THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

ISSUE BRIEF

# Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act

June 2013

## Getting into Gear for 2014

## EXECUTIVE SUMMARY

The Affordable Care Act (ACA) will significantly increase coverage options through an expansion of Medicaid and the creation of new health insurance exchange marketplaces. However, effective outreach and enrollment efforts will be key to ensuring these new coverage opportunities translate into increased coverage. Based on a review of existing research, this brief identifies five key lessons learned through previous Medicaid and CHIP experience to help inform outreach and enrollment under the ACA. It finds that:

1. **Individuals want to have health coverage and value the Medicaid program for the key benefits it provides to their health and lives more broadly.** Most individuals believe that having health coverage is important and say they would enroll in Medicaid if eligible. Individuals value the Medicaid program for the services it provides as well as for providing peace of mind and protection from large medical bills. Experiences among previously uninsured Medicaid enrollees show that obtaining Medicaid coverage enables individuals to get treatment for health needs and preventive care that they went without while uninsured as well as to establish a relationship with a primary care provider and seek care from a physician early, rather than delaying care or relying on the emergency room. Moreover, by helping individuals get their health under control, Medicaid coverage facilitates individuals' ability to focus on other priorities and goals, including work and caring for their family.

2. **A combination of broad and targeted outreach strategies is key for reaching eligible families.** Families learn about Medicaid and CHIP through multiple avenues, including word of mouth, mass media, and healthcare providers, and have varied preferences about where and how to receive information. Broad-based messages through mass media are effective in educating families about coverage, but targeted messages and efforts are important for reaching and enrolling hard-to-reach groups. As such, combining broad messages with more targeted outreach approaches, often through trusted community-based partners, is important. In particular, health care providers can serve as an important and trusted link to health coverage. In addition, having outreach materials and application forms available in plain language and in multiple languages may reduce enrollment barriers for individuals with limited English proficiency and low literacy.

3. **Providing accessible, welcoming, and family-friendly application and enrollment processes helps reduce enrollment barriers for families.** Numerous studies find that simplifying enrollment procedures, offering multiple enrollment avenues, eliminating interviews, and reducing documentation requirements, contribute to increases in Medicaid enrollment. In particular, use of electronic data to verify information and automatically enroll individuals into coverage has been shown to reduce paperwork burdens for families and eligibility workers. Shifts in eligibility worker culture to promote a culture of coverage and reduce stigma also facilitate enrollment.

4. **One-on-one enrollment assistance provided by trusted individuals within the community is a key component of successful enrollment efforts.** Research shows that direct one-on-one enrollment assistance is associated with increased enrollment rates. Such assistance can be provided through varied avenues. For example, 35 states have out-stationed state eligibility workers who provide enrollment assistance and preliminary eligibility determinations at hospitals, clinics, schools, and other locations within the community. In addition, community-based organizations are able to provide culturally competent and trusted assistance at convenient times and locations. To support this assistance, nearly half of states (23) fund community-based application assisters.

5. **Facilitating renewals of coverage is important for promoting stability of coverage over time.** Research shows that gaps in Medicaid and CHIP coverage due to coverage losses at renewal increase costs and have a negative impact on quality of care. Extending the length of time between renewals and providing continuous eligibility help families maintain stable coverage. In addition, simplifying renewal procedures, often through the use of technology and electronic data matches, supports increases in retention. Coordinating transitions between Medicaid and CHIP through aligned rules and policies and electronic referrals also has been shown to help maintain children's coverage.

Looking ahead, the ACA will significantly increase coverage options through an expansion in Medicaid and the creation of new health insurance exchange marketplaces in 2014. However, the Supreme Court ruling on the ACA effectively made the Medicaid expansion a state option, and, in states that do not expand Medicaid, poor adults will not gain a new coverage option and likely remain uninsured. Regardless of state decisions to expand Medicaid, however, the ACA will establish new streamlined eligibility, enrollment, and renewal policies for all Medicaid programs as of 2014.

Even with new streamlined enrollment processes in place, a broad range of outreach and enrollment strategies, including targeted approaches for specific populations, will be important to reach and enroll eligible individuals. As demonstrated by past experience, ensuring adequate direct one-on-one assistance will be available through a diverse range of assisters who can provide culturally competent, trusted assistance in languages spoken by the individuals they serve will be a fundamental component of successful enrollment efforts. The ACA establishes consumer assistance resources and requirements, including a number of programs to provide in-person assistance. However, resources to support this assistance will vary across states. Moreover, coordinating outreach and enrollment efforts between assistance programs and across different coverage types will likely be challenging. These challenges will be amplified in states that do not expand Medicaid, where there will remain a coverage gap for poor adults. In these states, it will be important to determine how these adults and other individuals who remain ineligible for coverage, including undocumented immigrants, can be directed to safety-net resources for care if they attempt to apply for coverage.

Major education and outreach efforts about new coverage options will begin in the summer of 2013 in preparation for the October 1, 2013 open enrollment date for the new exchange marketplaces. However, it is important to recognize that enrollment into new coverage options will likely be a long-term effort. As such, it will be important for there to be adequate resources for outreach and enrollment over time to identify and utilize lessons learned as new enrollment efforts and experiences unfold.

