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Introduction

From a policy perspective, all of California's children need health insurance and all parents should have the opportunity to enroll their eligible child in the Medi-Cal (MC) or Healthy Families (HF) program. In 2001, 355,000 uninsured children were eligible for MC and an additional 301,000 uninsured children were eligible for the HF Program.¹ This study examines participation in the children's MC and HF programs, and it identifies both family characteristics and county characteristics that affect children's enrollment. It also describes the enrollment process as it currently exists, and identifies the many ways that children can "fall off" the pathway to enrollment or can become disenrolled. Lastly, it describes the policy implications of these findings, and how these findings can be applied to improve access to health insurance coverage for all MC and HF eligible children.

With a voluntary health insurance program that necessitates an active application and enrollment process, we will never achieve 100% program participation. However, it is in the public's best interest to cover as many children as possible. In 2001, more than half of low-income parents reported not enrolling their uninsured eligible children because they did not know they were eligible, did not believe they were eligible, did not know the program existed, or they found the paperwork too difficult¹. Only 3% of parents reported that they didn't enroll their eligible, uninsured child because they did not want or need health insurance¹; yet, almost 20% of MC eligible children and almost 40% of HF eligible children remained uninsured. Because such a large proportion of MC and HF eligible children remained uninsured, one could argue that the system is not serving all families equally. By demonstrating which factors most strongly predict program enrollment, this study helps diagnose how the enrollment system can be made more effective.

Data

This report is based on data from the 2001 California Health Interview Survey (CHIS 2001), a telephone survey of more than 55,000 households drawn from every county in California—the largest population-based state health survey ever conducted in the United States. The CHIS 2001 random-digit dial (RDD) sample was drawn from 41 sampling strata. It includes 5,801 adolescents (ages 12-17) and 12,598 younger children (under age 12, for whom information was reported by the "most knowledgeable adult" in the family) who are associated with the 55,428 sample adults (age 18 and over). For each selected household, CHIS interviews one randomly selected adult, and in those households with children, one adolescent (ages 12-17) and one parent proxy of a sample child (under age 12). They were interviewed between November 2000 and September 2001.

This study focuses on children under age 18 who are eligible for either the MC or the HF program, and who are not enrolled in any other health insurance plan.* It excluded children whose parents reported receiving TANF, CalWORKS, General Relief/General Assistance, or Social Security Disability Income/Social Security Income, because families receiving cash aid are automatically enrolled in the MC program, and therefore they are not targeted for MC outreach. Participation rates were calculated using CHIS 2001 estimates of children's enrollment in and eligibility for the MC and HF programs. Enrollment estimates are based on parents' responses to CHIS 2001 survey questions on their child's insurance status and their families' participation in public programs at the time of the interview, rather than on administrative data from the

* Although individuals age 18 are eligible for both the MC and the HF programs for children, 18 year old respondents are excluded from this study. This is due to a data limitation. In CHIS, 18 year-old respondents are treated as adults and are administered a different questionnaire than respondents under age 18 and their proxies. Their parents are not interviewed, and thus we have no data on their parent's characteristics.

Department of Health Services or the Managed Risk Medical Insurance Board.

In addition, parents were asked a series of detailed questions that were included in the CHIS 2001 survey for the express purpose of determining their eligibility and their children's eligibility for the MC and HF programs.* These questions were used to construct a variable categorizing each respondent as eligible for MC, eligible for HF, or not eligible. About 100 contributing variables were used in the construction of the final eligibility variable.

Population-based estimates of program enrollment and eligibility were created by weighting the responses from each person in the sample to reflect the number of similar persons in the population in 2000 that that individual represented. Participation rates were calculated using the following formula:

$$\text{Participation Rate} = 100 \times \frac{\text{Number Enrolled}}{(\text{Number Enrolled} + \text{Number Eligible but Uninsured})}$$

The number enrolled consists of weighted estimates of the number of children who were enrolled in MC, or who were enrolled in HF, depending on whether we are estimating MC participation or HF participation rates. The number eligible but uninsured consists of weighted estimates of the number of uninsured children who were eligible for MC or HF (again depending on which participation rate we are calculating), yet who were not enrolled.† For more information on CHIS, including information on sample weights, please visit www.chis.ucla.edu.

In addition to the family- and individual-level data provided by CHIS, this study used administrative data from Kaiser Permanente, the California Kids Program, the California State Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB). These data are from fiscal years 1999-2000 and 2000-2001 and included:

- The number of applications processed by county
- The number of children deemed ineligible by county due to incomplete applications
- The amount of money dispersed to each county for outreach, including monies to:
 - o Train certified application assistants
 - o Fund media outreach (provided by designated market area)
 - o Fund community-based organizations and schools for outreach and enrollment support
 - o Fund outreach for MC 1931b, a program designed to enable working families to have full scope MC coverage when they are not receiving cash aid through TANF or other programs.

Lastly, this study incorporated data from a state-wide survey conducted by the Medi-Cal Policy Institute in March of 1999, which measured the number of sites in each county that had outstationed eligibility workers, whether these sites had evening and weekend hours and whether they allowed walk-in appointments.²

Data Analysis

Two different types of multivariate analyses were conducted in this study to accommodate the

* Parents' eligibility for the Healthy Families program has been put on hold due to the current state budget crisis, although Governor Davis signed legislation to cover the parents of eligible children who enroll in the program.

† Children who did not meet study criteria were not included in this analysis. These include eligible children with private insurance coverage and children who automatically receive Medi-Cal through a cash-aid program such as Temporary Assistance for Needy Families or CalWORKS.

unique data set. These multivariate analyses allow us to see the individual effects of each variable on children's enrollment.

