



LESSONS FROM CHIP FOR IMPLEMENTATION OF THE AFFORDABLE CARE ACT

OUTREACH, ENROLLMENT AND RETENTION

EUGENE LEWIT, PHD



MAY 2014

INTRODUCTION

Although the open enrollment period for Marketplace coverage under the Affordable Care Act (ACA) has ended, this is an important time for ACA outreach and enrollment efforts. Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) is open year round, and people who experience changes in life circumstances (including young adults who age-out of Medicaid, CHIP, or parental coverage) will still be able to enroll in Marketplace coverage. In addition, important work will be needed to improve Marketplace enrollment systems in time for the next open enrollment period that begins November 15. It may also be necessary to focus on improving retention of enrollees if it appears that disenrollment becomes a concern, as it has been in Medicaid and CHIP.

Outreach, enrollment, and retention have been emphasized in CHIP since its inception and as is the case with the ACA, enrollment was viewed as a primary measure of CHIP's success. As has been argued in previous briefs in this series,¹ many CHIP-driven innovations in this area spread to or were done in concert with children's Medicaid with the growth in both programs leading to a decline in the children's uninsurance rate to record lows. Not surprisingly many of the innovative policies and procedures developed in CHIP and Medicaid have been incorporated into the ACA. There are however, many other lessons from CHIP and Medicaid that may inform and help improve outreach, enrollment, and retention under the ACA.

This brief reviews at a high level many of the good outreach, enrollment, and renewal practices developed in CHIP and children's Medicaid and explores issues related to hard-to-reach populations, retention, and cross system data matching in greater depth. These issues will take on increasing importance as ACA implementation moves to its next stages.

THE CHIP ENROLLMENT REVOLUTION

Reducing the number of uninsured children was the explicit objective of the legislation that created CHIP. To that end, states were required to include enrollment targets in their CHIP implementation plans, and CHIP enrollment in individual states and at the national level was news. The nature of federal CHIP block grant funding, which required states to use all their federal allotment in three years or have the unspent funds reallocated to other states, also created a strong incentive for states to rapidly boost CHIP enrollment. In addition, CHIP allowed states to use up to 10 percent of their administrative budgets to support outreach and marketing activities. As a result, CHIP represented the first time that most states actively marketed any public health coverage program.² States were very enthusiastic and learned a lot in the early years from their experiences with CHIP. The experience with CHIP outreach and enrollment efforts spilled over into

OUTREACH, ENROLLMENT AND RETENTION – IMPLICATIONS FOR THE ACA

children’s Medicaid for several reasons. First, some states extended their Medicaid programs with federal CHIP funding so that growing enrollment in CHIP was growing enrollment in Medicaid. Second, CHIP’s screen-and-enroll policy required states to enroll in Medicaid any child who applied for CHIP but was found eligible for Medicaid. In addition, the focus on reducing the number of uninsured children called increased attention to the large number of Medicaid-eligible children who were not enrolled, as well as the fact that children’s enrollment in Medicaid had fallen substantially following welfare reform in 1996.

Marketing was the initial focus of new CHIP programs, including paid and unpaid advertising, and branding of CHIP in many states to distinguish it from Medicaid, which still carried a stigma associated with welfare in many places.³ Over time, however, it became clear that enrolling and retaining children in coverage is a complex process with many components, including:

1. General public education about the new program;
2. Specific outreach to those eligible for the program to get them to sign up;
3. Easy and convenient enrollment processes offering application assistance and requiring minimal documentation;
4. Accessible, quality health care services with minimal cost-sharing;
5. Minimally burdensome re-enrollment processes.

With experience, states modified their outreach strategies to engage harder-to-reach populations, frequently through community-based organizations.⁴ Efforts to simplify the enrollment process, such as shortening applications, using linguistically appropriate forms and application assistance, and reducing documentation requirements, proceeded gradually, varying by state and program.⁵ In recent years, there has been a movement towards automated verification of required information – for example, verifying citizenship status through data matching. In some states, similar process simplifications have also been applied to re-enrollment.