## INTRODUCTION

The Affordable Care Act (ACA) provides a historic opportunity to significantly reduce the number of uninsured through new coverage options provided through an expansion in Medicaid and the creation of new health insurance exchange marketplaces. While the ACA intended for the Medicaid expansion to occur in all states, the Supreme Court ruling on the ACA effectively made the Medicaid expansion a state option. If a state does not expand Medicaid, poor adults in that state will not gain a new coverage option and will likely remain uninsured. Regardless of state decisions to expand Medicaid, however, the ACA will establish new streamlined eligibility, enrollment, and renewal policies as of 2014 for Medicaid, CHIP, and coverage through exchange marketplaces. Even with these new streamlined enrollment processes in place, effective outreach and enrollment efforts will be fundamentally important for translating the new coverage opportunities into increased coverage. To help inform these efforts, this brief identifies five key lessons learned about outreach and enrollment through previous Medicaid and CHIP experience, based on a review of existing research.

## BACKGROUND

**Medicaid and CHIP serve as key sources of coverage for low- and moderate-income children, but Medicaid eligibility for low-income adults lags far behind.** As of January 2013, all but four states cover children in families with incomes up to at least 200% of the federal poverty level through Medicaid and CHIP. States have not expanded Medicaid coverage for adults to the extent that they have done so for children. As of January 2013, 33 states limited Medicaid eligibility for parents to less than 100% of the federal poverty level, with 16 of these states limiting eligibility to less than half of the poverty level. Moreover, in most states, other non-disabled adults remain ineligible for Medicaid regardless of their income. As such, the ACA Medicaid expansion to adults up to 138% FPL would significantly increase eligibility for low-income parents and adults in many states.

**Most eligible children are enrolled in Medicaid and CHIP, but eligible, uninsured children remain, and participation rates are lower for eligible adults.** As of 2010, 86 percent of children who were eligible for Medicaid and CHIP were enrolled, with participation rates across states ranging from 67 percent in Nevada to 97 percent in the District of Columbia.[1] While most eligible children are enrolled in Medicaid and CHIP, eligible but uninsured children remain. Nationwide, it is estimated that as of 2010, over two-thirds (4.4 million) of the 6 million uninsured children were eligible for Medicaid or CHIP but not enrolled.[2] Moreover, certain groups of uninsured children are more likely to be eligible but not enrolled in coverage, including teens,[3,4] Latinos,[5,6] non-citizen children,[7] children in families with mixed citizenship status such as citizen children with non-citizen parents,[8] and children in families with mixed eligibility for Medicaid and CHIP (in which one child is eligible for Medicaid and another is eligible for CHIP).[9] Research also suggests that Medicaid participation rates for eligible adults are lower relative to children. Sommers and Epstein estimated that between 2007 and 2009, fewer than two-thirds (62%) of adults eligible for Medicaid were enrolled.[10] As is the case for children, adult participation rates also varied significantly by state, from less than 44 percent in Florida, Oklahoma, and Oregon to 88 percent in DC.[11]

**Individuals have historically faced a variety of barriers to enrollment in Medicaid.** One key barrier has been lack of knowledge, including how and where to enroll, and misunderstanding of eligibility requirements.[12,13,14,15,16] In addition, difficulty completing the enrollment process, particularly providing required documentation or paperwork, has served as a barrier.[17] Language and low literacy levels create additional enrollment challenges for some individuals.[18,19,20, 21,22] Moreover, studies suggest that many eligible immigrant families are reluctant to apply due to fears about jeopardizing their ability to obtain permanent status and/or exposing undocumented family members, despite federal guidance clarifying that enrollment in Medicaid and CHIP will not negatively affect an individual's immigration status.[23 ,24, 25] Research also shows that even modest premiums can negatively affect low-income families'

participation in Medicaid and CHIP.[26,27] In addition, perceived costs can deter enrollment—for example, 16 percent of low-income parents in one study believed that they would not be able to afford Medicaid or CHIP coverage.[28] Over time, many states have streamlined enrollment processes and developed outreach and enrollment initiatives to reduce these enrollment barriers. The ACA's new streamlined enrollment and renewal requirements that go into place in 2014 build on these previous efforts.

## FIVE KEY LESSONS LEARNED ABOUT OUTREACH AND ENROLLMENT

States' experience with Medicaid and CHIP has provided important understanding of the barriers families face to enrolling in coverage as well as effective strategies to overcome these challenges. Following are five key lessons learned based on this experience, which may help inform outreach and enrollment efforts under the ACA.