First, a logistic regression was conducted using sampling weights to adjust the data to make it more representative of all MC and HF eligible children in the state. Weights incorporated the probability that each child in the sample would be selected to participate in the survey, and corrected biases due to non-response and the exclusion of households without telephones. The first analysis also controlled for the fact that observations made within counties are clustered, and are thus somewhat correlated. Second, an unweighted, three-level, hierarchical logistic regression was conducted to control for clustering at the family and county level. These very different models yielded similar results.

The unit of analysis in this study was the eligible child, and data on the characteristics of children and teens were linked with data on their parents' characteristics. Individual-level variables used in this analysis included:

- Parent factors: Age, ethnicity, immigration status, English language proficiency, years in the US, marital status, hours worked per week, mental well-being, education
- Child factors: Age, gender, health status, enrollment status
- Household factors: Income per member, languages spoken in the home, number of kids, rural vs. urban location

County-level variables used in this analysis included:

- Outreach dollars received from the state per eligible child in the county
- Media campaign dollars spent per eligible child in the Designated Market Area (DMA)
- Whether a county "expansion program" was in place. During the time when CHIS 2001 data was collected, three counties had instituted comprehensive children's health insurance coverage initiatives or "expansion programs" to enable all children in low- to moderate-income families to qualify for subsidized health insurance at minimal cost. These three counties were Alameda, Santa Clara, and San Francisco.
- Whether a California Kids program or a Kaiser Permanente Cares for Kids program was operating in that county. These programs offer subsidized health insurance to children who do not qualify for MC or HF because they are undocumented or their families earn between 250% and 300% of poverty.
- The number of outstationed MC eligibility workers per eligible child in the county
- County size

Two Programs, Two Samples

The MC program has different eligibility requirements than the HF program, and a child eligible for MC can not be eligible for HF. Thus the MC and HF eligible populations have different characteristics with regards to age and income. This is demonstrated in Figure 3. For these reasons, we ran separate analyses for children eligible for or enrolled in MC, and those eligible for or enrolled in HF.

Figure 1.

Age and Income Eligibility for Children in the Medi-Cal and Healthy Families Programs

201% to 250% Poverty	200%	Healthy Families Eligible	
134% to 200% Poverty			133%
101% to 133% Poverty	Medi-Cal Eligible		100%
Less than 100% Poverty			
	Up to 1 Year	1 to 5 Years	6 to 18 Years

Note: "Poverty" refers to the Federal Poverty Guidelines.

