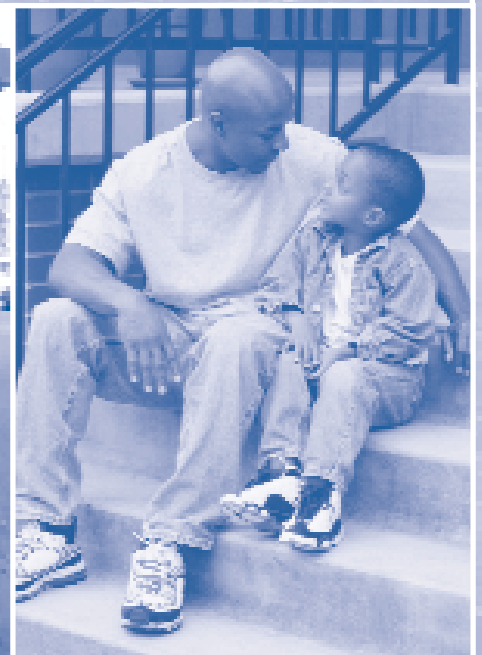


NEW YORK'S DISASTER RELIEF MEDICAID

Insights and Implications for Covering Low-Income People

August 2002



The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

The United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York.

NEW YORK'S DISASTER RELIEF MEDICAID:
*Insights and Implications for Covering Low-Income
People*

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August 2002

Kaiser Commission on Medicaid and the Uninsured
in Collaboration with the United Hospital Fund

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EXECUTIVE SUMMARY

The United Hospital Fund and the Kaiser Commission on Medicaid and the Uninsured sponsored a new study of New Yorkers who enrolled in Disaster Relief Medicaid (DRM), a temporary public health insurance program created after the September 11th attacks. In all, nearly 350,000 New Yorkers enrolled in DRM in a four-month time period to obtain Medicaid benefits. DRM was created in the wake of the terrorist attacks because damage to New York City Medicaid's computer systems made it difficult to process Medicaid applications.

DRM was a temporary program that used a vastly simplified, expedited application process. Higher income eligibility guidelines and new immigrant eligibility rules were implemented as part of DRM, making many more New Yorkers eligible for coverage. The income eligibility levels for DRM were higher than under traditional Medicaid because the Family Health Plus (FHP) guidelines were used. FHP is a Medicaid expansion for adults that was scheduled to be implemented in the fall of 2001, but was delayed in New York City as a result of the World Trade Center disaster. Income eligibility levels were increased from 87 percent of the federal poverty level (FPL) for parents and 50 percent for single adults/childless couples to 133 percent and 100 percent, respectively. FHP also has no asset test.

This study was commissioned to learn about New Yorkers' experiences with the program. Six focus groups were conducted with 55 New Yorkers May 30-June 4, 2002. A diverse group of DRM enrollees who applied in "high volume" areas and reflect the race, ethnic mix, and languages spoken among DRM enrollees participated in the focus groups. Study participants were drawn from three boroughs – the Bronx, Brooklyn, and Queens. Three focus groups were conducted with Hispanic participants in Spanish, two focus groups with Chinese participants in Cantonese, and one group with African Americans in English.

Key findings include:

DRM Enrollees: Diverse and Previously Lacked Access to Care

- ▶ **Participants have diverse employment backgrounds, including many who lost jobs as a result of the September 11th attacks and the poor economy afterwards.** Many participants in the study were unemployed, but for most this was a fairly recent development and not a chronic condition. While many participants came from service or blue-collar jobs, there were a number of individuals from white-collar backgrounds who were unfamiliar with government health programs.
- ▶ **Many focus group participants were recently uninsured, but a large number had been uninsured for a while before enrolling in DRM.** Some participants said they lost their health coverage recently when they lost their jobs.

However, a significant number had been uninsured for a while, and many had experience trying to obtain Medicaid in the past and had been turned down.

- ▶ **Prior to DRM, most focus group participants said they rarely received health services because they could not afford them.** Focus group participants were more similar in their experiences obtaining health services in the months prior to enrolling in DRM. Most said that before DRM, they did without health care services because they could not afford them and were uninsured.
- ▶ **Health status was mixed among participants. It appears that DRM attracted the chronically ill as well as those in good health.** In every focus group, participants in poor health or with chronic illnesses such as diabetes or high blood pressure were seated next to someone in good health who had no pressing need for medical care.

Positive Views about DRM

- ▶ **Focus group participants were overwhelmingly positive about DRM.** The majority praised the program and said they are thankful it was created. A recurring theme in the groups was that DRM gave enrolled New Yorkers peace of mind and a sense of security during an unsettled time because they now had health coverage.
- ▶ **Most participants learned about the program through friends and family.** They explained that there was a positive buzz about the program because it was “free health care that was quick and easy to get.” Most also knew that there were higher income eligibility levels with DRM, which meant more people could qualify.
- ▶ **Most participants said their motivation for enrolling in the program was simply to obtain health coverage.** They felt nervous without it and worried about becoming sick or incurring medical bills while uninsured. Knowing that enrolling in DRM was simple and that they could start using the coverage right away increased the appeal of the program.

Praise for the Enrollment Process

- ▶ **Most participants perceived that enrolling in “regular” Medicaid, [before DRM], is difficult.** They believe the Medicaid application and enrollment process is arduous, that they must provide a lot of paperwork, and that the income limits are low.
- ▶ **Participants had mostly positive views about DRM’s enrollment process.** They praised the short application form, the limited documentation requirements, the higher income levels, and the helpful eligibility workers. Chinese and Hispanic participants appreciated that they could find workers who spoke their language.

- ▶ **All participants appreciated that they could use their coverage so quickly after enrolling.** Some could see the doctor immediately after enrolling, while many had to wait only four or five days before using services.
- ▶ **One problematic area for some focus group participants was the long lines at some enrollment sites.** Many participants said they had to wait hours in line before applying for DRM. Some had to come back multiple days to the enrollment site before they could be seen. Some participants asserted that lines became longer in December and January as more people learned about the program.
- ▶ **A number of participants said the program was not explained to them when they enrolled.** Many did not receive a booklet of information about coverage, providers, or limits on the program. Many said they had to figure out for themselves which doctors would accept their coverage, and what medications and treatments were covered.

Enrollment Leads to Use of Primary and Preventive Services

- ▶ **Most participants said they used many different health services while enrolled in DRM.** They knew that DRM was a temporary program and they used it accordingly. Many said they had check-ups, saw specialists, had prescriptions filled, had dental visits, had their eyes examined, and some even had surgery. Most participants said these were services they needed and had been postponing or simply doing without before they enrolled in DRM – there was a pent-up need for medical care.
- ▶ **There was heavy use of preventive services, including overdue screenings.** Many participants said they took advantage of the program to have a check-up – for some, their first in many years. Some women in every focus group said they had a mammogram.
- ▶ **Some participants in every group found it difficult to find a doctor, dentist, or pharmacist to accept their DRM coverage.** They explained that they were turned down by a number of providers who said they did not accept DRM coverage.

Enrollees are Confused about DRM's Transition Process

- ▶ **The biggest challenge currently facing participants is what will happen when their DRM coverage ends, with most confused about the process for keeping health coverage.** Some participants believe they have already been approved for Medicaid since they received a white plastic Medicaid card in the mail. Others seem to understand that they must be interviewed first to determine if they qualify – but they are nervous about the interview and many are unfamiliar with the Family Health Plus program. A number of participants are also unclear about their insurance status – some believe they are uninsured now

because their four months of DRM have expired. Others continue to use their DRM coverage even though they have gone over their four months and have not yet heard from the program. Chinese participants complain that the transition letters mailed to their homes were in English, which most could not understand.

- ▶ **Some participants assume they will not qualify for coverage after DRM ends because their income is too high.** They perceive the income limits for "regular" Medicaid are low and that they will not qualify for any coverage once the temporary DRM ends. For these reasons, some participants may have less incentive to apply for "regular" Medicaid or Family Health Plus once DRM ends. They also do not seem to understand that the higher income limits of DRM will continue with Family Health Plus.