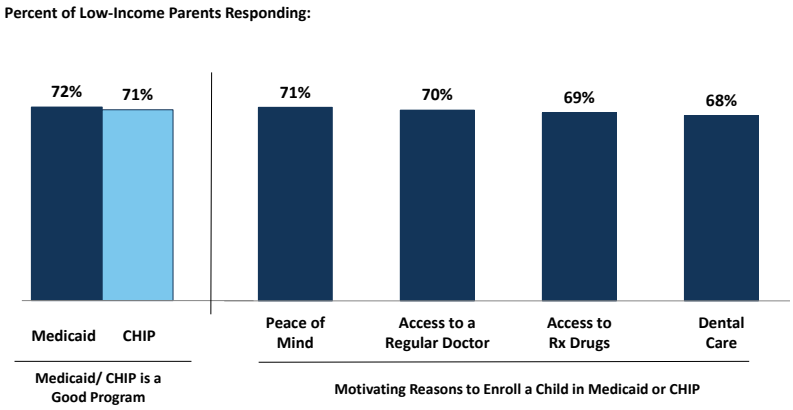
1. **Individuals want to have health coverage and value the Medicaid program for the key benefits it provides to their health and lives more broadly.**

***Most individuals believe that having health coverage is important and say they would enroll in Medicaid if eligible.*** One national study conducted in 2000 found that 97 percent of parents of Medicaid-enrolled children and 91 percent of parents with uninsured children reported that having health coverage for their children was very important.[29] The study also revealed that over 9 in 10 (93%) parents of eligible uninsured children would be willing to enroll their child in Medicaid.[30] More recent survey data also show that adults want health coverage for themselves, with over three-quarters of low-income adults reporting that they would be interested in enrolling in Medicaid if they were uninsured and learned that they could qualify.[31]

***Individuals highly value the Medicaid program.*** Numerous studies have documented parents' satisfaction with the Medicaid program as an affordable source of health coverage for their children.[32,33] A recent national survey of low-income parents found that nearly three-quarters perceive Medicaid or CHIP as a good program (Figure 1).[34] In other studies, over 9 in 10 parents (94%) of children enrolled in Medicaid think it is a good program.[35] Specifically, parents value that Medicaid is affordable and that it provides access to a regular doctor and coverage of comprehensive services, including prescription drugs, dental care, preventive check-ups, and care in case of serious illness.[36,37] About 7 in 10 parents also cite peace of mind as a reason for enrolling their child in Medicaid or CHIP.[38] In addition, survey data show that low-income adults value Medicaid for themselves. In surveys with low-income adults in Alabama, Maryland, and Michigan, approximately 8 in 10 adults described the program as very or somewhat good.[39] Key motivations that low-income adults cited for enrolling in Medicaid included security in case of unexpected accidents, protection from large medical bills, and the ability to have regular medical check-ups to remain healthy.[40]

Figure 1

**Views of Medicaid and CHIP Coverage Among Low-Income Parents**




SOURCE: Ketchum and Lake Research Partners, conducted for CMS. "Informing CHIP and Medicaid Outreach and Education: Key Findings from a National Survey of Low-Income Parents." (November 2011).

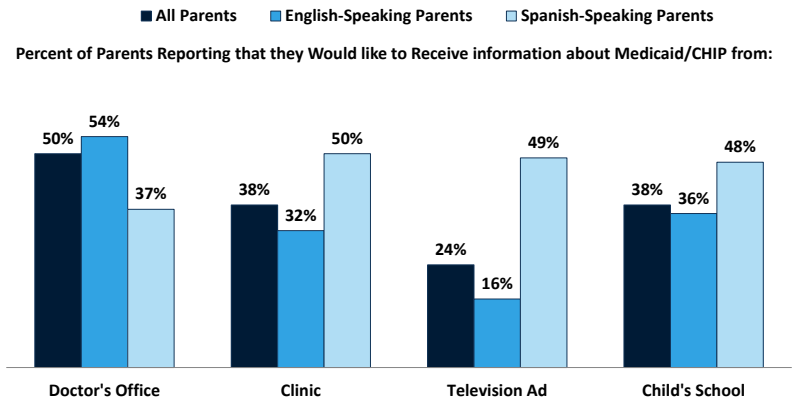
***Enrolling in Medicaid coverage has important benefits for individuals' health and their lives more broadly.*** Findings from Oregon demonstrated that adults who obtained Medicaid coverage had higher health care utilization, lower medical debt, and better self-reported physical and mental health than adults that remained uninsured.[41] In addition, focus groups with previously uninsured, low-income adults who gained Medicaid coverage found that obtaining coverage enabled them to get treatment for health needs and preventive care that they went without while uninsured. Many focus group participants also noted that having Medicaid enabled them to establish a relationship with a primary care physician and seek medical care from a physician early, rather than delaying care until their conditions worsened or relying on the emergency room. Moreover, by helping individuals get their health needs under control, Medicaid coverage facilitated individuals' ability to focus on other priorities and goals, including work and caring for family members.[42]

**2. A combination of broad and targeted outreach strategies is key for reaching eligible families.**

***Families learn about Medicaid and CHIP through multiple avenues including by word of mouth, mass media, and healthcare providers.***[43] Families also have varied preferences about where and how to receive information.[44] Half of parents in a recent survey reported that they would want to obtain information about Medicaid and CHIP from a doctor's office, approximately 4 in 10 (38%) would prefer to receive information from a clinic or from their child's school (38%), and about a quarter (24%) would prefer to receive information from a TV advertisement.[45] Preferences also differ by subgroup. For example, Spanish-speaking parents are less likely than English-speaking parents to prefer information from a doctor's office, but are more likely to prefer information from a clinic, television ad, or from thir child's school (Figure 2).