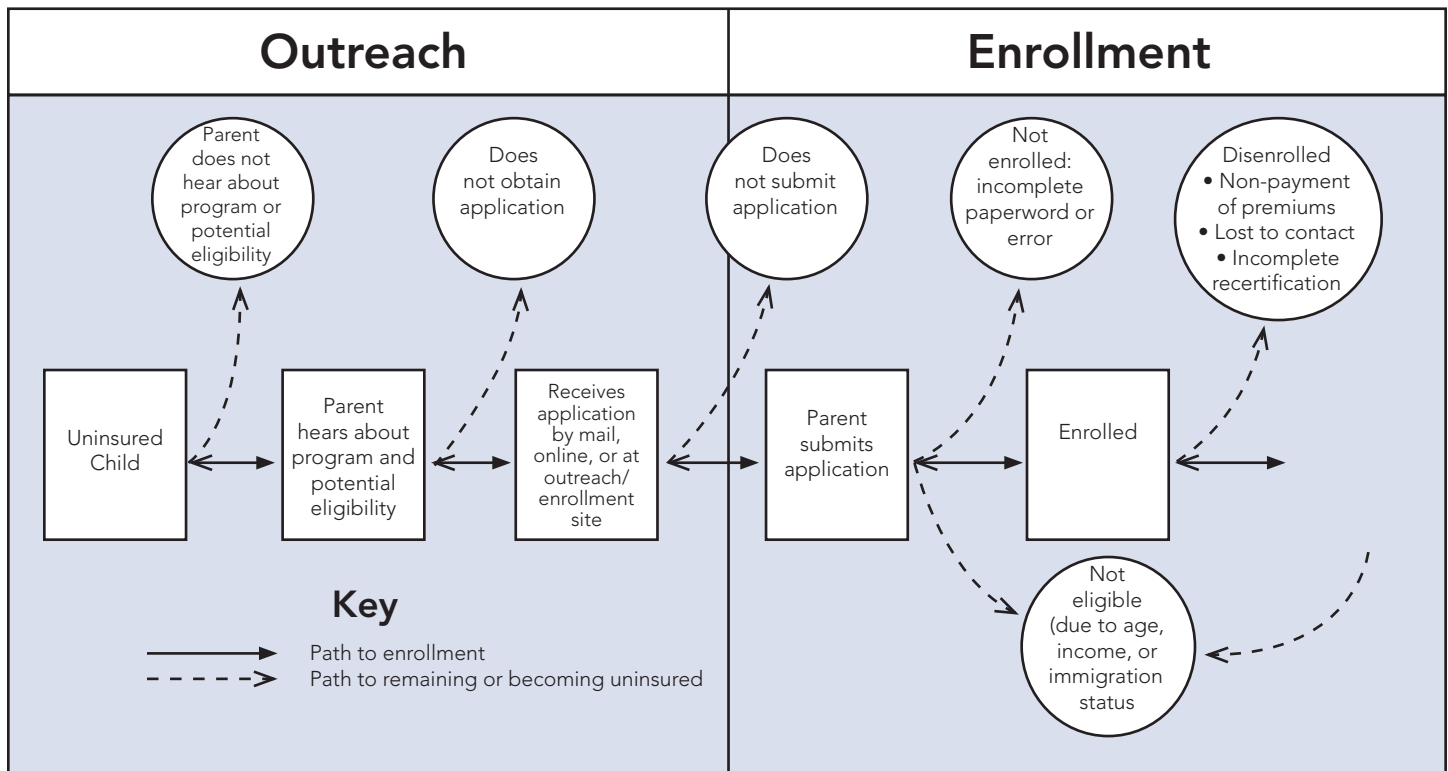
The Current Pathway to Enroll Children

Figure 2 presents the Current Pathway to enroll and retain children in the Medi-Cal and Healthy Families programs for children. The "Current Pathway" graphically represents the process parents of an uninsured child must now undergo in order to obtain and keep MC or HF coverage for their child, and the many opportunities for this process to go wrong.

Parents must first hear about the existence of the MC or HF program for children and that their child might be eligible. They must obtain an application either at an outreach site, on-line, or through the mail and decide that they want to apply. Then they must submit a correct and complete application, along with complete documentation of their family's income and their child's immigration status/citizenship. Additional documentation may also be required, including school enrollment status or living arrangements of family members. When their child is deemed eligible and given coverage, that coverage will last for one year, provided they pay their premiums

Figure 2.

Current Pathway to Enroll and Retain Children in the Medi-Cal and Healthy Families Programs.



(for HF only). If they fail to pay their premiums, they will be disenrolled. After one year, they must undergo recertification or their child will be dropped from the program.

Recertification involves burdensome paperwork and documentation. If it is determined that their child is no longer eligible for one program (for example, MC) due to a change in their age or income, then they can complete paperwork for a transfer to the other program (in this case, HF). If a family's income rises above 250% of the federal poverty guidelines, the child will no longer be eligible for coverage under either program.

Findings

Finding 1: Statewide, almost 20% of Medi-Cal eligible children and almost 40% of Healthy Families eligible children remained uninsured in 2001. Participation rates for the Medi-Cal and Healthy Families programs vary by county.

In general, participation rates for children in the MC program were higher than in the HF program. For the state overall, 81% (range: 79% to 83%) of MC eligible children participated in the program in 2001, excluding children from families receiving cash aid. By contrast, only 62% (range: 58% to 66%) of HF eligible children participated in the program. County-level participation rates for the MC program ranged from 65% (range: 44% to 80%) to 100%. Participation in the HF program ranged from 39% (range: 21% to 60%) to 100%. These estimates are based on relatively small sample sizes; thus we consider the point estimates to be approximations. However, we are confident that 95% of the time, the true value lies within the range provided. When confidence intervals (ranges) are wide, we focus on the range rather than on the point estimate. Many of the county-level participation estimates are unstable due to the small sample sizes, and can be misleading. For this reason, we have chosen not to publish them here.

For information on participation rates in specific counties, please see our previous CPAC report entitled "Who Signs Up? Family Participation in the Medi-Cal and Healthy Families Programs" (available at www.healthpolicy.ucla.edu). In that report, we combined MC and HF eligible children to create sufficient sample sizes to provide stable estimates of program participation regionally and by county or by groupings of smaller counties.

Finding 2: Public charge may still be a barrier to enrollment.

Immigration status was a strong predictor of enrollment in MC ($p < .01$), but was not a strong predictor of enrollment in HF ($p = 0.38$). As expected, the children of noncitizen parents were less likely to be enrolled MC than children with two citizen parents. Contrary to expectations, it was not the children of parents who are noncitizens without green cards (which include the "undocumented" but also includes those legally present in the U.S. who have certain types of work or student visas) who had the lowest program participation. In fact, it was the children of parents with green cards who were the least likely to enroll in MC.

The fact that green card holders are less likely to have enrolled children is possibly due to fears surrounding the "public charge" issue, and the general distrust many immigrants have of government entities, both in the US and in their countries of origin. Green card holders may fear that if they enroll their children in MC, it will interfere with their ability to obtain citizenship, or that they will be made to repay the government for services received by their children, as had been done in the past.³

The public charge issue may have somewhat less impact among undocumented parents who

have no legal path by which they may obtain citizenship, and thus have less to lose by enrolling their children in MC. However, undocumented immigrants who work for cash may have greater difficulty reporting their income for the application process, and may also want avoid contact with a government agency out of fear of being deported.

Finding 3: White and Latino children had the lowest odds of enrollment in Med-Cal, and most uninsured eligible children were Latino.

Ethnicity was a strong predictor of enrollment in both the MC and the HF models ($p < .01$). Contrary to expectations, Whites were much less likely to enroll than certain Non-White groups. African Americans had almost 4 times the odds of being enrolled compared with Whites ($p = 0.01$). Asians had 3 times the odds of Whites ($p = 0.04$), and American Indians and Alaskan Natives had almost 6 times the odds of Whites ($p < .01$). Latinos had odds that were similar to Whites.

Because large numbers of Latino children qualify for MC, and because program participation by Latino families is relatively low, large numbers of eligible Latino children remain uninsured. An estimated 239,000 (CI: 204,000 to 274,000) Latino children under 18 years of age were eligible for MC but not enrolled in any insurance plan in 2001. In addition 52,000 (CI: 34,000 to 69,000) White children were eligible but uninsured. This is compared with only 7,000 (CI: 2,000 to 12,000) Asian Pacific Islander American children, 500 (CI: 100 to 1,000) American Indian and Alaskan Native (AIAN) children and 4,000 (CI: 800 to 7,000) African American children. In addition, 13,000 (CI: 5,000 to 22,000) children whose parents did not identify with any one ethnic group were eligible but uninsured.

