutureChild. 2003 Spring;13(1):55-79.

⁶ See note 2, Dubay, et al.

⁷ Hudson JL, Selden TM. Children's Eligibility and Coverage: Recent Trends and a Look Ahead. Health Affairs. 2007 Sep-Oct;26(5):w618-29. Epub 2007 Aug 16.

⁸ State-specific Medicaid/SCHIP enrollment figures obtain through personal correspondence with Dr. Lisa Dubay at Johns Hopkins Bloomberg School of Public Health. Figures are derived using March 2005 Current Population Survey (CPS) which represents data from calendar year 2004. See note 2, Dubay et al., for reference to more detailed explanation of state-specific data.

⁹ Kempe A, Beaty BL, Crane LA, Stokstad J, Barrow J, Belman S, Steiner JF. *Changes in access, utilization, and quality of care after enrollment into a state child health insurance plan*. Pediatrics. 2005 Feb;115(2):492-4.
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¹⁰ See note 9, Kempe, et al.

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¹³ Eisert S, Gabow P. Effect of Child Health Insurance Plan Enrollment on the Utilization of Health Care Services by Children Using the Public Safety Net System. *Pediatrics*. November, 2002, Vol. 110, No. 5, pp940-945.

¹⁴ Szilagyi PG, Dick AW, Klein JD, Shone LP, Zwanziger, Bajorska, Yoos HL. *Improved Asthma Care After Enrollment in the State Children's Health Insurance Plan of New York*. *Pediatrics*, February, 2006, vol.117, no.2, pp486-496.

¹⁵ Szilagyi PG, Shone LP, Klein JD, Bajorska A, Dick AW. *Improved Health Care Among Children with Special Health Care Needs After Enrollment Into the State Children's Health Insurance Program*. *Ambulatory Pediatrics*. Jan./Feb 2007, vol. 7, no.1, pp10-17.

¹⁶ Wooldridge J, Hill I, Harrington M, Kenney G, Hawkes C, Haley J. *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program*. February, 2003. Mathematica Policy Research, Inc.

¹⁷ Kenney G, Haley J. *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* The Urban Institute, a national survey of American families. May, 2001.

¹⁸ See note 5, Holahan, et al.

¹⁹ Sommers BD. *Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention versus Poor Takeup*. *Health Affairs*. 2007 Sep-Oct;26(5):w560-7. Epub 2007 Jul 26.

²⁰ Fairbrother GL, Emerson HP, Partridge L. *How Stable is Medicaid Coverage for Children?* *Health Affairs*. March/April, 2007. Vol.26, No.2, pp520-28.

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