Figure 2

**Low-Income Parents' Preferred Sources of Information about Medicaid and CHIP, by Language**




SOURCE: Ketchum and Lake Research Partners. "Informing CHIP and Medicaid Outreach and Education: Key Findings from a National Survey of Low-Income Parents." November 2011.

***Broad-based messages effectively educate families about coverage, but targeted messages and efforts are important for reaching and enrolling hard-to-reach individuals.*** In the initial years after CHIP was launched, many states successfully used a variety of broad-based outreach strategies, including mass media and partnerships with celebrities and professional sports teams to inform families about new coverage options.[46,47] Today, a number of creative mass media outreach approaches for Medicaid and CHIP continue to be used, including Alameda County's recent "Cover Your Family" campaign (Figure 3). These broad marketing strategies effectively educate families about the availability of coverage, but analysis of their continued effectiveness over time and their ability to increase enrollment is mixed.[48,49]

Figure 3

**Alameda County Medicaid Billboard Campaign**

Combining these broad messages with more targeted outreach approaches, often through trusted community-based partners, is important to help reach and enroll hard-to-reach groups.[50, 51]

***Health care providers can serve as an important and trusted link to health coverage.*** For example, half of low-income parents in one survey reported wanting to receive information about Medicaid and CHIP from doctors' offices, and over half (57%) reported that they would trust a doctor a lot about whether they should enroll in Medicaid or CHIP.[52] Moreover, community health centers can serve as a key source for providing trusted and linguistically and culturally appropriate outreach and enrollment assistance.[53] Further, providers have incentive to enroll uninsured patients in health coverage to claim payment for services that may otherwise result in uncompensated care.[54] As such, many states conduct outreach through hospitals, clinics, and other health providers.[55]

***Several states have documented success with school-based outreach approaches.*** These initiatives involve a range of efforts including enrolling children through school-based health centers, conducting back-to-school enrollment campaigns, and partnering with school sports teams to ensure all eligible players are enrolled.[56] Grantees of the Covering Kids and Families Initiative identified school-based outreach as the most promising strategy to enroll eligible, uninsured children in coverage.[57] A California study also found school-based enrollment strategies to be highly effective.[58]

***Having outreach materials and application forms available in plain language and in multiple languages may reduce enrollment barriers for individuals with limited English proficiency and low literacy.*** For example, in one survey, half of Spanish-speaking parents said that the belief that application materials would not be available in their language discouraged them from trying to enroll their child.[59] Moreover, half of parents with eligible uninsured children say that receiving help from someone who spoke their language would make them much more likely to enroll.[60] Recent efforts by some groups to provide outreach flyers and notices in multiple languages appear to have increased enrollment and retention among children in Medicaid and CHIP.[61]

**3. Providing accessible, welcoming, and family-friendly application and enrollment processes helps reduce enrollment barriers for families.**

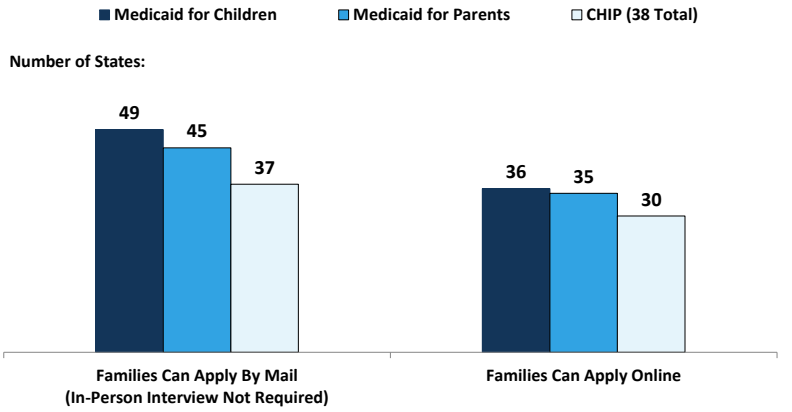
***Simplifying enrollment policies and procedures facilitates enrollment in Medicaid and CHIP.*** Numerous studies find that simplifying enrollment procedures, including eliminating interviews, coordinating program rules between Medicaid and CHIP, offering multiple enrollment methods, and reducing documentation requirements, contribute to increases in enrollment among Medicaid-eligible groups.[62, 63, 64] For example, as part of the temporary Disaster Relief Medicaid (DRM) program created after the September 11th attacks in 2001, New York utilized a vastly streamlined one-page application, allowed applicants to self-attest to eligibility criteria such as income, and provided applicants with an on-the-spot eligibility determination.[65,66] There was rapid enrollment in DRM, and many of those applying reported that they preferred the simplified application process.[67] Studies also demonstrate that reinstatement of enrollment barriers leads to significant enrollment declines. For example, in September 2003, Texas increased premiums, established a waiting period, and moved from a twelve- to six-month renewal period for children enrolled in the state's CHIP program and experienced a nearly 30 percent decline in enrollment in the nine-month period after these changes were implemented.[68]