Finding 4: American Indian and Alaskan Native children had the lowest odds of enrollment in the Healthy Families Program, followed by White and Latino children.

Among HF eligible children, Asians had 2.32 times the odds of being enrolled compared with Whites, and African Americans had almost 3 times the odds of Whites ($p = 0.02$ and $p = 0.04$ respectively). As in the MC program, Latinos had similar odds to Whites. Surprisingly, AIAN children had only 40% the odds of Whites, a reversal of what was found in the MC program ($p = 0.07$).

In addition to a general lack of awareness of the HF program among AIAN families, is possible that lower participation by AIAN in the HF program may be partially explained by an administrative hitch.²⁹ Beginning in 2000, a waiver exempted AIAN children from paying premiums or co-pays to participate in the federal SCHIP program (called Healthy Families in California). At the time of this study, the waiver was not being fully implemented and many Certified Application Assistants were not aware of the waiver.

To get free HF coverage, California requires AIAN children to prove their tribal ancestry. This extra layer of paperwork may have served as a barrier to enrollment if parents who could not produce these documents did not complete the application process. If the parents of AIAN children were not able to produce this paperwork but otherwise completed the application, they were charged premiums and co-payments.*

* For detailed recommendations regarding the AIAN Healthy Families Program waiver, see Satter D, et al. Improving Health Insurance Coverage for American Indian Children and their Families under Healthy Families (SCHIP), UCLA Center for Health Policy Research, 2002, www.healthpolicy.ucla.edu/pubs/files/AIAN_report_062002.pdf

Even among children who did prove their tribal ancestry, half continued to send in premiums, which were kept by the Managed Risk Medical Insurance Board. Although AIAN children are not required to pay co-pays, their insurance card lists an office visit co-pay of \$5, leading to further confusion.⁴

Future research is needed to explore the reasons for the differences between racial and ethnic groups, and how to narrow the gaps in enrollment between groups.

Finding 5: Funding outreach increases children’s enrollment in MC and HF.

Among children eligible for MC, the odds of being enrolled increased by 6% for each additional dollar spent on outreach per eligible child in the county ($p=0.08$). Among HF eligible children the odds increased by 7% for each additional dollar spent on outreach per eligible child ($p=0.05$). Specifically, we refer to outreach dollars spent on training certified application assisters, funding community-based organizations and schools for outreach and enrollment support, and outreach for MC 1931b, a program designed to enable working families to have full scope MC coverage when they are not receiving cash aid through TANF or other programs. The impact of funds spent on the media campaign were examined separately.

Finding 6: All outreach strategies are not equally cost-effective.

The mass media campaign produced by the state did not increase children’s enrollment in MC, and appears to have had a negative effect on enrollment in the HF program. This is likely due to the fact that the media campaign was a “one-size-fits-all” effort to deliver a message to the masses quickly, and did not take into account California’s tremendous diversity.

Initially, the HF program featured a lengthy and burdensome application process, and many people had bad experiences trying to enroll their children. It may be that the increased awareness of the program actually fostered the spread of the negative “buzz” about the program and resulted in decreased program enrollment. A similar phenomenon was noted by Gaskell and colleagues who study public perceptions of biotechnology. They found that greater media coverage, even when it is positive in nature, is associated with greater negative perceptions of biotechnology. In both cases, increased awareness of the product (biotechnology or public health insurance) interacted with negative information about the product, resulting in more widespread dissatisfaction than among areas with lower product awareness.⁵ This same relationship was not seen with the MC program, which existed long before the HF program was initiated in 1998 and already had wide spread name recognition and an established reputation.

Surprisingly, outstationed MC eligibility workers were also negatively associated with children’s enrollment. At the very least, outstations do not appear to be increasing the number of children who enroll in the county. Many hospitals partner with counties to have outstationed Medi-Cal eligibility workers located on-site at their facility to assist patients in applying for Medi-Cal as a mechanism for reducing uncompensated care. These outstationed workers may increase Medi-Cal enrollment among adults, but not children, because adults are more likely to have expensive hospital bills.

Most outstations are located in DSH hospitals and FQHC clinics, and many children that are enrolled at outstations are presenting for treatment. The parents of sick children have a strong motivation for enrolling them in health insurance, and perhaps they would have applied for coverage even if they had to make a trip to the welfare office. If this were true, outstations could

enroll a large number of children without increasing the overall enrollment.

Outstations have been partially funded by MC and HF outreach monies.² When counties use state MC and HF outreach monies to fund outstations, they take funding away from other outreach and enrollment efforts that may actually be more effective with children. Outstations may consume precious outreach dollars, supplanting other outreach activities, without increasing children's enrollment. However, outstations may be effective at enrolling adults in Medi-Cal, and play an important role in reducing uncompensated care among safety net providers.

Finding 7: Older children and adolescents are the least likely to be enrolled.

In both the MC and HF programs, younger children were more likely to be enrolled when compared with older children. HF eligible children age three to eleven had 40% lower odds of being enrolled compared with children aged two and under ($p=0.11$). Adolescents had 60% lower odds compared with children under age two ($p<0.01$). The relationship was similar but not statistically significant among the MC sample.

Finding 8. Children who live in urban areas and large counties are less likely to be enrolled.