Policy Implications

It is tempting to look at DRM and conclude that it was a distinct program created in response to a unique situation facing New York, and therefore not particularly relevant to other Medicaid programs around the country. In many regards, this is true. The September 11th attacks may have made New Yorkers more concerned about their health, more stressed about the future, and more vulnerable to losing their jobs and health insurance coverage – all of which made them more likely to enroll in DRM. The “buzz” and positive word-of-mouth about DRM may also have been the result of increased concern New Yorkers were feeling about each other, and the networking to obtain services that followed the attacks. However, there are also aspects of DRM that may not be so unique, and which may have relevance to Medicaid programs across the country. These tended to be process and rule changes that attracted New Yorkers to the program in the first place and which allowed so many to qualify and created such a positive buzz about the program. Specifically, these include:

- ▶ **Higher income eligibility levels and no asset test made a difference.** Despite being low-income, a number of focus group participants have been denied Medicaid before because their income was too high, especially for childless adults. By applying FHP’s higher income standards and excluding assets from consideration, DRM enabled more uninsured New Yorkers to obtain health coverage. In addition, word-of-mouth about these higher income eligibility levels encouraged applicants to apply, including those denied "regular" Medicaid for income reasons before.
- ▶ **An easier enrollment process paved the way.** Since most participants in this study have a negative image of the "regular" Medicaid enrollment process (much of it based on firsthand experience), they were pleasantly surprised with the speed and ease of the DRM process – and passed the word among their friends. Important features of this process include: short application forms, minimal documentation requirements, brief interviews with helpful enrollment workers, and the ability to use health services right away.
- ▶ **Enrollees benefited from assistance completing applications and the in-**

language forms and workers. There were virtually no complaints about language barriers among Chinese and Hispanic enrollees when applying for DRM – most said they could access forms and interact with workers in their own language. Likewise, another key element for successful enrollment in DRM, according to participants, was the helpful workers who often completed the forms for the applicant.

- ▶ **Creating a positive word-of-mouth was key.** While the September 11th attacks played a role in New Yorkers' willingness to consider enrolling in DRM, the higher income levels and easy enrollment process played an important role. This is a valuable insight for states that have also raised income levels of their Medicaid, State Child Health Insurance Program, and other programs and streamlined their enrollment processes. It is likely that the public is unaware of these changes, and that old and negative images of Medicaid enrollment still deter people from applying. These findings suggest that it may be possible for states to create their own positive buzz about the enrollment improvements they have made.

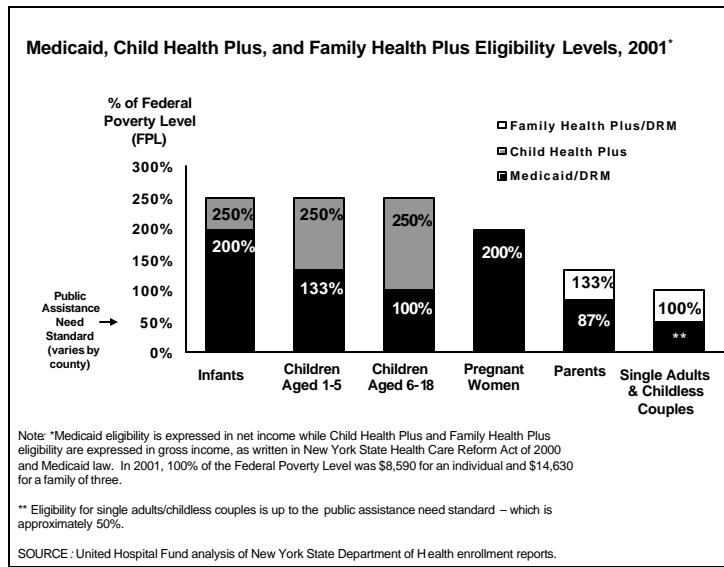
INTRODUCTION

The United Hospital Fund and the Kaiser Commission on Medicaid and the Uninsured sponsored this focus group study of New Yorkers who enrolled in Disaster Relief Medicaid (DRM), a temporary public health insurance program established in the days following the September 11th attacks. The purpose of the focus groups was to learn about New Yorkers' experiences while enrolled in the program, and their opinions about key features of the program, such as the streamlined enrollment process and the transition period during which enrollees can apply for regular Medicaid or Family Health Plus.

Much attention has been focused on DRM because of the large number of New Yorkers who enrolled in it – nearly 350,000 in four months. By all accounts, this enrollment rate is unprecedented, greatly exceeding the typical rate of enrollment in the regular Medicaid program during the same length of time. Not only did the program draw large numbers, but it also attracted individuals who had never applied for a public health program before as well as many immigrants. These outcomes have invited speculation about how much the heightened sense of need and vulnerability in New York caused by the September 11th attacks accounts for the extraordinary enrollment, and how much of the program's success has to do with its design. This report lends some insight into this central question by exploring how New Yorkers became aware of the program, their understanding of why it was created, and their motivations for enrolling in it.

About DRM

DRM was created in the wake of the September 11th terrorist attacks because damage to New York City Medicaid's computer systems made it difficult to process Medicaid applications. DRM was a temporary program that used a vastly simplified, expedited application process. Higher income eligibility guidelines and new immigrant eligibility rules were implemented as part of DRM, making many more New Yorkers eligible for coverage. The income eligibility levels for DRM were higher than under traditional Medicaid because the Family Health Plus (FHP) guidelines were used. FHP is a Medicaid expansion for adults that was scheduled to be implemented in the fall of 2001, but was delayed in New York City as a result of the World Trade Center disaster. Income eligibility levels were increased from 87% of the federal poverty level (FPL) for parents and 50% for single adults/childless couples to 133% and 100%, respectively (see chart on next page). FHP also has no asset test. The New York State Department of Health estimated that 600,000 people would be eligible for FHP statewide when fully implemented. In addition, the *Aliessa v. Novello* court decision, which stated that legal immigrants are eligible for Medicaid regardless of their date of entry to the US, was implemented as part of the DRM program. New York State later applied this ruling to FHP administratively. Previously, with some limited exceptions, only legal immigrants who had been in the U.S. before August 22, 1996 were eligible for Medicaid.



Word of this new coverage opportunity spread rapidly across New York City. UHF led a coalition of organizations that worked to “get the word out” about DRM. These groups trained more than 1,400 New York City community-based organizations and health care providers about DRM rules and procedures. In addition, a UHF-sponsored advertising campaign and a toll-free phone line helped inform people about the program.

Enrollment Process

New York City residents could apply for DRM at any of the 22 community Medicaid offices and receive same-day authorization. In many cases, because of long lines, applicants were asked to return another day to apply. Starting in late November 2001, Medicaid offices began referring excess volume from its offices to selected community-based facilitated enrollment organizations and health plans. The Human Resources Administration (HRA) designated 25 organizations throughout New York City to be DRM client representatives. These organizations provided enrollment assistance to DRM applicants and submitted DRM applications to HRA on their behalf. Applications submitted by client representatives were brought to HRA in bulk, usually once per week. Because of this multiple-step process, persons who applied through a client representative received their DRM authorization anywhere from two to seven days after applying. Focus group participants were among those who applied through the client representative process.

Transitioning from DRM to Regular Coverage

DRM enrollees received four months of coverage. When the four months ended, a transition period began. Depending upon when the four months of DRM ended, enrollees have received one to three letters from HRA explaining this process. The first letter notified DRM enrollees that their coverage would be extended for another four to seven months. In the second letter, they received a plastic Medicaid card (or, if they had Medicaid within the last six years, they were told to use their old Medicaid card) so that they could use services during the transition period. Finally, the third letter had an interview appointment at HRA so that DRM enrollees can apply for coverage through

Medicaid or Family Health Plus. The client representative process continued during the transition period so that enrollees would have the opportunity to apply for coverage with a health plan or community-based enroller. However, those who apply through the client representative process must do so one month before their scheduled appointment with HRA.

Research Methodology

To learn about the experiences of the diverse New Yorkers enrolled in DRM, Lake, Snell, Perry & Associates conducted six focus groups with enrollees between May 30-June 4, 2002. The focus groups drew participants from three boroughs of New York (the Bronx, Brooklyn, and Queens) with high enrollment to ensure we learned about the different enrollment experiences. In addition, groups were held with African American, Chinese, and Hispanic adults to gain insight into how race, ethnicity, culture, and language affected their experiences with DRM. Focus groups were conducted in Cantonese, English, and Spanish.

All participants had to be DRM enrollees to be recruited for the focus groups. They were told about this study – i.e., that we wanted to learn about their experiences in DRM but that participation in this study had no bearing on their enrollment status – and they were paid for their time. A profile of focus group participants is as follows.