Since the launch of CHIP, much has been written about the evolution of outreach, enrollment, and retention. Cutting red tape and changing the culture of state eligibility systems and workers have been critical to progress. Many of the documented successful outreach and enrollment strategies are summarized in Exhibit 1. These strategies are as important today as they were when first implemented, and states and others looking to boost enrollment would be well served to implement those that they have not already adopted. In addition, many best practices such as “no wrong door” have been incorporated into the ACA itself. Data matching to reduce documentation requirements, simplify, and speed enrollment is another CHIP/Medicaid innovation which, expanded in scale and scope, is a cornerstone of enrollment under the ACA.

Exhibit 1: Better Outreach and Enrollment Strategies Developed in CHIP and Medicaid

Outreach Efforts Must be Broad Based and Targeted	<ul style="list-style-type: none"> • A combination of mass media, word of mouth, and information from providers, schools, and community organizations is key for reaching eligible families.^a • Provide a variety of ways to enroll - online, over the phone, by mail, and in person.^a • Eligibility staff must be friendly and reduce stigma associated with applying.^a
Use of a Single Streamlined Application	<ul style="list-style-type: none"> • Applications must be short and in plain language. Translation into foreign languages in the vernacular is important for some hard-to-reach populations.^a • Use a single application to determine eligibility for multiple programs (Medicaid, CHIP, SNAP).^b • A “no wrong door” enrollment approach ensures that regardless of the applicant’s point of entry, eligibility is determined for all programs. Coordination of program rules simplifies the process.^c
Simplify Enrollment Policies	<ul style="list-style-type: none"> • Reduce documentation requirements.^c • Data match income and citizenship information with government databases.^b • Allow self-attestation of eligibility criteria, such as residency and date of birth. • Presumptive eligibility: provide coverage immediately based on stated income while full determination is made.^b • Express Lane Eligibility – allows states to use federal and state programs and data sources to identify eligible but unenrolled individuals.^d
Navigators / Assistors and Community Based Organizations	<ul style="list-style-type: none"> • One-on-one assistance from trained professionals to provide personalized technical assistance is important.^b • Hard-to-reach populations rely on trusted community based organizations and providers.^a • People trust information from their health care providers and community health centers.^a
Renewal Policies	<ul style="list-style-type: none"> • Provide continuous coverage for a 12-month period regardless of change in situation. • Make renewal easy with strategies such as pre-printed renewal forms with notification only necessary where there are changes, renewal by phone or Internet, renewal when recertifying eligibility for other government programs and using databases to verify eligibility on an on-going basis.

^a Jessica Stephens and Samantha Artiga, “Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act,” Kaiser Commission on Medicaid and the Uninsured (June 2013). Retrieved from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8445-key-lessons-from-medicaid-and-chip.pdf>.

^b Jennifer Sullivan, “Ten Ways to Make Health Coverage Enrollment and Renewal Easy,” Enroll America (August 2011). Retrieved from: <http://www.enrollamerica.org/ten-ways-to-make-health-coverage-enrollment-and-renewal-easy/>.

^c Martha Heberlein et al., “Getting into Gear for 2014: Findings from a 50 State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013,” Kaiser Commission on Medicaid and the Uninsured (January 2013). Retrieved from: <http://ccf.georgetown.edu/wp-content/uploads/2013/01/Getting-Into-Gear-for-2014.pdf>.

^d Katie Baudouin, Alice Weiss, and Maureen Hensley-Quinn, “Paving the Way to Simpler: Experience from Maximizing Enrollment States in Streamlining Eligibility and Enrollment,” National Academy for State Health Policy (February 2014). Retrieved from: <http://www.maxenroll.org/files/maxenroll/resources/paving.way.to.simpler.pdf>.

To date, a large number of people have enrolled in ACA coverage, including Marketplace plans, Medicaid, and CHIP, with some states exceeding their enrollment goals. Nonetheless, several concerns have emerged, such as low rates of enrollment in some apparently hard-to-reach groups, including Hispanics. Another problem is limited utilization of program participation data from other means-tested programs for outreach and easy enrollment into Medicaid. In addition, not much attention has yet been paid to renewal and retention, but experience with other programs suggests that concerns about renewal and retention of enrollees in coverage could well become a concern within a year. Accordingly, the balance of this brief explores these three issues: hard-to-reach populations, cross-program data sharing, and retention, in more depth.