Eligible children living in urban settings had more than 40% lower odds of HF enrollment than children living in non-urban settings ($p=0.03$). When compared with children living in large counties (defined as having more than 100,000 children), children in medium-sized counties (defined as having between 10,000 and 100,000 children) had 80% greater odds of being enrolled in HF or MC. Children living in smaller counties (less than 10,000 children) had three times the odds of being enrolled in HF ($p=0.11$) and 50% greater odds of being enrolled in MC ($p .05$).

Large bureaucracies may be less responsive or less connected to the diversity within the communities they serve compared with smaller bureaucracies, and thus may be less able to foster enrollment by eligible children.

Finding 9: County-sponsored expansion programs increase enrollment in MC and HF.

Children who lived in counties with a county-sponsored expansion program had almost three times the odds of being enrolled in MC compared with children from counties without an expansion program in place ($p=0.06$). The Kaiser Permanente Cares for Kids (KPCFK) and the California Kids (CK) programs, which are private charitable programs, were not associated with increased MC enrollment. In the HF program, county-sponsored expansion programs, KPCFK and CK were positively associated with enrollment, but these results were not statistically significant.

It is interesting that county-sponsored expansion programs would have such a strong impact on MC enrollment and less of an impact on HF enrollment when a goal of these programs is to increase enrollment in both. This may have to do with the fact that MC applications are processed at the county level and HF applications are processed at the State level. The Alameda County Health expansion project reported that although Social Services referred applications to HF program, they were unable to track approval because of access difficulties, and were unable to follow-up due to confidentiality issues.⁶

Policy Recommendations

Finding 1: Statewide, almost 20% of Medi-Cal eligible children and almost 40% of Healthy Families eligible children remained uninsured.

Recommendation: Reduce barriers to enrollment by simplifying the application process and allowing families to self report income. This would especially reduce barriers for citizen children of undocumented parents who may have difficulty documenting their income. States that allow families to self-declare their income have found this to be an effective means of simplifying eligibility, reducing administrative costs without compromising the accuracy of eligibility determinations.⁷ With the passage of Senate Bill 437, California has taken steps to allow children enrolled in HF to self-certify their income when they renew their coverage. In addition, the MC program will embark on a pilot program to allow self-certification of income for families applying for or renewing MC coverage.

Recommendation: Roll back provisions in the federal Deficit Reduction Act of 2005 that require citizens to provide proof of identity and citizenship in order to enroll in Medicaid. These new documentation requirements represent an additional hurdle that can delay or prevent parents from enrolling their eligible, citizen children in Medi-Cal. Since the implementation of the DRA in July 2006, multiple states have reported sharp declines in Medicaid enrollment, which state officials attribute to the additional barriers created by the new documentation requirements, and to administrative delays created by back logs from the increased work load shouldered by eligibility workers.⁸

Recommendation: Fully implement “Express Enrollment” to expedite MC, HF and local Children’s Health Initiative enrollment for children who are already enrolled in programs with comparable eligibility provisions such as the National School Lunch Program, WIC, and Food Stamps. Almost 80 percent of low-income, uninsured children live in families that already receive benefits through food stamps, school lunch, or the Supplemental Nutrition Program for Women, Infants, and Children (WIC).⁹

California has taken steps toward implementing express enrollment, but more work remains. In October 2001, California adopted Express Enrollment for children enrolled in the School Lunch program for Medi-Cal eligible children only, but it has not been widely implemented and has not been implemented with children eligible for the Healthy Families Program or for those eligible for local Children’s Health Initiatives. In 2006, Senate Bill 437 was signed into law establishing an automated enrollment system from the WIC program to the Medi-Cal and Healthy Families programs to expedite enrollment, but it will not coordinate with local Children’s Health Initiative enrollment.

Recommendation: Foster, support and evaluate innovative pilot programs such as California HealthCare Foundation’s web-based enrollment system, One-e-App, which is designed to screen and enroll applicants in multiple publicly funded health programs through a single application. Recommendation: Integrate the MC and HF programs into one program, thus eliminating the need for program transfers, which are opportunities for enrolled children to lose coverage when their family income changes or they have a birthday. This would reduce fragmentation for families, who often have a young child enrolled in MC at the same time that an older child is enrolled in HF, and would reduce administrative costs. An alternative strategy proposed by E. Richard Brown, is to create a seamless “administrative overlay” so that the two programs present a uniform face to the public even though, beneath the surface, the administrative complexities of two programs remain. This compromise would not reduce administrative costs, but could simplify the enrollment process for families and thus increase enrollment.

Finding 2: Public charge may still be a barrier to enrollment.

Recommendation: Inform immigrant parents that enrolling their children in MC or HF will not be counted against any family member applying for permanent residency or citizenship. Immigrant parents need to learn this from a trusted source, and to hear it from the government as well.

- Put it on the application.
- Tell parents at every contact during the outreach and enrollment process. Make it a part of standard outreach protocols.
- Partner with the U.S. Citizenship and Immigration Services to make applications available in their offices, and hang posters in their offices advertising the MC and HF programs and telling parents they can enroll their children without damaging their applications for permanent residency or citizenship.

Findings 3 and 4: White and Latino children have the lowest odds of enrollment in Medi-Cal, and most uninsured eligible children are Latino. American Indian and Alaskan Native children had the lowest odds of enrollment in the Healthy Families Program, followed by White and Latino children.

Recommendation: Specifically target White, Latino, and AIAN children with culturally appropriate outreach.