Participant Profile

Total Participants	55	<u>Gender</u>	
		Female	73%
		Male	27%
<u>Race/Ethnicity</u>		<u>Marital Status</u>	
African American	16%	Single	18%
Chinese	31%	Married	54%
Hispanic	51%	Separated/Divorced	25%
Filipino ¹	2%	Domestic Partner	2%
<u>Annual Household Income</u>		<u>Ways They Heard About DRM²</u>	
Less than \$10,000	54%	Family and Friends	87%
\$10,000-\$14,999	11%	Radio/TV	9%
\$15,000-\$19,999	16%	Newspaper	4%
\$20,000-\$29,999	11%	Nurses/Doctors	9%
No Answer	7%	ER/Hospital/Clinic	9%
<u>Age</u>		Social Worker	4%
20-29	16%	Community Organization	5%
30-39	25%	<u>Young Children</u>	
40-49	20%	Have Children Under 18 In House	58%
50-59	29%		
60-64	9%	<u>Length of Time in US</u>	
		(asked only of Chinese and Hispanic Participants)	
<u>Prior Medicaid Experience</u>		Less than 2 Years	7%
Enrolled in Medicaid Before	45%	2-5 Years	5%
Not Enrolled Before	55%	6-10 Years	14%
		More than 10 Years	47%
		Born in US	7%
		No Answer	18%
<u>Borough</u>		<u>Language</u>	
Bronx	18%	Cantonese	31%
Brooklyn	49%	English	18%
Queens	33%	Spanish	51%

¹ The one Filipino respondent participated in the African American focus group in Brooklyn.

² Percentages add up to more than 100% because multiple responses were allowed.

FINDINGS

I. DRM Enrollees and Their Impressions of the Program

If the focus groups' participants are a window into the kinds of New Yorkers who enrolled in DRM, then they are a diverse group of individuals with varied backgrounds and experiences. Participants in this study were hard to categorize and may broaden conventional wisdom about who benefits from public health programs. The slogan, “If you build it right, they will come,” could be an apt slogan for DRM since a variety of New Yorkers were drawn to the program.

The one thing that most participants had in common, however, was that before DRM they were uninsured and struggling to access health services. Most were going without care, or postponing it until they could afford it. For these reasons, enrolling in DRM gave many participants peace of mind and a sense of security that they could obtain medical care if they needed it. Indeed, participants said the best aspect of DRM was being able to use health services.

While virtually all participants said they applied for DRM because they wanted health care coverage, the positive “buzz” surrounding the program soon after it was created was what really motivated them to apply. Most participants explained that word-of-mouth about DRM made the program sound appealing – that it was “free” and “quick and easy” to get. Following is a brief look at the types of individuals who enrolled in DRM and their motivations for applying.

a. DRM Enrollees: Diverse and Previously Lacked Access to Health Care

Participants have diverse employment backgrounds, including many who lost jobs as a result of the September 11th attacks and the poor economy afterwards.

Many participants in the study were unemployed, but for most this was a fairly recent development and not an ongoing condition. In every focus group, a number of participants indicated they lost their jobs because of the September 11th attacks and the poor economy that followed. While many participants came from service or blue-collar jobs, there were a number of individuals from white-collar backgrounds who were unfamiliar with government health programs. Participants in the focus groups worked in restaurants, garment factories, an airline company, grocery store, home health care, hotel housekeeping, construction, retail sales, community centers, liquor store, house painting, and also included college students. What this eclectic group of individuals had in common, however, was that they wanted affordable health coverage.

“I used to be in a garment factory before 9/11. And then I lost my job after 9/11. So now I am unemployed.”

Chinese man from Brooklyn

Many were recently uninsured, but a large number had been uninsured for a while before enrolling in DRM. Many also had been denied Medicaid coverage

previously. Nonetheless, the overwhelming majority of participants say that health coverage is integral to their sense of security and peace of mind.

Some participants said they lost their health coverage recently when they lost their jobs. However, a significant number had been uninsured for a while, and many had experience trying to obtain Medicaid in the past and had been turned down. “They denied it [before] because, I don't know, I was earning too much at that time. I was taking a chance [applying for DRM],” said a Hispanic woman from Brooklyn. This experience of being denied Medicaid played an important role in the focus group discussions and hearing how DRM differed from regular Medicaid seems to have influenced many of these individuals to apply for DRM. Another important factor in the focus groups is the degree to which participants placed value on having health insurance coverage. To the overwhelming majority of focus group participants, having health coverage appeared to be vital to their sense of security and peace of mind.

Prior to DRM, most said they rarely received health services because they could not afford them.

Focus group participants were more similar in their experiences obtaining health services in the months prior to enrolling in DRM. Most said that before DRM, they did without health care services because they could not afford them and were uninsured. “I was seeing a doctor [but] once I become unemployed, I couldn't pay for the doctor. But, I also didn't have the money to buy the medicine or to get the tests that I needed to have,” explained an African American woman from Brooklyn. Some participants revealed that they had chronic health conditions – for example, diabetes and high blood pressure – and were unable to receive consistent care prior to DRM or afford to see their providers regularly. Those needing prescription medications regularly implied that before DRM they did without their medications some months due to cost. Finally, many participants indicated they had not received preventive care services for many years – if ever – because of cost. Indeed, for some women in the focus groups, the mammograms they received while enrolled in DRM were their first, despite being well into the age range when regular mammograms are advised.

“Every time I went to the hospital, it was because of a big emergency. I never had money to pay for it. I was motivated [to apply for DRM] because I wanted to get a check-up because I had never had one my whole life.”

Hispanic woman from the Bronx

Health status was mixed among participants. It appears that DRM attracted the chronically ill as well as those in good health.

In every focus group, participants in poor health or with chronic illnesses such as diabetes or high blood pressure were seated next to someone in good health who had no pressing need for medical care. DRM seemed to attract both kinds of enrollees, and most of those in good health said they enrolled in order to receive a check-up, dental care, or vision care rather than to treat an ongoing medical condition. On the other hand, the chronically ill invariably said they enrolled in order to receive specific treatments and medical care that they obtained only sporadically, and when they could afford it, before DRM.

The high cost of health care [outside of the DRM program] was an ongoing theme in the focus groups, and affects participants' access to care in multiple ways.

Participants in every focus group said that in a variety of ways, the high cost of health care services, insurance coverage, and prescription medications have made it difficult for them in the past to receive the care that they want and need. Generally, the effect has been to make participants use health services only when very sick or when they have saved enough money. A Chinese man from Queens made this point when he said, “It’s very expensive to go to the doctor in the U.S. It’s at least \$100 each time for an exam. So if you have health insurance you don’t need to worry.” It is because of cost that focus group participants appreciate DRM so much.

Chinese and Hispanic participants appear to rely heavily on their communities for information. Newer immigrants face more challenges.

While UHF data suggest that a number of newer immigrants enrolled in DRM, they were not fully represented in the focus group discussions.³ Rather, most Chinese and Hispanic participants had been in the country many years and were fairly savvy about health care and Medicaid. However, the few newer immigrants present did seem much more confused by DRM and faced more communication problems. “I’m a new immigrant so I don’t know these things and after 9/11, I applied [for DRM], because in the past I didn’t even know how to go about it,” said a Chinese man from Queens. Both newer and more established immigrants seemed to rely heavily on their respective communities for information and assistance regarding DRM and health coverage in general. The garment industry was also a key source of information for Chinese focus group participants. Hispanic participants, on the other hand, were more likely to mention Spanish-language newspapers and radio stations as a source of information.

Childless adults were represented in the focus groups and underscored the importance of health coverage for them as well as children and seniors.

A number of participants in the focus groups were parents with young children, and every now and again they discussed their children’s health care needs. However, the groups were perhaps more striking in how many adults with no children – or with grown children – participated, and the emphasis that they placed on their own need for health coverage. The large number of childless adults enrolled in DRM may set the program apart from “regular” Medicaid, in which young parents with children, or individuals over 65, make up the bulk of enrollees. The higher income limits of DRM partially accounts for the many childless adults who enrolled – i.e., now they could qualify whereas before they could not because their income was too high (income eligibility under DRM and FHP is \$8,592 for an individual, up from \$4,225 under regular Medicaid in 2001). Insights from the focus groups underscore that these adults also value coverage for themselves as well as for children and appreciate that they could qualify for DRM.

³ A UHF DRM Enrollee Survey found that three-quarters of DRM enrollees spoke a language other than English, perhaps suggesting that many were new immigrants. (United Hospital Fund, December 2001)

b. Favorable Views of DRM

Focus group participants said they appreciate DRM. A few thought it sounded too good to be true.