HARD-TO-REACH POPULATIONS

In the early years of CHIP, states and the federal government targeted their outreach efforts at the overall target population with a particular focus on information about the new program, including branding efforts to generate excitement about the new program and distinguish it from Medicaid. Over time, however, state outreach efforts evolved to more targeted approaches directed at families who were eligible but unenrolled.⁶ Despite these more targeted enrollment efforts, enrollment among some individuals and groups continued to lag, and even more attention was directed to these so-called hard-to-reach groups. Unlike the uninsured *per se*, many of whom have few good coverage options, the hard-to-reach are eligible to participate in an affordable coverage program such as Medicaid or CHIP but are not enrolled. Hard-to-reach groups are therefore characterized by relatively low rates of participation in affordable coverage programs for which they are eligible.

Promotoras de Salud

One best practice is to have outreach and applications assistance in ethnically diverse and immigrant communities provided by trusted individuals who have a shared background and/or experience with community members. *Promotoras de salud* (lay health workers) have served this function in some Latino communities. *Promotoras* also help connect families to providers and facilitate care for pregnant women and people with chronic illness. This helps establish trust and reinforces the value of coverage. There are no formal evaluations of the use of *promotoras* but anecdotal evidence is promising.

A 2007 survey of low-income parents with uninsured children found that most had heard of Medicaid or CHIP, and 95 percent who knew about the programs thought that the programs were good.⁷ Nearly 50 percent, however, thought that their child was not eligible because parents earned too much or simply were working, that enrollment was difficult, or did not know how to enroll their child or how to get more information. Other surveys suggest that such misconceptions can be persistent, widespread and apply to health coverage for adults as well as children.⁸ The findings underscore the importance of addressing these specific issues, if coverage among the uninsured is to be increased.

Many of the strategies listed in Exhibit 1 can be used to facilitate enrollment of hard-to-reach populations. In fact many were developed precisely for that purpose. These include employing trusted community-based organizations and providers for both outreach and to facilitate enrollment, developing outreach and enrollment materials that are culturally and linguistically appropriate, and making the enrollment and renewal process streamlined and simple. Dissemination of information by word-of-mouth may be particularly important in groups that are

suspicious of or less reliant on mainline information sources. An individual's difficult experience enrolling or getting information about program options can reinforce negative perceptions not only for the individual but for his/her associates and community as well. Limited access to providers after enrollment can lead to the

conclusion that program participation is “not worth it.” Addressing these drags on enrollment requires attention to the quality of the enrollment experience and access to quality care post enrollment.⁹

Approximately 88 percent of Medicaid or CHIP eligible children were enrolled (participated) in the programs in 2012.¹⁰ That was the highest rate of program participation for children among a number of other means-tested programs. It also represented an impressive increase in children’s participation since the early years of CHIP and an increase of over six percentage points since just before the enactment of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in February 2009.¹¹ Nonetheless, approximately two-thirds of all uninsured children were eligible for either Medicaid or CHIP. Despite the increase in participation overall, participation remained low among some population groups and in some states. Groups with participation rates about five percentage points below the national average included teenagers, children without an English speaking parent in the home, children not living with their parents, American Indian/Alaskan Native children, and eligible noncitizen children.¹² A 2009 study identified other groups with low participation rates: Hispanic children, noncitizen children, citizen children with noncitizen parent(s), and children with at least one parent eligible for Medicaid but unenrolled.¹³ While these data apply to children, it is reasonable to expect that program participation rates will be especially low for adults with similar characteristics since the aggregate participation rate for adults is well below the rate for children.

While it is not possible to directly attribute recent gains in program participation to the Children’s Health Insurance Program Reauthorization Act (CHIPRA), it seems likely that the law contributed to these gains, given its focus on increasing program participation among eligible children. CHIPRA provisions aimed at increasing participation among Medicaid/CHIP eligible children include: performance bonuses for states that adopt five of eight simplification/outreach processes and exceed Medicaid enrollment targets; \$100 million for outreach and enrollment grants; higher federal match rates for translation and interpretation services; new options for “Express Lane Eligibility” (which allows states to use data from other government programs when assessing eligibility for Medicaid and CHIP) and for complying with citizenship documentation requirements. It may not be possible to disentangle the contribution of the different elements of CHIPRA to the increases in participation among hard-to-reach populations. Nonetheless, the CHIPRA experience mirrors earlier experiences, which of course used different strategies, such as the very rapid rise in CHIP enrollment in Texas in 2000,¹⁴ suggesting that hard-to-reach groups can be enrolled with adequate resources and innovative strategies.