Recommendation: Improve implementation of the Healthy Families waiver, which exempts AIAN children from paying Healthy Families Program premiums and co-payments.*

- Allow American Indian and Alaskan Native children to self-certify their ancestry, as is done in other states.
- Improve Certified Application Assistor training on the AIAN waiver.
- Issue special HF insurance cards to AIAN kids, which list the co-pay as \$0.
- Return premiums to AIAN families, explaining that they are not required.

Recommendation: Study and apply techniques learned from our African American, Asian American, Pacific Islander American, who have been the most successful at enrolling their children.

Finding 5: Funding outreach increases children's enrollment in MC and HF.

California has had a checkered past with regard to funding outreach. In FY 2001-2002 California spent over 42 million dollars on MC and HF outreach. However, in 2003 outreach funding was cut from the state budget. In 2006 22.6 million dollars was allocated for outreach to uninsured children.

Recommendation: Consistently fund outreach for children's Medi-Cal and the Healthy Families Program.

* For detailed recommendations regarding the AIAN Healthy Families Program waiver, see Satter D, et al. *Improving Health Insurance Coverage for American Indian Children and their Families under Healthy Families (SCHIP)*, UCLA Center for Health Policy Research.

Finding 6: All outreach strategies are not equally cost-effective.

The mass media campaign did not work. Outstations may be effective at increasing enrollment among adults and at reducing uncompensated care among safety net providers. However, they do not appear to increase enrollment among children, but actually have a negative impact on children's enrollment. This may be because they take resources away from other programs that may be more effective with children.

Recommendation: Avoid investing in one-size-fits-all media campaigns. There have been media campaigns targeting specific groups, but the effectiveness of these programs has not been demonstrated.

Recommendation: Consider shifting children's outreach funds away from outstations and towards other outreach programs that are more effective with children. Investigate whether outstations located in schools or other community settings are more effective with children than outstations located in hospitals and clinics.

Finding 7: Among families who do not receive cash aid, the poorest children are the most likely to be uninsured.

Recommendation: Specifically target the poorest children. They are California's most vulnerable residents. Partner with community-based organizations, schools, and churches to reach very low-income families, especially children who may be outside the school system.

Finding 8: Older children and adolescents are the least likely to be enrolled.

Recommendation: Specifically target the parents of older children with outreach messages about the importance and availability of health insurance coverage for their children.

Finding 9. Children who live in urban areas and large counties are less likely to be enrolled.

Recommendation: Fund further research to explain why urban areas and large counties are negatively associated with enrollment.

Finding 10: County-sponsored expansion programs increase enrollment in MC and HF.

Perhaps the best strategy for increasing enrollment in the MC and HF programs identified in this study is the creation of local expansion programs, which provide coverage to children who are not eligible for MC or HF because of their immigration status or their family income. County-sponsored expansion programs have the positive externality of increasing children's enrollment in MC and HF—one more reason why local expansion programs are a good investment. County-sponsored expansion programs involve the mobilization of community groups and resources, local media coverage, and commitment from community leaders. This local "buy-in" may also translate into enthusiasm and commitment to children's health insurance coverage among outreach and enrollment staff.

Since CHIS 2001 was in the field, 15 more county-sponsored expansion programs have begun operation or are in the planning phase, bringing the total number of county-sponsored expansion programs to 18.

Recommendation: Expand health insurance eligibility to all children under 300% of poverty residing in California, including undocumented children. As this report is being completed in January 2007, health care reform proposals from the Governor, the Speaker of the Assembly, and

the President pro Tem of the Senate all include this provision.

A Better Pathway to Enroll and Retain Children in the Medi-Cal and Healthy Families Programs for Children

The *Current Pathway to Enroll and Retain Children in the Medi-Cal and Healthy Families Programs for Children* presented in Figure 2 graphically represents the process parents of an uninsured child must now undergo in order to obtain and keep MC or HF coverage for their child, and the many opportunities for this process to go wrong. Figure 3 presents a *Better Pathway to Enroll and Retain Children in the Medi-Cal and Healthy Families Programs*. The “Better Pathway” shows how policy changes recommended in this report could improve on the current system and keep parents on the “path” to enrolling their children. Any one of the policy recommendations featured in the Better Pathway could be adopted independently of the others and would improve program participation. Each of these policies has been successfully implemented in some form within some communities in California.