Participants in every focus group said they were grateful DRM was created. “It’s incredibly helpful. They cannot imagine the help they have provided,” said a Hispanic woman from the Bronx. Indeed, some participants seemed to believe that DRM was created with their personal situation in mind. “I think they have thought about us – about our situation. They are focusing on people’s health,” explained another Hispanic woman from the Bronx.

“Even if it’s temporary, I feel better. I feel more relaxed.”

Some participants could not believe that such a program could exist. A Hispanic woman from Queens, explained, “It was a gift from God because it had never been so easy. Everything was very easy.” A Hispanic man from that same focus group added, “I could hardly believe it because I have asked for help and have been denied.”

Chinese woman from Brooklyn

To a few, the program seemed too good to be true. A Hispanic woman from Queens said, “At the beginning I had some doubts because if they said they were offering Medicaid without any problems and it was free, one begins to doubt.” A Chinese woman from Brooklyn said, “When I saw it in the newspaper, I thought it was just an ad. I don’t believe it because you can’t trust newspapers. So if someone tells you, then you know it’s real. I was very suspicious because [with] Medicaid, we don’t meet the conditions [to qualify].” Part of the wariness of DRM had to do with its higher income limits – now people who had never qualified for Medicaid before were suddenly eligible for DRM.

Having DRM gave many participants “peace of mind,” “less stress,” and more “security.”

A number of participants said that having DRM gave them peace of mind because now they had health insurance coverage. “It just eased the stress because you know if something happens, you can go somewhere and get care. It was just a good thing,” explained an African American woman from Brooklyn. A Chinese woman from Brooklyn said, “After I got it, I had [fewer] stomachaches because I’m not tense and I was more relaxed, so I have less stomach trouble.”

The most tangible benefit of DRM, according to participants, was being able to use health services.

Affording health services was a challenge for most participants prior to receiving DRM. Because of this, most participants appreciate that they can now go to a doctor or dentist, or fill a prescription when they need to rather than just when they can afford it. “I felt happy because I am getting treatment [even though] my husband stopped working after the disaster. They closed the company he was working with. It helps me a lot,” explained a Hispanic woman from Brooklyn.

Because they were uninsured before enrolling in DRM, many participants explained that

DRM now enabled them to receive health services that they would have postponed before. “I could not go to the doctor because I did not have the means – [it costs] \$250 for a consultation, a specialist. I did not have money for a specialist,” said a Hispanic woman from Queens. A Hispanic man, also from Queens, added, “It was a big help for my wife and I. We were both sick and we did not have money. The little we had was spent on food and rent. Once this Medicaid came along, well, it has helped us a lot with our illnesses.”

Most believe DRM was created to help New Yorkers who lost jobs after 9/11.

Most participants suppose that DRM was created to help those who lost jobs because of the terrorist attacks of September 11th and the downturn in the economy that followed. “It was a result of the Twin Towers attack and all the unemployment it caused,” said a Hispanic man from Queens. A Chinese man from Brooklyn explained, “Because people had economic pressure after 9/11, so the government wanted to help.” Another Hispanic man from the same focus group commented, “They told me Bush was helping everybody from the disaster so they could get better and go to the doctor. It was about illnesses as a consequence from that and that is why he was giving Medicaid.”

“So many people got laid off. So many people died. That was the reason I got it, because I was laid off.”

Hispanic woman from Brooklyn

Many also believe that the poor air quality after the World Trade Center attacks led to DRM.

In every focus group, about half of the participants mentioned the poor air quality after the World Trade Center collapsed as a reason DRM was created. Specifically, they mentioned the chemicals in the air after the towers collapsed and the possible negative effect this had on New Yorkers’ health. “Because the pollution was so bad and people were sick... so they wanted to help them,” said a Chinese woman from Brooklyn. An African American man from Brooklyn said DRM was created because of “chemicals and all type of, you know, stuff all in the air.” A Hispanic woman from the Bronx said, “I have the understanding that since there were many deaths from the disasters and the environment is full of viruses and all those things, the government of the United States wants to prevent serious illnesses, possibly cancer and deaths, chronic diseases.”

c. A Positive "Buzz" about DRM

Friends and family were the main source of information about DRM.

Almost all of the focus group participants cited friends and family as the primary way they heard about DRM. They explained that there was a “buzz” around the program – similar to the word-of-mouth that often accompanies a popular movie – where friends would tell other friends about it. For example, when asked about the program, a Chinese man from Queens explained, “Because this [program] was very hot... It was very popular. This was important because it involves my health.” An African American woman from Brooklyn commented, “My cousin got it and then she told me about it.” A Hispanic woman from Queens said, “Because I work at a store, a lot of people came in and they commented about it.” When asked how she learned about DRM, a Hispanic woman from the Bronx replied, “Through friends and neighbors. I received an important

“You know when people get together, we began talking about the good and bad things that are happening. The issue of Medicaid for people without work came up.”

Hispanic woman from Brooklyn

phone call, 'Go apply, they'll give you temporary Medicaid.' That was my sister. I don't know how she found out."

Some Chinese participants mentioned the garment district as a source of information about DRM. "The garment factories get their information very quick. I was told by them because garment factory [workers] are very nervous about [losing insurance coverage]," said a Chinese man from Brooklyn. A Chinese woman from Queens told a similar story: "The garment factory had insurance and on 9/11, we were still working. Then slowly, afterwards, work was much more scarce... My colleagues at the garment factory applied, many of them. We all went together to apply."

In addition to word-of-mouth, about three or four participants in every focus group said they had seen an ad about DRM, or a friend of theirs had seen the ad and told them about it. A Hispanic woman from Queens said, "I found out through the newspaper and the radio – *El Diario* and 93.5." Later in that focus group, participants were uncertain whether it was *El Diario* or *El Especialito* in which the ad appeared. An African American man from Brooklyn commented that he saw an ad for DRM in *The New York Times*. Other focus group participants recall seeing posters in doctors' offices and elsewhere. A Chinese woman from Queens said, "They have a poster that says, 'This is your benefit, why don't you go?'"

Finally, a few focus group participants explained that when they tried to apply for regular Medicaid, they were told about DRM and encouraged to apply. An African American woman from Brooklyn said, "I went to apply for Medicaid again and they gave me an application for the Disaster Relief."

DRM was described as free health coverage that was easy to get and that anyone could qualify.

When asked how DRM was described by friends and family, most say they were told that the program was free and that it was quick and easy to get. A Hispanic man from Queens said, "They said, 'Look, my aunt went to Medicaid and you can go tomorrow to apply. They give it to you fast at the hospitals.'" An African American woman from Brooklyn said, "I heard everybody was eligible." A Hispanic woman from Queens said, "The notice [said] that they were going to give Medicaid without any problems because there [usually] are certain rules to get Medicaid." A Chinese man from Queens heard that they were not checking into people's backgrounds when they applied, "It's not necessary. This is an emergency. They don't check you." A Hispanic woman from the Bronx said she heard, "After the disaster, all legal residents could apply for temporary Medicaid."

"It's not necessary. This is an emergency. They don't check you. After the disaster, all legal residents could apply for temporary Medicaid."

Hispanic woman from the Bronx

Most knew that DRM was temporary.

Most participants said they knew that DRM was a temporary program, although some hoped it would last longer. "I thought it was going to be longer than four months. But, once I got there, they told me it was temporary. It was four months. Four months is better

than no months,” said an African American man from Brooklyn.

Many said they lacked information about covered services and participating providers before applying and even while enrolled in the program.

While most participants seemed to know the general parameters of the program – i.e. that it was temporary, that it was free care, that it allowed a higher income than regular Medicaid, etc. – many lacked knowledge about the particulars of the program. Many said they did not know what services were covered, what limitations there were on coverage, or which providers would accept DRM coverage. A Hispanic woman from Queens said, “There was the uncertainty of what it was and wasn’t going to cover.” When asked if she would have like to received booklet of information about the program when she enrolled, an African American woman from Brooklyn said, “Yeah, because I’m not familiar with it. A lot of people have never had it before, Medicaid at all.”

II. The Process of Applying for DRM

Most focus group participants applied for DRM because they wanted health services they could not afford without the program. Those with chronic health conditions enrolled to receive specific health services related to their illness. Others applied for DRM mainly to obtain prescription drug coverage or dental care, and to a lesser degree, vision care. Of note, many enrolled to get preventive care services like check-ups, lab tests, and mammograms. Others said they applied because they perceived that enrolling in DRM might better their chances of qualifying for regular Medicaid.