Oregon’s experience with its Healthy Kids Program is another case in point. Following legislation to expand state health care coverage for children in 2009, Oregon set a goal of enrolling 80,000 more children in all its public programs and cutting the uninsurance rate among children in half. It succeeded in enrolling about 114,000 more children over two years, with a corresponding drop in the child uninsurance rate to 5.6 percent. Along the way, Oregon achieved large enrollment gains among some hard-to-reach ethnic groups, with reductions in disparities by race/ethnicity in all measures. Key to Oregon’s success was a simple, positive “all kids” marketing campaign designed to dispel the notion that some children were not eligible. That welcoming message was combined with targeted outreach through community-based organizations and health clinics, culturally relevant marketing including community based bi-cultural, bi-lingual outreach staff and materials, and advertising made for (not just translated for or adapted to) the communities they needed to reach (Exhibit 2).¹⁵

Exhibit 2: Examples from Oregon of Integrating the “all kids” Message with Targeted, Population Specific Outreach Materials



Is electronic Web-based enrollment for everyone?

A hallmark of the ACA enrollment process is its heavy reliance on Healthcare.gov as well as Web-based enrollment sites in states that have chosen to operate their own marketplaces. The initial inability of Healthcare.gov and some of the state sites to function properly, their inability to accommodate large numbers of applicants at the same time, and the failure to link to and exchange information with other data systems slowed enrollment, occupied the media, and gave fodder to critics of the ACA. Less attention, if any, has been paid to the characteristics of the users of online enrollment systems and whether certain individuals or groups will not be comfortable with the online enrollment systems.

Online enrollment systems for health insurance were pioneered in CHIP and children's Medicaid programs. By the end of 2010, over two-thirds of states offered an online enrollment and/or renewal option. In general, online systems have been well received, and in some states, a large proportion of applications are submitted online. However, a recent evaluation of California's Health-e-App, a Web-based application that was used to enroll children and pregnant women in Healthy Families (California's former CHIP program) and screen them for Medi-Cal (a Medicaid program), suggests that online systems may not work well for some groups.¹⁶

Enrollment professionals had used Health-e-App in California since 2000, when in December 2010 a self-service version of the tool, Healthy-e-App Public Access (HeA PA), was introduced to enable applicants to use it independently via the Internet. The evaluation by Mathematica Policy Research focused on the first year of HeA PA implementation. The evaluation findings were generally favorable: HeA PA was associated with a 14 percent increase in total applications and did not seem to affect trends in other application methods; 93 percent of HeA PA applicants reported it was easy or very easy to use and most used the online help features when they needed help. HeA PA users were, however, a self-selected group. Almost all the HeA PA applicants reported that they were Internet-savvy and online daily for other purposes. Not surprisingly, HeA PA users were also somewhat younger, had more education, and slightly higher incomes than applicants who used paper applications or application assisters. Most significantly, less than five percent of HeA PA applicants preferred to communicate in Spanish as compared with 35-45 percent of applicants who used paper applications or application assisters. Consistent with the latter finding, although a Spanish version of HeA PA was offered, only two percent of applications were in Spanish as compared with over 35 percent of paper applications. Beginning in July 2011, California implemented an outreach campaign to promote HeA PA to low-income families. The campaign was in Spanish as well as English, featured the well-respected

Latino television personality Dr. Aliza, and worked in conjunction with Univision to target Spanish-speaking audiences. The campaign was associated with a substantial increase in online visits to the HeA PA website and an increase in the proportion of applications submitted via HeA PA. Nonetheless, the number of applications submitted in Spanish remained very low.¹⁷ These findings are consistent with the finding from another study that three-in-four Spanish-speaking parents say that they would be more likely to apply for coverage if they could get help from someone who also speaks Spanish¹⁸ – rendering them hard-to-reach by a self-service Web-based enrollment system.