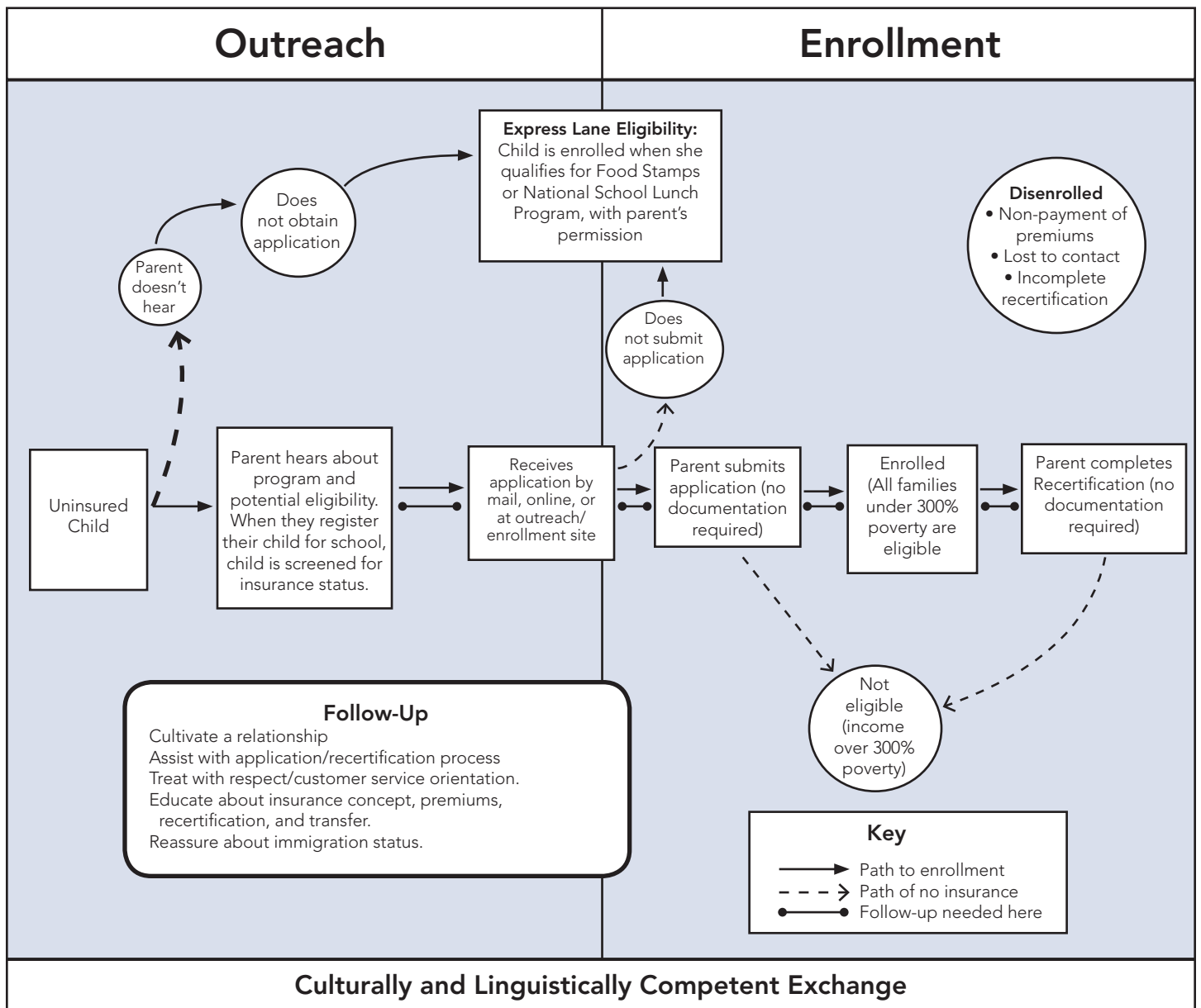
The Better Pathway begins with an uninsured child. The parents of this child may hear about the program and their potential eligibility and go on to obtain an application. Alternatively, they may not hear about the program and/or they may not obtain an application, or they may never submit a complete application. In the “Current Pathway” the children of these parents have been derailed from the path to enrollment and thus remain uninsured. However, in the Better Pathway, many of these children will be brought back onto the path through a policy called “Express Lane Eligibility,” which has been piloted, but not fully implemented in California. When a family applies for the National School Lunch program, or food stamps, the parent is asked permission to automatically forward their family’s information to the MC or HF Programs to be adjudicated for enrollment. Thus, children are automatically enrolled in MC or HF when they apply for programs with similar eligibility requirements.

In the Better Pathway, outreach and enrollment is school-based. When parents enroll their children in school, they are screened for insurance status. Parents of uninsured children are encouraged to enroll their eligible children in MC or HF, purchase private coverage, or to sign a waiver. Parents can also learn about the MC and HF programs in the immigration office when they apply for green cards or citizenship where posters encourage parents to enroll their eligible children and display a phone number where parents can get a free application.

The enrollment process is streamlined in the Better Pathway. Parents self report income, thus no documentation is required. The MC and HF programs are merged so that no cumbersome program transfer is required when family income fluctuates or a child has a birthday. Because all children are eligible, there is no need to document citizenship status. Parents of eligible children are also eligible for coverage, making it even more likely that parents will enroll their children. In the Better Pathway, the path to enrollment indicates at what point outreach workers should engage in “follow-up,” and the elements that follow-up should ideally comprise. As the model indicates, linguistic and cultural competence is the foundation of all outreach and enrollment activities. Implicit in this statement is that enrollment and outreach activities will differ when targeting different groups in California. Thus our recommendations for follow-up are not a one-size-fits-all template for outreach but rather a few core guidelines and principles that apply across many populations.

The Office of Minority and Women’s Health defines cultural competence as “A set of skills that allow understanding and appreciation of cultural differences and similarities within, among, and between groups.” This requires an ability to draw on community-based values, traditions, and

Figure 3. A Better Pathway to Enroll Uninsured Children in Medi-Cal and Healthy Families



customs to work with knowledgeable persons of and from the community in developing targeted interventions, communications, and other supports.¹⁰

The quality of follow-up activities conducted in counties can be measured against five basic guidelines, which we developed based on the literature. These are represented by the acronym **CATER**. An outreach worker can “cater” to the enrollment needs of a family by following these steps: **C**ultivate a relationship with the family; **A**ssist with the application/recertification/program transfer process; **T**reat with respect/customer service orientation; **E**ducate about the insurance concept, premiums, recertification, and program transfer; and **R**eassure about immigration issues.

Cultivate a relationship with the family. The literature suggests that outreach and enrollment for the MC and HF programs are best conducted in the context of a long-term relationship between the eligible family and a trusted source — usually through a community-based organization, church or school.¹¹ Organizations that have won the trust of families, especially families with

complicated legal or immigration issues, are better able to woo families to participate in a program sponsored by a government they may not trust.¹² Effective outreach goes beyond simply spreading the word about the existence of a program, but includes extensive education and follow-up beyond what could be achieved in a single contact. An organization that already has repeated contact with the family is well positioned to accomplish this.