When asked about their experiences applying for DRM, most praised the process and said it was quick and easy. They liked the one-page application, the limited documentation requirements, the help they received completing the forms, and that they could use services right away. Hardly any participants complained of language barriers when applying. The one problematic area, however, was the long lines at some enrollment sites. Some participants report that they waited hours in line or had to come back numerous days before they could apply.

Applying for DRM looks even more positive when compared to the enrollment process for regular Medicaid, according to many participants in the groups. Many have firsthand experience applying for regular Medicaid, and they describe this process as humiliating, difficult, takes too long, and intrusive. More details about these and other findings follow.

a. Reason for Applying: To Obtain Needed Health Services

Those with chronic health conditions enrolled for specific health services.

A number of participants said they had chronic health conditions or were in poor health, which is why they needed health coverage. “My health is not very good, so I needed this,” said a Chinese woman from Brooklyn. An African American woman from Brooklyn said, “I needed some type of medical coverage. I was unemployed and still am right now and I had an ulcer problem years ago and it flares up every now and then. I

needed some type of coverage where I could go to the hospital and be seen and took care of and because, you know, you have to have medication with that.” A Hispanic woman from the Bronx said she suffered from depression that she wanted to treat with DRM coverage.

For some, being able to get free prescription medications was an incentive to apply for DRM.

Many said they had ongoing prescription drug costs and perceived the program as a way to relieve some of the cost pressure. “My problem is that I know I’m on a pressure medicine, so this medication has to be picked up once a month and it’s very expensive,” explained an African American woman from Brooklyn when discussing why she enrolled in DRM. A Chinese woman from Brooklyn said, “After this card, I save \$200 a month for doctors and for medicine.”

“I previously applied for Medicaid and I was denied. This was a way to try once again to see if I would be accepted. When I tried, they accepted me right away. It helped me a lot.”

Obtaining preventive health services was also a motivator for a number of participants to enroll in DRM.

Many of the focus group participants report that they have not seen a health care provider or had a check-up in many years. The reason they often give is high cost – they could not afford a preventive visit to the doctor or dentist prior to receiving DRM. “I was motivated because it had been four or more years since I had gone to a doctor... because I don’t have insurance and you have to pay a lot of money. So, if I obtained [DRM] I would automatically do everything,” said a Hispanic woman from Queens. A Chinese woman from Brooklyn, in speaking about her husband who is also enrolled, said, “Before we had it, he didn’t go for a health check-up. But once [he] got it, I told him to go.” Women in many of the focus groups shared that they received mammograms while enrolled in DRM and said that this preventive health service was important to them.

Hispanic woman from Brooklyn

Dental care was a reason why some say they applied for DRM. To a lesser degree, vision care also was an attraction.

In every focus group, many participants said one of the reasons they enrolled in DRM was to see a dentist. “I need to go to the dentist all the time. If I can get this Medicaid again, I can go to the dentist because I really want to go,” explained an African American woman. A Hispanic woman from the Bronx said the vision coverage was the reason she applied for DRM. “I lost my glasses. The glasses I use are very expensive. I applied to get the glasses.”

For many, DRM was perceived as their best chance of obtaining Medicaid.

Many of the focus group participants had prior experience applying for Medicaid and being denied. In most cases, participants said their incomes were too high to qualify. However, when they learned about DRM, most saw it as their chance to finally qualify for Medicaid. “If I apply for it without there being an emergency, they won’t give it to me because of my husband’s income,” explained a Hispanic woman from Queens. A

Chinese man from Brooklyn said, “I couldn’t get any health insurance from the government. So after 9/11, we applied when our friends told us that we can apply.” As mentioned earlier, many participants perceived that eligibility rules, particularly those regarding income, were higher for DRM than regular Medicaid, which encouraged previously declined New Yorkers to try again and apply for DRM. In fact, DRM’s income levels were higher because the FHP eligibility levels were applied.

Some perceive that enrolling in DRM would better their chances of qualifying for regular Medicaid.

These participants believe that qualifying for DRM would help them qualify for Medicaid or another health program once DRM concludes. As an African American from Brooklyn said, “Well, I’m thinking that being that I was accepted for the temporary one, that I’ve bettered my chances that I’ll still be able to receive it again.”

b. Praise for the Enrollment Process

Most participants gave high marks to the DRM enrollment process.

Even though a number of focus group participants experienced long lines at enrollment locations, overall most praised the DRM enrollment process. “Everything was easy,” asserted a Hispanic woman from Queens. A Chinese woman from Brooklyn commented, “It was very easy, very convenient.” A Hispanic woman from Brooklyn commented, “I think it was easy.” Another Hispanic woman from the same group described the enrollment process as “efficient.” Those who had applied for regular Medicaid before were particularly enthusiastic about the DRM enrollment process. “It’s a lot easier to get it this time than it was before,” commented an African American woman from Brooklyn.

“Once they see you, it’s easy. It was quick. Once it got to be your turn, you just went there and they give it to you.”

Chinese man from Queens

Participants had mixed experiences, however, in terms of long lines at enrollment locations.

While some participants told of long waits at enrollment sites, even overnight in some cases, other participants said their waits were brief. Chinese participants, in particular, mention long waits to enroll in DRM. “It was difficult because I had to go three times, three mornings, three days. The first time [I had number] two hundred and something, so I couldn’t get it that day. So I came back the next day and the same thing happened. [I got it] the third time,” said a Chinese man from Queens. A Chinese woman from Brooklyn said, “I went to the Pacific Avenue [site], but they said, ‘No, we’re out of it. You have to go to Eastern Parkway, a long way off.’ So I went there, but it was very busy. A lot of people were there. It was a little late already, so the people had been standing in line very early.” An African American woman from Brooklyn commented, “It was very crowded. They kept sending people out. It was so crowded. That was why we went to another [enrollment] place.”

“I had to stand in line a long time, several hours, like half a day I stood in line.”

Chinese woman from Queens

There were, however, almost as many stories from participants about how quickly they were able to apply for DRM. “I went in November. I only waited 30 minutes,” explained

an African American woman from Brooklyn. A Chinese man from Brooklyn said, “I went in the morning, but very quickly, maybe an hour. I filled the form and waited an hour.” A Hispanic woman from Brooklyn said, “They had me sit down in a chair. There were only two more people [ahead of me]. After my turn, people started coming in little by little.”

Some focus group participants theorized that the lines grew longer as New Yorkers learned about the program through word-of-mouth, and that lines peaked in December and January. “I’m thinking because more people found out about it,” said an African American woman from Brooklyn. A Hispanic woman from Brooklyn said, “[I waited] two and a half hours. There were too many people when I went... in December or January.”

Outside of long waits for some, most participants found much to praise about the DRM enrollment process – the brief application form, the minimal documentation requirements, and the helpful enrollment workers.

Virtually all participants praised the DRM application form. They appreciated that it was so brief: “It was a few pages,” said an African American woman from Brooklyn. A Hispanic man from Brooklyn described the application form as “very easy” to complete. Focus group participants said the form was easy to understand – indeed, most said that their enrollment worker actually filled out the form and simply asked them the questions.

“The people who had previously applied for it said the information they were asking for was not as much, it was not like the book you have to fill out for the regular Medicaid.”

Likewise, most focus group participants applauded the limited documentation requirements of DRM. In many cases, participants only showed a picture ID. “Only the ID,” said a Hispanic woman from Brooklyn. As a Hispanic woman from the Bronx said, “Two simple questions. Name and social security... This is so easy I arrived at the office at 1:00 and left at 1:30. I had the paper in my hand.”

Hispanic woman from the Bronx

Enrollment workers helping participants to apply for the program also were commended. Regardless of enrollment location, most participants characterized the workers as “helpful” and “nice.” “They were very nice, very nice. They really were out to help. They were very good,” said a Chinese woman from Brooklyn. A Hispanic woman from Queens said her enrollment worker “helped me fill out the application.” A Hispanic woman from Brooklyn said the following about her enrollment worker: “They helped us immediately. They were very nice. They treated us in the best manner. It did not take long.”

Most participants say they had to wait four or five days before they could start using health services, which they consider to be fast turnaround.