“We are from a strong culture of asking questions and we are talking about a long form with a lot of questions which people are not familiar with. I don’t think a website is going to do it.”

Yurina Melara
Health Reporter, *La Opinion*
On the Media, Broadcast March 28, 2014

DATA SHARING: STREAMLINING ELIGIBILITY USING INFORMATION FROM OTHER MEANS-TESTED PROGRAMS

An Urban Institute analysis published in 2000 found that about 60 percent of uninsured children and three-quarters of low-income uninsured children lived in families that participated in at least one of four other means-tested programs, with participation highest for the free and reduced school lunch program (60 percent of low income uninsured children).¹⁹ This finding increased the attractiveness of outreach for Medicaid and CHIP in schools, and in many areas using the free and reduced school lunch program was viewed as particularly promising strategy. The approach, however, faced a number of barriers, including the need to protect the privacy of school lunch applicants, and the fact that Medicaid and CHIP required more detailed information to determine eligibility. In addition, free and reduced school lunch programs were administered at and by local schools, many of which were burdened with other responsibilities and not well positioned to take on outreach for children’s health insurance.²⁰

Over time, other approaches were tried to boost enrollment in Medicaid and CHIP of eligible children whose families participate in other means-tested government programs, but issues similar to those encountered with the free and reduced school lunch program were an impediment. In addition, incompatibility among the legacy data systems used by the different programs made it difficult to link data across programs. Ultimately, Express Lane Eligibility (ELE) evolved and was incorporated into CHIPRA in 2009. With ELE, a state Medicaid or CHIP agency can rely on another agency’s eligibility findings to determine a child eligible for Medicaid or CHIP and retain that child in coverage even if the other agency uses a different method to determine eligibility.²¹ The only additional step is that U.S. citizenship must be verified based on Medicaid rules.

ELE is optional for states, and states have great flexibility to implement ELE in ways that suit their individual circumstances within a number of fairly broad federally specified parameters. States may also apply ELE to adults with a waiver from the federal Centers for Medicare and Medicaid Services (CMS). A federally mandated evaluation of ELE, released in December 2013, was generally favorable.²² Findings from the evaluation supported the “promise” of ELE to increase enrollment of eligible children and yield administrative savings compared with standard processes. The extent of the gains appeared, however, to depend on how states implemented the policy. Specifically the evaluators report that, “automatic ELE processes serve the most individuals, yield the greatest administrative savings, and eliminate procedural barriers to coverage.” In addition, it appears that ELE had its greatest impact when used to renew enrollment rather than for new enrollment and where Express Lane partners had centralized, linkable data systems.²³ State officials also report that an added benefit of ELE is that it can reduce administrative costs and free up staff to deal with complex cases and the increase in applications generated by the ACA.²⁴

RETENTION: THERE'S A HOLE IN THE BUCKET

Several years after the launch of CHIP, state program directors became acutely aware that despite the continued focus on growing program participation and the honing of their outreach and enrollment efforts something was going awry with their program enrollment numbers. Some investigation revealed that children were leaving the program in increasing numbers, and in some states, total program enrollment stagnated as the number of new enrollees approached the number disenrolling.²⁵ High rates of disenrollment had long been recognized as a concern in Medicaid as well, but had attracted less attention from program administrators and policy makers because many were focused on minimizing enrollment in Medicaid due to state budgetary concerns. A 2005 analysis found that 12.6 percent of eligible children dropped out of Medicaid and CHIP within 12 months although they had no alternative source of coverage.²⁶

Closely related to disenrollment is “churn” which occurs when a child is disenrolled from a program for which they still may be eligible only to re-enroll several months later.²⁷ Typically children re-enroll when they try to access services and learn they are no longer covered. This can lead to a delay in getting necessary care and subjects both the family and the program to the cost of re-enrolling an eligible child. Churn can also disrupt continuity of care, access to preventive care, and care during the early stages of illness that can head off more serious illness down the road.

In response to state concerns about CHIP disenrollment, the National Academy for State Health Policy (NASHP) assembled a workgroup of seven states, to examine CHIP disenrollment and how to retain eligible children in CHIP.²⁸ Leaving aside children who become ineligible for the program under state and federal rules, the workgroup identified a variety of reasons why families allowed their eligible children to disenroll, including: lack of knowledge that children needed to re-enroll annually, complexities of the renewal process, difficulties paying premiums, and parents forgetting or failing to complete the required paperwork.