***Families want a variety of methods available to apply for coverage.*** In one recent survey, over half (55%) of parents said they would be likely to apply for Medicaid and CHIP by mail, while nearly two-thirds (62%) said they would be likely to apply online, and about one-third (34%) said they would be likely to apply at a government office.[69] As of January 2013, nearly all states allow children to apply for Medicaid and CHIP by mail, although fewer states provide this option to parents.[70] In recent years, states have also increasingly provided families with the option to

apply online (Figure 4). Oklahoma is the first state to implement a fully-automated, real-time electronic eligibility system that enables families to apply at any time and receive a determination within 15-20 minutes (Box 1).[71]

Figure 4

**Availability of Simplified Application Methods in Medicaid/CHIP, January 2013**




SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

***Use of electronic data to verify information and automatically enroll individuals into coverage reduces paperwork burdens for families and eligibility workers.*** Over the past several years, states have increasingly relied on electronic data matches to verify eligibility criteria. For example, nearly all states (45) now conduct an electronic data match with the SSA to verify citizenship. Early adopters of the SSA data match found that it reduced the administrative burden for both states and families applying for coverage.[72] Moreover, as of January 2013, thirteen states have adopted the Express Lane Eligibility (ELE) option to enroll or renew children in Medicaid or CHIP using data from other benefit programs.[73] When California piloted an ELE-like program in 2003-2004, the state was able to enroll children that the state had not previously been able to reach through traditional enrollment methods.[74] Similarly, Louisiana enrolled more than 10,000 children in Medicaid in the month following implementation of ELE, and its volume and quality of eligibility processing remained steady despite a 12 percent reduction in the state Medicaid workforce.[75]

***Shifts in eligibility worker culture also support outreach and enrollment. Studies suggest that families' perceptions of unfriendly eligibility staff and stigma associated with Medicaid can be deterrents to seeking coverage.***[76,77,78] While the direct impact of organizational culture has not been measured, states that have undergone cultural changes within eligibility offices have seen positive results in enrollment.[79] For example, Louisiana attributes some of its success in enrolling and retaining eligible children in Medicaid and CHIP to internal marketing in eligibility offices about the importance of coverage and other efforts to change caseworker culture.[80] To reduce stigma associated with coverage, Kansas also trained staff to shift away from describing health coverage as a social services program.[81]

## Box 1: Oklahoma's Online, Real-Time Medicaid Enrollment System

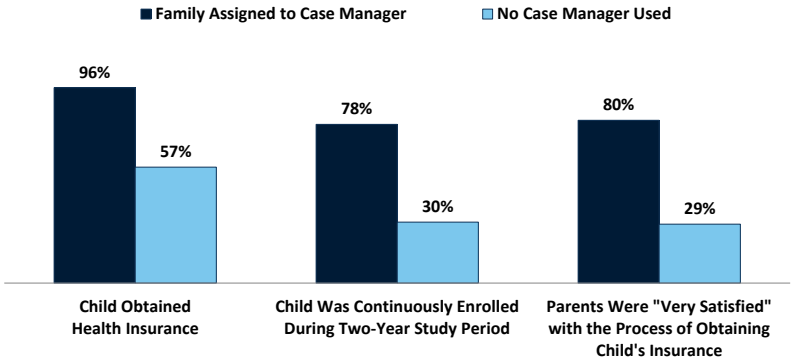

Oklahoma is the first state to maximize the use of technology through a web-based, fully-automated real-time eligibility determination system that is available 24 hours a day, seven days a week. The system allows individuals to apply online and receive an immediate or "real-time" decision on their application after the system has queried various electronic data sources to verify eligibility. Thereafter, individuals can use the account to renew coverage and update information such as an address or change in family status or employment. Using this system, the state processes more than a thousand applications per day, and 90 percent receive on-the-spot eligibility decisions, even when state offices are closed.

**4. One-on-one enrollment assistance provided by trusted individuals within the community is a key component of successful enrollment efforts.**

***Direct one-on-one enrollment assistance is associated with increased enrollment rates.*** For example, a study of Latino families in Boston found that those assigned to case managers who provided direct assistance were nearly twice as likely to obtain health coverage for their children as those without a case manager (Figure 5). Moreover, families with case managers were nearly three times as likely as those without assistance to report that they were "very satisfied" with the process of obtaining insurance.[82] Similarly, children whose families were provided one-on-one application assistance at a Utah clinic were nearly three times more likely than those without direct assistance to enroll in coverage (Box 2).

Figure 5

**Impact of Community-Based Case Management on Medicaid/CHIP Enrollment for Latino Children**




Based on the results of a two-year randomized, controlled trial conducted in Boston, MA from May 2002 to August 2004. Case managers provided 139 families with information on program eligibility, helped families complete applications, and assisted in maintaining coverage.
SOURCE: G.Flores et al. "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." Pediatrics. 116.6. (December 2005).