Based on comments by focus group participants, the typical wait to receive their DRM “paper” authorizing them to use health services was about four or five days. Most participants found this timeline to be quick and they were thankful they could obtain medical care so soon. “After the interview, I waited a while and then they told me to come back in a couple of days and they were going to give me the results. That’s it,” said

a Hispanic woman from Queens. Indeed, a number of participants say they received their DRM authorization the same day they applied. “I got it right away. Right away they tell me I can go to the doctor tomorrow or whatever,” explained an African American woman from Brooklyn. A few participants said that it took a little longer for them to receive their authorization – some said ten days while a few said it took two weeks. Those with prior Medicaid experience seem particularly impressed by the quick turnaround for DRM authorization. As an African American woman from Brooklyn said, “You have to wait much longer for regular [Medicaid]. For regular, you’ve got to wait 30 days. This, you waited three to five days.”

Both Hispanic and Chinese focus group participants said they did not encounter language barriers during enrollment.

No Hispanic focus group participants complained about communication problems when applying for DRM. When asked if the application was in Spanish they could understand, they replied “yes” and said they were given the choice of completing it in either Spanish or English. Also, some participants mentioned that their enrollment worker spoke Spanish too. “The man knew how to speak Spanish,” commented a Hispanic woman from Brooklyn.

Most Chinese participants also say they did not encounter language problems during enrollment. Many purposely went to enrollment locations where they knew there would be a worker who could speak Cantonese or Mandarin. They mentioned enrollment sites at 34th Street, the Chinese Community Center, and the Chinese Equality Organization as locations where they could find workers who spoke their language, or at least translators to help them complete the application. Indeed, in most cases, Chinese participants said their worker completed the application for them.

c. Negative Views of the Regular Medicaid Enrollment Process

Many participants have a negative image of the enrollment process for “regular” Medicaid.

A number of participants say that the regular Medicaid enrollment process is a hassle and complicated. As a Hispanic man from Queens said about the program:

[They want] the title of the house. The owner. You have to give it to the government in order to get welfare and Medicaid. They then send you to another office in Northern Boulevard and in neither one they tell you to take all the papers from the first time. One day they tell you to take certain information and later to take other information and later more information; they do it so the person gets mad and loses patience so he won’t apply again.

“Like she said, they [regular Medicaid] want everything. They want your life story.”

African American woman from Brooklyn

An African American woman from Brooklyn said, “[Applying for regular Medicaid] is a horror because you’ve got to wait so long. They want your life story and they still tell you no. It’s an all day [event], so make sure you have some water, lunch, make sure you have some money for food.” A Chinese woman from Brooklyn found the process so difficult she does not want to go through it again. She said, “First, I didn’t want the trouble. It was

very time consuming and if I can do it, I don't want to apply. I still don't want to apply.”

Many believe the regular enrollment process requires too much paperwork and is too invasive into their personal lives. One Hispanic man from the Bronx said he felt “humiliated” by all the paperwork requested. A Hispanic woman from Queens said, “You don't feel good because automatically, if you provide all the information, you know... for example, a person who earns a little more money than what he should earn, they start investigating all of that.” One woman, also from Queens, said that she did not continue the Medicaid enrollment process because of the paperwork. She said, “I went to the office to apply and they told me I had to take the income tax papers and I had to take a letter from work. I did not go back. I did not apply.”

“They ask for things out of our reach. For example, I was living with my mother at that time. I had no bills in my name. My mother had to write a letter saying I was her son and I was living with her.”

The biggest complaint that focus group participants had about enrolling in Medicaid had less to do with the application process, however, and more to do with the program's income eligibility rules.

Hispanic man from the Bronx

A large number of participants said they were turned down from Medicaid before because they earn too much income to qualify. “They said, ‘Well, you can't get it because you make too much money.’ How? How do you make too much money? It just bugged me out,” said an African American woman from Brooklyn. A Hispanic woman from Queens said, “I only made \$15,000 a year. I applied for Medicaid. It was fair for them to give it to me [but] they denied it. With my miserable income and they even sent a letter saying that in order to get Medicaid, I had to pay \$353 every month.” A Chinese participant from Queens explained, “They have limiting conditions. Like your bank account cannot be over \$2,300. Usually, Chinese people with several children, you would have \$2,000 or \$3,000 dollars in a bank account for medical purposes and for regular living expenses.” This last concern – that their savings would make them ineligible for Medicaid – was a particular concern for Chinese participants in this study.

Ultimately, the overwhelming majority of participants preferred the simpler and faster enrollment process of DRM, as well as the higher income levels and fewer paperwork requirements.

III. Access to Health Care for DRM Enrollees

Most focus group participants indicated that they used a significant amount of health services while enrolled in DRM and had numerous visits with their providers. It seems from comments made in the focus groups that most participants had a pent-up demand for health services. Since they knew it was a temporary program, many squeezed in services that they had not been able to obtain for many years. In some cases, the services they used were for ongoing or specific medical conditions for which they were receiving treatment – often on an inconsistent basis – prior to DRM. However, a surprisingly large number of enrollees took advantage of DRM to receive preventive health services such as check-ups, lab tests, and mammograms.

The one barrier to care that participants reported was in relation to providers – many say they had an experience where a doctor, dentist, or pharmacy would not accept their DRM

coverage. These and other findings are described below.

a. Utilization of Services – Both Primary and Preventive

Based on comments in focus groups, most participants made use of their DRM coverage to obtain a lot of health services – many of which participants could not afford before.

In all of the focus groups, participants appeared to be using DRM to make up for lost time in terms of their health care. “When you have a big problem then you have to [see a doctor], no matter what. But after 9/11, after I got this [DRM] card, I used it more,” explained a Chinese man from Queens. Many participants revealed that they used the program to receive medical care they had been putting off, or could not afford before. This includes visits to specialists, diagnostic tests and procedures, and specific treatments for ongoing and chronic health conditions like diabetes. “I have some stomach trouble. Before [DRM], I still needed to see the doctor. But with it, it’s better,” said a Chinese man from Brooklyn. “I have a problem. I get allergies when flowers bloom, pollen. I could never go to the doctor because I did not have Medicaid. I would go to the drugstore. Now I can go to the doctor,” said a Hispanic man from the Bronx.

“[DRM] opened a path for people to become more interested in their health, in taking better care of themselves, getting check-ups, especially older and pregnant women. It’s a bridge to feeling better.”

Hispanic woman from the Bronx

A large number of participants used DRM to have check-ups, mammograms, and other preventive services.

A large number said they had check-ups, lab tests, and mammograms during their time enrolled in DRM. Their apparent use of these services suggests preventive services are important to participants – and that DRM removed the primary barriers to obtaining this kind of health care (cost and no coverage). “I went to the doctor and showed him the paper and asked him if he took that, he said yes. So, I immediately made an appointment to get a physical,” commented a Hispanic woman from Queens. “I went for an exam, a physical. I always used to do it, so since they had it I made use of it, because it took me such a lot of trouble to apply for [DRM] ...” said a Chinese man from Queens. Many female participants said they received mammograms through DRM. “I had a mammogram and a sonogram for my stomach,” said a Hispanic woman from the Bronx. Another Hispanic woman in the group said, “I also had a mammogram and x-rays for the arthritis in my knee and hips.” A Chinese woman from Brooklyn said, “I did use [DRM] for my foot, to see the doctor – and a mammogram.”

A number of participants also said they used their DRM coverage to pay for their medications, which they struggled to afford before.

For these participants, DRM provided reassurance that they could obtain their prescriptions every month, rather than just when they had the money to afford them. In describing her feelings about DRM, a Hispanic woman from Brooklyn said, “I say very good because you go to the doctor and buy your medicines.” A problem a few found with their DRM prescription drug coverage was that some medications they wanted were not covered by the program. An African American woman from Brooklyn mentioned this

challenge when she said, “Some prescriptions they don’t cover.” A Hispanic woman from Brooklyn said, “Some expensive medicines they do not allow. They don’t accept cough medicine that was expensive.” However, this problem did not seem to affect most participants.

Many enrollees used dental services and a number used vision care services.

When listing the services they used while enrolled in DRM, invariably half of the participants in every focus group would mention dental services. Mostly they had dental check-ups, but some also had extractions or other dental work. “The first thing I did was make a dentist appointment,” commented a Hispanic woman from the Bronx. However, a handful of participants said the dental services they needed were not covered by DRM. An African American woman from Brooklyn said, “Medicaid wouldn’t cover some of the dental work that I needed done.” In addition, a number of participants said they obtained vision care while enrolled in DRM – mainly vision tests and check-ups, and purchasing glasses.

b. Providers Not Accepting DRM

Many focus group participants said they had difficulty finding doctors, dentists, or pharmacies that would accept their DRM coverage.