Subsequent research has identified program features, which independently or in conjunction with family behavior, decrease program retention.²⁹ These include shorter eligibility periods (the more frequently families need to undergo eligibility redetermination the more likely is it that children will be disenrolled); higher premiums (high premiums may not only be difficult to pay on an on-going basis but are more likely to be a challenge when families face unexpected expenses); and unnecessarily burdensome redetermination processes (the more complex the process the more likely that families will not be able to complete it successfully on time). In addition, narrow income eligibility bands increase the likelihood that children's eligibility status will fluctuate with transitory changes in family income.

Premium lock-out periods have also been associated with prolonged periods of lapsed coverage and may prove important in interrupting coverage of families and individuals enrolled in ACA marketplace health plans as well. In order to discourage families from missing premium payments, many states required families who had missed premiums to reapply for the program and repay all back premiums before coverage could resume. Some states went further and automatically locked children out of their plans for one to six months after a missed premium. Lock-out periods can reduce enrollment substantially. When Rhode Island imposed a premium and lock-out policy for RItE Care (its Medicaid program for children, families, and pregnant women), each month 18 percent of families subject to the premiums were locked out of RItE Care for non-payment of premium.

Over time, states have instituted a number of program changes to help reduce disenrollment. Louisiana has been a leader in reducing the number of children who inappropriately lose Medicaid and CHIP (known as LaCHIP) at renewal. In 2008, less than one percent of children enrolled in LaCHIP lost coverage at renewal for administrative or procedural reasons, compared to as many as 50 percent of children in other states. Louisiana accomplished this outcome by using a variety of administrative and data matching- procedures to

minimize the number of families that need to submit a renewal form to renew coverage. In addition, state employees aggressively follow-up by phone with families when additional information is needed and allow families to renew “off-cycle” online or on the phone when convenient.³⁰ Other policies states have implemented to ease renewal include lengthening the period of continuous program eligibility to 12 months (from six or even three months), making the renewal process easier by eliminating the requirement for a face-to-face interview at renewal, and reducing paperwork and documentation requirements. Community Catalyst, a national nonprofit advocacy organization, recently released a “toolkit” focused on reducing churn in Medicaid and CHIP.³¹ Exhibit 3 summarizes some problems and solutions to reduce churn from that toolkit.

Exhibit 3: Policy Approaches to Ease Renewal and Reduce Churn

Problems	Possible Solutions
<p><u>Complicated renewal process</u></p> <ul style="list-style-type: none"> • Renewal materials written at too high a literacy level or linguistically or culturally inappropriately • Materials mailed to wrong addresses • Incomplete or improperly completed paperwork 	<ul style="list-style-type: none"> • Adjust renewal materials to meet the linguistic and cultural needs of families • Provide assistance by phone and in person • Confirm addresses by phone or email before mailing • Electronic or other administrative verification of income and extend period of eligibility
<p><u>Premium and premium lockout periods</u></p> <ul style="list-style-type: none"> • Premium amounts are excessively burdensome • Missed premium results in disenrollment and lock-out 	<ul style="list-style-type: none"> • Reduce or eliminate premiums • Shorten or eliminate premium lock-out periods
<p><u>Low perceived value</u></p> <ul style="list-style-type: none"> • Limited access to providers and long wait times to obtain appointments 	<ul style="list-style-type: none"> • Increase provider reimbursements and provide other incentives to practice in underserved areas

Source: Adapted from Kate Lewandowski, “Churn Toolkit: Policy Approaches to Reducing Churn,” Community Catalyst (March 2014). Retrieved from: <http://www.communitycatalyst.org/resources/publications/body/policy-approaches-to-reducing-churn.pdf>.

CMS also released a rule in July 2013 to reduce the negative effects of lockout periods in CHIP. Under the new rule, children must be allowed to re-enroll as soon as their premium arrears are paid or at the end of the lockout period which is limited to 90 days.