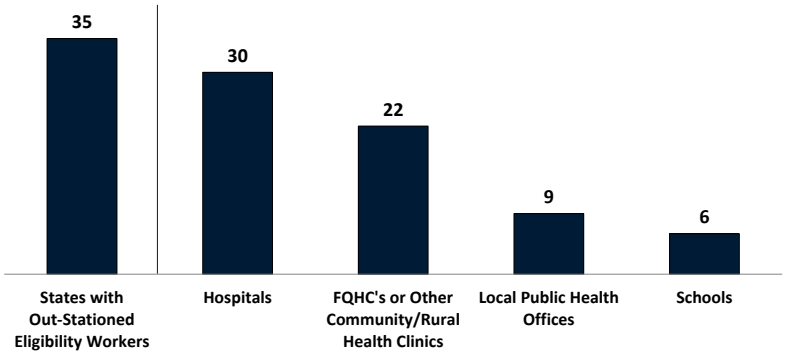
## Box 2: One-on-One Assistance through Community Health Centers in Utah


To increase enrollment in Medicaid and CHIP among uninsured low-income children, health centers in Utah launched a successful initiative in which enrollment specialists in clinics assist families through each step of the application and enrollment process. An evaluation of the program's pilot clinic found that 74 percent of children in families that were provided application assistance were successfully enrolled compared to 26 percent of children at a comparison clinic in which families were provided a Medicaid/CHIP application but no direct enrollment assistance. Children whose families received enrollment assistance also were subsequently more likely to utilize preventive care.

***Out-stationed state eligibility workers can provide enrollment assistance and preliminary eligibility determinations at hospitals, clinics, schools, and other locations within the community.*** As of January 2013, 35 states have out-stationed workers in hospitals, FQHC's, public health offices or schools (Figure 6).[83] These workers can make preliminary eligibility decisions for children and pregnant women and help families enroll in coverage, thereby increasing enrollment within the communities they serve.[84] For example, in Kansas, out-

Figure 6

**Locations of Out-Stationed State Medicaid/CHIP Eligibility Workers, January 2013**




SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

stationed state workers have increased enrollment by conducting outreach and enrollment assistance with the help of community partners.[85] Mississippi was also able to increase enrollment among American Indians after assigning out-stationed workers to a reservation.[86]

***Community-based organizations (CBOs) are able to provide culturally competent and trusted information and assistance at convenient times and locations.*** CBOs are able to provide trustworthy assistance, tailored messaging, flexible schedules, and proximity to eligible uninsured populations.[87] For certain populations, such as immigrant families, those with language or cultural differences, or those with negative past experiences with government agencies, CBOs and other local enrollment partners can serve as important trusted resources to help overcome fears and language barriers.[88, 89,90] For example, the involvement of trusted community leaders in outreach activities in familiar locations like churches and housing developments was a primary contributor to high take-up of public health insurance among low-income uninsured Latino families in Massachusetts.[91] Moreover, several states that achieved significant success in covering children identified strong relationships with trusted community partners and advocacy groups as important for broadening outreach, facilitating enrollment of families, and identifying opportunities for continued improvement.[92] Community-based assisters also can provide sustained contact with families to ensure they successfully obtain coverage, access needed health services, and maintain coverage over time.[93] Surveys have also noted that community-based assisters help reduce stigma, clarify income eligibility rules, and provide enrollment support.[94]

***Nearly half of states (23) fund community-based application assisters, who serve as a key enrollment avenue for eligible families.*** These programs provide funding to community partners to support enrollment assistance. For example, New York funds a network of multilingual facilitated enroller partners, which include managed care plans and CBOs, to help individuals enroll. Reflecting this broad network of community-based assistance, only 20 percent of new enrollees apply for coverage in a traditional Medicaid office.[95] Similarly, as of February 2010, California had over 20,000 Certified Application Assistants (CAAs), many of whom are multilingual and mirror the ethnic and racial composition of the communities they serve.[96] Statewide, applications submitted with the help of CAAs in California are over four times less likely to be incomplete (1.9% vs. 8.4%) than those submitted without assistance.[97,98,99]

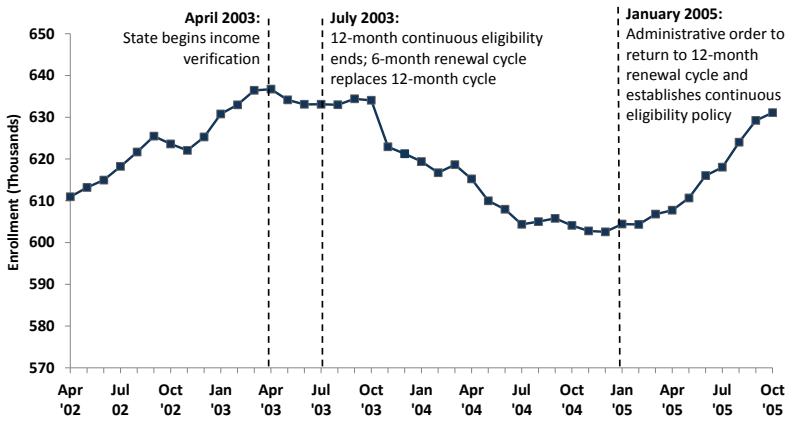
**5. Facilitating renewals of coverage is important for promoting stability of coverage over time.**