Finding providers who would accept DRM was a common problem across all focus groups. “That’s the bad part. Even if the doctor referred you, they won’t [see you]... So you have to go everywhere to look. It’s very troublesome – one address after another,” explained a Chinese woman from Brooklyn. A few participants had to leave their current doctor when they enrolled in DRM. “The doctor where I got my exams did not receive or did not have Medicaid, so I had to change,” said a Hispanic woman from Queens.

Participants had the same complaint about dentists and pharmacies not accepting their coverage. An African American woman from Brooklyn said, “I found out that most dentists don’t accept Medicaid.” A Hispanic woman from Brooklyn commented, “I went to a pharmacy for a prescription. I gave them the prescription and the [DRM] paper and they said they did not accept that Medicaid. They told me to go somewhere else. I looked until I found a pharmacy that did accept it. I looked for about two or three hours more or less because they could not tell me where they accepted that type of Medicaid.”

While some providers turning away Medicaid participants may not be a new problem, some participants believe that some aspects of DRM may have made this problem worse.

Some participants offer theories about why it was hard for them to find a provider who accepted DRM. A few believe that the program was so new that, initially, providers simply did not know about it nor were they prepared to accept this coverage. A Hispanic woman from Brooklyn explained, “Many doctors who accept regular Medicaid do not accept temporary Medicaid. They had to have an authorization so they could accept you when you arrived. They did not accept it at the pharmacy either. They did not have the

“Well first you have to ask the doctor whether they accept it. I look for a doctor and find out if they accept this health insurance. If they don't, I go to another one. But some pharmacies will not accept it because the government takes a long time to reimburse [them]. That was a problem.”

Chinese woman from Queens

necessary forms.” She continued, “Medicaid gives you a letter in case people don't believe you. Even with that, at the pharmacy they would say they didn't have the forms to be able to accept the prescription.”

Some participants also perceived that providers were initially required to accept DRM, but stopped accepting it as the program went on. A Chinese woman from Brooklyn said, “Many of them accept it, but I don't know because after 9/11 they accepted it. Because right in the beginning, the government made them do it. Then later on they dropped off. I'm seeing the foot doctor and they started not to accept it anymore.”

A few participants also believe that DRM should have provided them with a book or list of participating providers so that they did not have to search on their own. “They should have a list. They might improve this,” said a Chinese woman from Brooklyn.

Many participants are matter-of-fact about having to search for providers and pharmacies to accept their DRM coverage. They said they simply kept looking until they found one.

Many participants were surprisingly tolerant of the challenges they faced in finding providers who accepted DRM. They did not seem overly upset by being bounced around among providers, nor does it appear to have affected their overall positive views of the program. “No, I don't have this experience. I only go to ones that accept it. You just go to a different one. The doctor may be afraid. Since it's Medicaid and emergency, they don't want to do it. And maybe the government didn't notify some clinics and pharmacies to say that if you accept this we will definitely pay the bill. Maybe they were not notified,” said a Chinese woman from Queens.

IV. After DRM Coverage Ends

Insights from the focus groups show that the transition process from DRM to Medicaid, Family Health Plus, and other health programs is confusing many participants. Within the same focus group, participants put forth different information about how to retain their health coverage. While the letters participants received describing next steps did clarify the process for some, others are still unclear about what to do next. Some of the challenges with the transition process mentioned by participants include:

- Chinese participants (and a few Hispanic participants too) said the transition letters were in English, which most could not understand;
- The white plastic Medicaid cards most enrollees were mailed led a few participants to believe they had already been approved for regular Medicaid;
- Some participants were unclear how Family Health Plus is different from Medicaid and they are unaware of differences in income limits (i.e., that Family Health Plus has the same eligibility limits as DRM which are higher limits than “regular” Medicaid);

- Some of those who have been denied "regular" Medicaid in the past assume they will not qualify for coverage once their DRM expires because their incomes are too high—they are unaware that the Family Health Plus income limits will continue;
- Many are unclear of their current coverage status – some believe they are uninsured since their four months of DRM have expired, while others continue to use their coverage even though they have not heard from the program; and
- A few participants said they received letters saying their coverage was automatically extended for one year without having to take additional steps to re-apply.

These challenges with the DRM transition process are described in greater detail below.

a. Confusion about Transitioning to Other Health Coverage

Most focus group participants are confused about next steps to retain their coverage.

A Chinese woman from Queens demonstrated some of the uncertainty that most participants seem to feel about the transition process. “I don't know at the moment whether they're going to approve it or not. I don't know whether I can continue to use [my DRM card] or not. But maybe [I'll be moved to] another insurance? They didn't tell me. Right now, I don't have peace of mind. I don't know whether I have it or not.”

The white plastic Medicaid cards mailed to participants in the spring were also a source of confusion for many participants. “They sent me a card. I don't know if it's the regular one or temporary,” said a Hispanic woman from Brooklyn. Some thought the card meant they had been transferred to "regular" Medicaid already and did not need to take further steps. Others seemed to understand that the card was only an extension of DRM, and that they would still need to be interviewed to qualify for "regular" Medicaid or other programs. A Hispanic woman from the Bronx seemed to understand the latter: “It's a Medicaid card, but it is not Medicaid Disaster Relief. They give it to you so you don't run around with a paper.” She continued, “The card is easier to carry around, but it's an extension of Medicaid Disaster Relief because the letter says you will get this card and you will later receive an appointment so you can apply for the regular Medicaid. The letter I received said that.”

A few participants said they never received a letter informing them of an interview, and so assume that they are no longer covered by DRM since their four months are over. “I know I didn't get that letter because I would have went back and extended mine,” said an African American woman from Brooklyn. Others received a letter asking them to come in for an interview, but believe they are uninsured until that interview.

Many of these participants are not using health services currently since they believe they are no longer covered. “That's why I'm not even sure if I still could use it or not.

“Well, I didn't get any advice on how to keep it going, but what I was going to do, I was going to go back to Brookdale [clinic] and find out if I can apply again and am I eligible and ask all the questions I could think of.”

African American Man from Brooklyn

“I went to that [Medicaid] interview and they didn't give me a definite answer so I don't know whether I can use this card or not. So they need to improve this because there are a lot of questions. For example, I don't dare go see a doctor now. [Medicaid] doesn't tell me that after awhile, after a certain amount of time they'll give you a new card. They don't say so.”

Chinese man from Queens

But, I'm hearing that some people are still using it," said an African American man from Brooklyn. In addition, some received a letter telling them they have already been extended for one year, and that they do not need to have an interview or reapply. "I've gotten a letter just telling me they're going to extend it. They didn't tell me to go in," said an African American woman from Brooklyn. Others just keep using the DRM card even though they have gone beyond the four months and still have received no letter from the program. An African American woman from Brooklyn said, "I'm going into my sixth month. [Perhaps] they'll do like they do to everybody else, they just give it to me and I don't have to do anything. It [DRM coverage] just keeps on going."

Some assume they will not qualify for health coverage once DRM is over because their income is too high. They only know about regular Medicaid's income limits (which they feel are too low), and do not know the higher income limits of DRM will carry through with the Family Health Plus program.

Since many focus group participants were previously denied Medicaid, they worry that they will not qualify for "regular" Medicaid or Family Health Plus when their DRM ends. "I know I wouldn't be eligible because I'm receiving unemployment compensation right now. The amount of unemployment compensation I'm receiving, they said it makes me ineligible for Medicaid," said an African American woman from Brooklyn. A Hispanic woman from Queens said, "I would like to keep having Medicaid, but if I apply for it they won't give it to me." Some of these participants appear to making their own eligibility determination, and concluding that they would not qualify because of their income. Furthermore, they are unaware of Family Health Plus' rules—higher income limits and no asset test—which means many (if not most) may actually qualify for continued coverage. Among Chinese participants, there is particular concern about assets, and a number of these participants believe they will not qualify because they have saved money.

While a number of participants have heard of Family Health Plus, they are not sure how it differs from regular Medicaid.

Some participants seem to know that Family Health Plus is the program they may be enrolling in when they go for their transition interview. "I found out about it. They said, you're not expired yet, so wait until it's expired and then you can switch to the Family Health Plus," explained a Chinese woman from Brooklyn. Most are not sure how Family Health Plus differs from Medicaid. "We applied for Family Health Plus. I don't know if it's the same [as regular Medicaid]," said a Hispanic woman from Queens. One man said he preferred to stay enrolled in Medicaid. "If I can continue with Medicaid, I'm going to continue. And, if not, I will apply for the Family Health Plus," said a Chinese man from Brooklyn.