To make retention even less burdensome for families, some states have implemented so-called “passive” or “administrative” renewal procedures. Some states use the data they have on file to prepopulate renewal forms. These forms are sent to families with instructions to change and resubmit the form if the information on the form is no longer accurate, otherwise the child is re-enrolled. More recently, states have used Express Lane and other data matching options to retain children in Medicaid based on their participation in other means-tested programs such as SNAP.

Many states maintain more stringent processes for both enrollment and renewal for childless adults in their Medicaid programs. States have also at times made renewal more difficult, for example, shortening the period between renewals, to reduce program enrollment and save money when budgets are tight. The ACA has made it more difficult for states to use these tactics to manage enrollment in Medicaid and CHIP.

APPLYING LESSONS LEARNED TO THE ACA

As evidenced in this brief, much has been learned from the work to grow enrollment in CHIP and children’s Medicaid over the past seventeen years. Many of these efforts have been evaluated and summarized in the exhibits in this brief and in toolkits for those working to boost ACA enrollment. Others have been incorporated into the ACA itself, including requirements that enrollment systems be:

1. *Consumer-friendly* - help consumers understand their options, use a single streamlined application, reduce administrative burden, and provide assistance;
2. *Coordinated* – Marketplace, Medicaid and CHIP enrollment work together so that there is “no wrong door” to coverage;
3. *Simplified* - uniform income rules for all subsidized programs, paperless verification of required documents;
4. *Technologically Enabled* - maximizes use of the Internet for application, eligibility verification, and enrollment.³²

In addition, the ACA provides for Navigators, Application Assistors, and others to provide individualized assistance to those who need it, and some states have used their CHIP/Medicaid applications assistance networks as the foundation for their ACA Navigator/In-Person Assistance/Certified Applications Counselor programs.³³ There is also the opportunity to apply for coverage on-line, by mail, or over the phone.

The ACA also built on the CHIP/Medicaid experience in other ways. For example, building on the experience with ELE, CMS has offered states a limited time opportunity to “fast track” eligible adults into Medicaid using data already available from their Supplementary Nutrition Assistance programs (SNAP, formerly Food Stamps) and/or their Medicaid or CHIP programs for children.³⁴ As is the case with ELE, states must take additional steps to verify citizenship and immigration status, must secure an applicant’s signature and any additional information that Medicaid might require, and must also advise applicants of their rights and responsibilities.³⁵ Those states that use managed care to deliver Medicaid services must also facilitate the enrollment of fast track enrollees into available health plans.

A report on the experiences of four states, Arkansas, Illinois, Oregon, and West Virginia that implemented these fast track enrollment strategies in 2013 found that the four states had enrolled more than 223,000 people in coverage in a relatively short period of time.³⁶ These enrollment gains constituted a significant share of adults eligible for the Medicaid expansion in those states. In addition, the fast track strategies were well received by both consumers and state program staff and were perceived to reduce the pressure on the new eligibility and enrollments systems.

“It (fast track enrollment) was quick and easy, gave us the biggest bang for the buck, and was easy for staff to manage.”

Unidentified State Official³⁷

There are also opportunities to build directly on the success of CHIP and Medicaid. For example, Oregon and West Virginia used Medicaid/CHIP enrollment data in addition to SNAP data to “fast track” parents of enrolled children. This is a particularly attractive option for a several reasons:

1. Because of the success of CHIP and Medicaid in enrollment and the historically higher income eligibility levels for children in those programs, there are many children in both programs whose parents are uninsured and who would benefit from coverage. A recent estimate is that there are 4.9 million uninsured parents of children enrolled in Medicaid and CHIP who would be eligible for Medicaid if all states implement the ACA’s Medicaid expansion for adults.³⁸

OUTREACH, ENROLLMENT AND RETENTION – IMPLICATIONS FOR THE ACA

2. Parents of enrolled children are more likely to be familiar with the programs, to understand how they work, and value the protection they offer. As a result, they may be more receptive to fast-track enrollment.
3. There is evidence that when parents are insured, children use health care services more often and effectively.
4. Children are more likely to thrive, families will function better and are more secure if parents' health care needs are met.³⁹

It is still too early to know the most effective way to target fast-track efforts. Targeting SNAP enrollees will engage a larger population, including uninsured adults without children and some families with uninsured children. Targeting parents of Medicaid enrolled children may yield a larger rate of positive responses for the reasons previously explained. Depending on cost and the administrative structure of the programs, it may be useful to build off enrollment information from several programs as was done in Oregon and West Virginia.