Assist with the application/recertification/program transfer process. Parents may require assistance completing the paperwork and gathering the correct documentation. Ideally, outreach workers would contact parents that have initiated the application or recertification or transfer process to help them with any problems that arise. For example, a family whose MC application was rejected may not realize that their coverage was denied because a social security number was mistranscribed. They may mistakenly assume that they do not meet the eligibility criteria. Through a follow-up contact, an outreach worker can clarify the issue and help them to reapply. The children of parents whose income drops may no longer be eligible for HF at their annual recertification. Ideally they would be contacted to help guide them into the MC program. Otherwise, they may not realize that they qualify for coverage and their children may simply remain uninsured.

Treat with respect/customer service orientation. The interactions between outreach workers and the family should be marked by a respectful customer service orientation so that families are not driven off by rudeness or condescension. Anecdotally, this has not been the traditional posture in many welfare offices, but is an important component of effective outreach and enrollment. In a national survey on barriers to Medicaid enrollment, 55% of parents said that better treatment at the enrollment office would make parents much more likely to enroll their child in Medicaid.¹³

Educate about the insurance concept, premiums, recertification, and program transfer. Parents may need to be educated about the insurance concept and the need to pay premiums even when their child is well, lest they lose coverage by failing to pay premiums.¹⁴ This education should include the appropriate utilization of health services.¹⁵ Parents should be informed ahead of time about the annual recertification process, which again entails complicated documentation, and the possibility of a program transfer should their family income change in the future (from MC to HF or visa versa). It is important to mention recertification and transfer at the time a parent enrolls their child and during other follow-up contacts, even though they are in the future. Repetition reinforces these important messages and helps to prepare parents ahead of time. It also takes advantage of an opportunity to communicate with the parents who later may move and be lost to contact.

Reassure about immigration issues. Parents need to be told about the programs and their eligibility, but also that the government welcomes their participation and that if family members are noncitizens, it won't be counted against their family's application for citizenship. 46% of HF eligible children and 53% of MC eligible children have at least one immigrant, non-citizen parent.

Limitations

A few limitations should be noted in using the CHIS data to study enrollment by eligible children in the MC and HF programs. First, CHIS may exclude vulnerable populations without access to telephones since it is a telephone survey. CHIS attempts to compensate for this factor by weighting, but this may not fully adjust for the exclusion of non-telephone households. The CHIS 2001 survey had a response rate of 37.7%, comparable to similar state surveys in California.¹ While CHIS attempts to compensate for any nonresponse bias by weighting, this may not fully adjust for the exclusion of those who did not participate.

As is typical with population-based surveys, there is a discrepancy between CHIS estimates of MC enrollment and DHS administrative data on enrollment for the same period of time.¹⁶ CHIS questions on Medicaid and HF enrollment have been developed especially to reduce underreporting, and CHIS estimates are closer to enrollment counts from DHS administrative data than other surveys, such as the Current Population Survey¹.

Another limitation of the CHIS 2001 survey is that it interviewed only one parent. Thus we do not have information on the second parent where present in the household, except in some cases where it is solicited in the child and adolescent surveys. Thus we do not know the ethnicity, employment status, or English language proficiency of the parent who was not selected to participate in the study. Also, we do not have information on the health status of all the children in the household, introducing an omitted variable bias.

Also, the CHIS survey questions measuring household income ask respondents to provide a figure for total household income for the past year. Some people may not accurately recall their household gross income, and instead may provide a “ball park” figure somewhat higher or lower than the actual figure.

Lastly, CHIS is a cross-sectional survey and thus it is not possible to draw conclusions about causal relationships between enrollment and county or individual-level factors. This was especially problematic when exploring the relationship between enrollment status and health status, as previously noted.

One limitation of the data from the “Statewide Survey of Counties on the Outstationing of MC Eligibility Workers” is that it was collected in March of 1999 and slightly predates the CHIS data collection period. However, Federally Qualified Health Centers (FQHC) and Disproportionate Share Hospitals (DSH) are invited to participate in MC outstationing only one time — when the facility receives their initial FQHC or DSH designation. Thus it is unlikely that the number of facilities with outstationed workers changed significantly in the short period between the collection of this data and of the CHIS data. Also, since children have the benefit of one-year continuous MC eligibility, and because children may recertify after their one-year enrollment, the presence of outstationed eligibility workers in 1999 would undoubtedly impact enrollment during the CHIS data collection period.

Conclusion

Much work remains before all eligible children have access to enrollment in the MC and HF programs. Outreach efforts should be tailored to target those with lower odds of enrollment including: adolescents and school aged children; very low-income children; Latino, White and American Indian/Alaskan Native children; the children of immigrant parents, especially green card holders; urban children; and the children of parents who work long hours.

Outreach strategies that are not associated with increased program enrollment, such as out stationing eligibility workers in the community and mass media campaigns targeting a broad audience, should be reevaluated and perhaps discontinued. More attention should be given to the strategies used by organizations targeting African Americans, Asians, Pacific Islanders and American Indians/Alaskan Natives (for the MC program only) in order to learn from their successes. Lastly, county expansion programs that extend subsidized health insurance coverage to children who do not qualify for either MC or HF should be supported and replicated. In addition to providing coverage to an otherwise uninsured and vulnerable population, these expansion programs have the positive externality of increasing enrollment in MC and HF.

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