***Gaps in Medicaid and CHIP coverage due to coverage losses at renewal increase costs and have a negative impact on quality of care.*** One national study estimated that 42 percent of eligible but uninsured children had been enrolled in CHIP or Medicaid in the prior year but had lost coverage because of fluctuations in income or failure to renew coverage.[100] In addition, before implementing several renewal simplifications in 2011, South Carolina found that each year, about 140,000 children were losing coverage, with 90,000 returning within the year—60,000 of whom were returning within one month.[101] A study of California's Medi-Cal program also found that approximately 1 in 5 children disenrolled and subsequently reenrolled in the program during the three-year study period, often within a short time frame.[102] This churning onto and off of coverage increases costs; creates burdens for administrative staff, families, and providers; and has a negative impact on quality of care.[103] One 2005 study estimated that California spent over $120 million annually to reenroll children previously covered in Medicaid or CHIP.[104] Further, in 2002, Medicaid managed care organizations in Virginia and Rhode Island estimated that churning in coverage cost between $230,000 and $286,000 annually.[105] Evidence suggests that even brief periods without coverage have a negative impact on health.[106,107] Children with interrupted coverage are less likely than those who are continuously insured to seek preventive health services and are more likely to delay care or have an unmet medical care need.[108]

***Extending the length of time between renewals and providing continuous eligibility help families maintain stable coverage.***[109] For example, Washington experienced sharp declines in enrollment of children when it moved from a twelve to six-month renewal period; however, enrollment quickly rebounded when the state returned to a twelve-month renewal period and instated a continuous eligibility policy (Figure 7)[110,111] All but two states now use a 12-month renewal period for children in their Medicaid and CHIP programs, while six states still require parents to renew coverage every six months.[112] States also have the option to implement 12-month continuous eligibility for children's coverage, which guarantees coverage for enrolled individuals for 12 months, regardless of fluctuations in income. Continuous eligibility has been shown to improve retention in Medicaid and CHIP and reduce the administrative costs associated with reenrollment.[113] More than half (32) states use 12-month continuous eligibility for children in their Medicaid or CHIP programs.[114] The Centers for Medicare and Medicaid services recently released new guidance extending the option for states to implement 12-month continuous eligibility to parents and other adults through a waiver.[115]

Figure 7

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

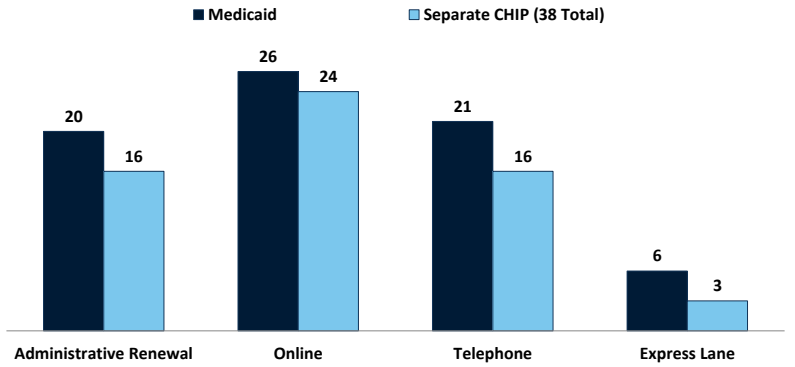



SOURCE: Washington State Department of Social and Health Services, 2005, updated 2006.

***Simplifications in renewal procedures, often through use of technology and electronic data matches, support increases in retention.*** States are increasingly providing new options for families to renew coverage, including by phone and online (Figure 8), as well as using electronic data matches to verify eligibility criteria at renewal.[116] For example, Louisiana implemented an administrative renewal process in 2005, which automatically renewed coverage for some families based on electronic data links to state databases. Following implementation of this policy, the proportion of children in CHIP who lost coverage at renewal due to procedural or administrative reasons fell from 17 percent to less than 1 percent.[117] Moreover, as of January 2013, three states have adopted the Express Lane Eligibility (ELE) option to use data from other state agencies to renew children's Medicaid or CHIP coverage. Following the implementation of ELE at renewal in South Carolina, the state renewed coverage for about 80,000 children in just nine months (Box 3).[118]

Figure 8

**Simplified Renewal Methods for Children in Medicaid and CHIP, January 2013**




NOTE: A state is classified as providing administrative renewal if it sends a pre-populated form or renewal letter to the family in advance of the renewal date and, if there have been no changes in circumstances the family is not required to take any action or, at most, must sign and return the form to continue coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

### Box 3: Simplifying Renewals through Express Lane Eligibility in South Carolina


In 2011, South Carolina initiated a data-driven decision making process to identify potential simplifications to its Medicaid enrollment process. Using data analysis, the state identified significant churn in its Medicaid program—each year, about 140,000 children were losing coverage, with 90,000 returning within the year, 60,000 of whom were returning within one month. This repeated movement into and out of coverage was creating burdens for families, administrative staff, and providers. Based on its analysis, the state determined that using eligibility information from other programs to conduct express lane renewals of Medicaid coverage would reduce churn. The state moved quickly to begin utilizing eligibility findings from its Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) program to conduct express lane renewals and renewed coverage for about 80,000 children in just nine months. The state estimated direct administrative cost savings of $1 million and 50,000 hours in staff time from implementing express lane eligibility at renewal.