Comments in the focus groups suggest that introducing Family Health Plus is adding somewhat to the confusion of the transition process, although most participants seem to have no objection to enrolling in a program different from Medicaid. A Hispanic woman from Queens explained her introduction to the program:

They called me at home from the Medicaid office. They told me to go to the office. I went and I had the required documents, they made a copy of them, it was more than a month ago. But, now I received this letter with an appointment in another place for Family Health Plus. I thought I did not have to go to this appointment because I had gone to where they gave me Medicaid. So, I have to go to this appointment to continue with the process.

Since focus group participants say their main objective is to retain health coverage, they seem much less concerned about what the program is called.

Chinese participants said their transition letters informing them of next steps were in English, not Cantonese or Mandarin, which added to their confusion. Some Hispanics also received letters in English, not Spanish.

In some cases, Chinese participants said they simply put the letters aside until an English-speaking friend or neighbor could read them. Others ignored the letters since they could not understand them. “No, [the letters were] not Chinese. We're not that lucky. No one receives something in Chinese. Of course, it's best if it's in Chinese. Some people just threw it away because they didn't understand it,” explained a Chinese man from Queens.

One Chinese man from Queens believes that language problems could keep eligible Chinese people from successfully enrolling in Medicaid. He said, “And many Chinese people, maybe they qualify, even for the previous Medicaid, but because of their language barrier they cannot communicate and so for many Chinese people, if they advertise the government benefits, then the Chinese people can enjoy these benefits. Many Chinese people don't know about it. They have many benefits but the Chinese people don't speak English so they just give up their rights. It's not that they don't qualify for the conditions.”

“Since Chinese people don't all know English or can read English, when they send letters in English we don't know what they're talking about. They know about me, but I don't know about them. It's my name but I just throw it aside. That's what most people do.”

Chinese woman from Queens

While the Hispanic participants did not mention language barriers to the same degree, a few did mention they received their transition letters and forms in English rather than Spanish. “They sent me some papers to fill out and to go to an appointment they gave me. I really don't know [what the papers said] because it's in English. I'm going to get help to fill them out.”

POLICY IMPLICATIONS

It is tempting to look at DRM and conclude that it was a distinct program created in response to a unique situation facing New York, and therefore not particularly relevant to other Medicaid programs around the country. In many regards, this is true. The September 11th attacks may have made New Yorkers more concerned about their health, more stressed about the future, and more vulnerable to losing their jobs and health coverage – all of which made them more likely to enroll in DRM. An African American man from Brooklyn made this point when he said, “I think people thought about their health a little bit more... It’s just a whole different outlook on things.” The “buzz” and positive word-of-mouth about DRM may also have been the result of increased concern New Yorkers were feeling about each other, and the networking to obtain services that followed the attacks. Numerous participants said that health became a frequent topic of discussion among friends, families, and even strangers, which is how many learned about DRM.

Another distinctive feature of DRM may be the diverse individuals who enrolled in the program. The sudden loss of jobs following September 11th meant that all kinds of workers were now unemployed – and looking for health coverage. According to a Hispanic woman from the Bronx, “People were very nervous” during this time period and an African American woman from Brooklyn said it was “panic time” for New Yorkers. White-collar and blue-collar workers who were used to having health insurance were thrown into the mix with New Yorkers who were more experienced with Medicaid and with being uninsured.

There are also aspects of DRM that may not be so unique, however, and which may have relevance to New York’s public health insurance programs as well as Medicaid programs across the country. These tended to be process and rule changes that attracted New Yorkers to the program in the first place and which allowed so many to qualify and create the positive buzz about DRM. Specifically, these include:

► **DRM implemented FHP’s rules: higher income eligibility levels and no asset test.**

Many focus group participants asserted that even though they are low-income and struggling financially, they have been turned down for Medicaid coverage in the past. By applying higher income levels and excluding assets from consideration, more uninsured New Yorkers obtained health coverage than before, especially childless adults. Word-of-mouth about these higher income eligibility levels added to the positive buzz surrounding the program, which attracted applicants. Also, concerns about asset testing was particularly high among Chinese focus group participants, which suggests eliminating asset tests may attract more Chinese applicants to Medicaid.

► **Easier enrollment process: shorter application form, minimal documentation required, brief interview with an enrollment worker, and the ability to use**

services right away.

Many focus group participants have a negative image of the current Medicaid enrollment process and a few admitted that they have avoided applying for Medicaid in the past because of the burdensome process. Easing the enrollment process in ways that mirror the DRM process may reap significant benefits – indeed, much of the positive word-of-mouth was about the easy enrollment process. Finally, being able to use their coverage almost immediately appealed to focus group participants, many of whom were anxious about their health prior to enrolling. The typical month or longer time period for regular Medicaid applicants to be approved for the program may seem too long to applicants who want to receive health services now.

► Assistance completing applications and in-language forms and workers.

While this feature of the DRM enrollment process was not discussed in great length in the focus groups – and may not even be unique to DRM – many participants nonetheless were thankful that eligibility workers either filled out the application for them or helped complete the forms. Since many DRM enrollees were immigrants or had language barriers, this assistance may have been vital in their success with completing the enrollment process. Similarly, there were almost no complaints about language barriers when enrolling. Chinese and Hispanic participants were either able to apply with someone who spoke their language, or were directed to another enrollment site that had this capability. However, the language barriers that have appeared during the transition period, particularly for Chinese participants, suggest that there is room to improve communication with non-English speaking enrollees.

► Creating a positive word-of-mouth.

The atmosphere in New York following the September 11th attacks certainly accounted for much of the interest surrounding DRM, but there may be lessons for how states market their own Medicaid programs in the absence of a national crisis. First, focus group participants said that the way DRM was described to them made the program seem attractive – i.e., free health coverage that was easy and quick to get. This kind of description could be applied to Medicaid programs across the country if changes were made to enrollment processes that reduced hassle and time spent by applicants (e.g., shorter application forms, less documentation, quicker approval, etc.).

Similarly, there was a perception that DRM allowed people with higher incomes to qualify. While states will always have income limits for Medicaid and other public programs, focus group participants overwhelmingly feel these limits are currently too low. However, some states have already raised their income levels for Medicaid and the State Child Health Insurance Program and other programs have higher income levels too. It may be possible to spread the word about these different eligibility rules so that potential enrollees see that the program is not just for the very poor, but also for families like their own.

Finally, there was a perception among focus group participants that DRM was a different

kind of government health program, which may have appealed to New Yorkers who have never applied for Medicaid before. The fact is that DRM was different – a temporary health program that implemented higher income limits, had no asset test, and required few documents. However, it could be argued that changes some states have been making to their Medicaid program, not to mention the new programs introduced in recent years such as Family Health Plus, constitute a new breed of health programs. A way to create a positive buzz around these programs, consequently, may be to update the public's image of government health programs and advertise changes to the programs and who qualifies for them.

Appendix

**2001 Eligibility Levels for Medicaid and Disaster Relief Medicaid/Family Health Plus
(Annualized Income)**

Family Size	Parents		Single Adults/ Childless Couples		Pregnant Women & Infants		Children: 1-5		Children 6-19	
	MA	DRM/FHP	MA	DRM/FHP	MA	DRM	MA	DRM	MA	DRM
1	\$7,500	\$11,436	\$4,225	\$8,592	\$17,184	\$17,184	\$11,436	\$11,436	\$8,592	\$8,592
2	\$10,800	\$15,444	\$5,622	\$11,616	\$23,220	\$23,220	\$15,444	\$15,444	\$11,616	\$11,616
3	\$10,908	\$19,464			\$29,268	\$29,268	\$19,464	\$19,464	\$14,640	\$14,640
4	\$11,004	\$23,484			\$35,304	\$35,304	\$23,484	\$23,484	\$17,652	\$17,652
5	\$11,904	\$27,492			\$41,340	\$41,340	\$27,492	\$27,492	\$20,676	\$20,676
6	\$13,608	\$31,512			\$47,388	\$47,388	\$31,512	\$31,512	\$23,700	\$23,700

Source: United Hospital Fund estimates based on data from New York City Human Resources Administration, Medical Assistance Programs, Eligibility Information Services, 2001.



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