***Coordinating transitions between Medicaid and CHIP helps maintain children's coverage.*** Approximately 2.4 million children transition between Medicaid and CHIP each year and are more likely to experience gaps in coverage as their eligibility transitions from one program to another.[119] There is widespread evidence suggesting that states can minimize coverage losses as families move between programs by coordinating program rules and renewals.[120] For example, an evaluation of CHIP programs in ten states found that Medicaid expansion programs and those with separate CHIP programs where coverage was coordinated with Medicaid were less likely to have children disenroll from coverage.[121] One study found that North Carolina, which coordinated renewals between Medicaid and CHIP and jointly reviewed eligibility for the two programs, had the highest Medicaid coverage rates and lowest uninsured rates among its CHIP disenrollees.[122] In Iowa, after an electronic referral process was implemented to transfer children from Medicaid to CHIP when family income increased, referrals between the programs increased more than threefold, and there was a reduction in the volume of paperwork for eligibility workers to process.[123]

## LOOKING AHEAD

**The ACA will significantly increase coverage options through an expansion in Medicaid and the creation of new health insurance exchange marketplaces in 2014.** These new coverage opportunities offer the potential to significantly reduce the number of uninsured. However, the Supreme Court ruling on the ACA effectively made the Medicaid expansion a state option, and, in states that do not expand Medicaid, poor adults will not gain a new coverage option and will likely remain uninsured.

**Regardless of state decisions to expand Medicaid, the ACA will establish new streamlined eligibility, enrollment, and renewal policies as of 2014.** For most non-disabled individuals, financial eligibility for Medicaid will be based solely on income, eliminating the need for applicants to provide documentation of assets. The ACA also establishes a streamlined, integrated, technology-driven enrollment process for Medicaid, CHIP, and exchange coverage. For example, states will be required to provide multiple options for families to enroll, including in person, by mail, by phone, and online. States also must attempt to verify eligibility criteria through electronic data matches with other data sources to the greatest extent possible, which will help minimize documentation burdens and barriers for families. In addition, states will be required to provide a 12-month renewal period for many Medicaid-eligible groups and must seek to renew coverage based on available information before requesting information from a family. Lastly, states must create coordinated eligibility and enrollment systems across the various coverage programs to facilitate transitions in coverage. Many of the new enrollment and renewal requirements under the ACA build on the

key lessons identified here as strategies to facilitate enrollment and improve retention in coverage, and experience suggests that these new requirements will help alleviate many historic barriers families faced to enrolling in and maintaining coverage.

**Even with new streamlined enrollment processes in place, a broad range of outreach and enrollment strategies, including targeted approaches for specific populations, will be important to reach and enroll eligible individuals.** The existing research and experience highlighted here points to the need for diverse outreach messages and strategies to help educate families about the availability of coverage and communicate their eligibility for different new coverage options. While broad-based messages through mass media will be important, targeted approaches will also be vital to help reach and enroll hard-to-reach groups such as individuals with limited English proficiency, individuals in immigrant families, and individuals living in rural areas. Past experience suggests that it will be important for states and the federal government to build partnerships and maximize the use of ethnic media, CBOs, and other trusted individuals, such as those in the faith-based community to reach out to uninsured families.

**One-on-one enrollment assistance provided by trusted individuals within the community will be key for translating the coverage expansions into increased coverage.** As demonstrated by past experience, ensuring adequate direct one-on-one assistance will be available through a diverse range of assisters who can provide culturally competent, trusted assistance in languages spoken by the individuals they serve will be a fundamental component of successful enrollment efforts. Moreover, a recent survey of low-income uninsured individuals found that nearly 8 in 10 (77%) say they would want in-person assistance to apply for Medicaid coverage in 2014.[124] The ACA establishes consumer assistance resources and requirements, including varied programs to provide in-person assistance.[125] However, resources to support this assistance will be varied across states. Moreover, coordinating outreach and enrollment efforts between assistance programs and across different coverage types will likely be challenging. These challenges will be amplified in states that do not expand Medicaid, where there will remain a coverage gap for poor adults. In these states, it will be important to determine how these adults and other individuals that remain ineligible for coverage, including undocumented immigrants, can be directed to safety-net resources for care if they attempt to apply for coverage.

In conclusion, Medicaid and CHIP are important coverage programs for millions of low-income Americans, and they have been important contributors to a reduction number of uninsured, particularly for children. State experiences with outreach and enrollment in Medicaid and CHIP indicate that families value the programs, but can face numerous barriers to enrollment. The ACA provides historic new coverage opportunities as well as new tools and policies to reduce barriers to enrollment. However, even with new simplified processes in place, outreach and assistance provided through trusted individuals within the community will remain important for reaching and enrolling eligible individuals, particularly among hard-to-reach groups. Major education and outreach efforts about new coverage options will begin in Summer 2013 in preparation for the October 1, 2013 open enrollment date for the new exchange marketplaces. However, it is important to recognize that enrollment into new coverage options will likely be a long-term effort. As such, it will be important for there to be adequate resources for outreach and enrollment over time to identify and utilize lessons learned as new enrollment efforts and experiences unfold.

**This issue brief was prepared by Jessica Stephens and Samantha Artiga of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.**

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