Because in all states income eligibility levels for children in Medicaid and CHIP exceed the level for adults under Medicaid, it may also be possible to use enrollment information from children with family income above 138 percent FPL to facilitate enrollment of other family members into subsidized coverage in the Marketplace. Although the insurance status of these higher income parents will typically not be known to Medicaid and CHIP programs, the child's family composition and income data can be used to create customized enrollment and/or outreach letters, informing parents of the availability of coverage as well as the subsidy, coverage options and final cost of coverage specific to their situation. While still only a concept, this facilitated enrollment strategy might work best in states which operate their own exchanges and where the Medicaid/CHIP and Marketplace eligibility systems and databases are well integrated.

While increasingly sophisticated technology may make it easier to automate enrollment and retention, experience with CHIP and Medicaid outreach and enrollment efforts offers important cautions about the need to tailor efforts to the characterizes and preferences of potential enrollees. In some sense the “hard-to-reach” are hard to reach because they do not respond positively to outreach and enrollment strategies that work for the majority. The experience with CHIP and Medicaid can be helpful with these groups as well by not only identifying better practices but also what might not work well as in the case of the effort to enroll those with preference for Spanish via the Internet.

“... all the hard work in California ‘proves that the Affordable Care Act is not self-implementing.’”

Diana Dooley
California Secretary of Health and Human Services
California Healthline (April 18, 2014)

It took years of effort and experimentation under CHIP and Medicaid to establish effective outreach, enrollment, and retention practices. The recent ACA experience, as well as experience with CHIP and Medicaid, also highlight, however, the need to focus on more than policy – effective implementation is ultimately the key to making policies succeed.

State and federal officials will need to be vigilant to identify problems and move quickly to correct them. The recent experience in California is encouraging in that regard. Despite respectable enrollment numbers in California during the recent open enrollment period, it appeared that Latinos were substantially underrepresented among new enrollees. The state moved quickly to address that issue by significantly increasing the number of enrollment counselors and culturally appropriate outreach in Latino communities. By the time the open enrollment period closed, the proportion of Latinos among all enrollees had risen by over 50 percent.⁴⁰

Moving forward, policy makers should focus on fixing systems and policies that do not seem to be working well and on other important outreach and enrollment issues that are likely to impact the ACA, including engaging hard-to-reach populations, retaining enrolled individuals, and utilizing cross system data matching to simplify enrollment processes. Utilizing these CHIP-driven innovations may combat some of the initial frustration with the ACA enrollment process and set the ACA up for the same kind of success and widespread support CHIP now enjoys.

ABOUT THIS BRIEF

Eugene Lewit, PhD is Consulting Professor of Health Research and Policy, and Adjunct Affiliate, Center for Health Policy and Primary Care and Outcomes Research, Stanford University. This brief is one of several that Lewit is writing for First Focus on Lessons from CHIP for Implementation of the Affordable Care Act with support from the California Health Care Foundation, the David and Lucile Packard Foundation, and Atlantic Philanthropies.

This brief draws on interviews with former federal and state officials and policy advocates who played important roles in the implementation of CHIP. In addition, Tricia Brooks, Carrie Fitzgerald, Joan Henneberry, Ian Hill, and Sandra Shewry provided very helpful comments on preliminary drafts of the brief. Kym Teppo helped with the research. Any remaining errors are the sole responsibility of the author.

REFERENCES AND NOTES

- ¹ Eugene Lewit, “CHIP Roll Out and Early enrollment Implications for the ACA,” First Focus (October 2013). Retrieved from: <http://www.firstfocus.net/sites/default/files/ACA%20Briefs%20-%20Enrollment%20Trends.pdf>. Eugene Lewit, “Successfully Navigating the CHIP State-Federal Relationship and Challenges to State Implementation,” First Focus (February 2014). Retrieved from: <http://www.firstfocus.net/sites/default/files/ACA%20Briefs%20-%20Federal-State.pdf>.
- ² Michael Perry et al., “Marketing Medicaid and CHIP: A Study of State Advertising Campaigns,” Kaiser Commission on Medicaid and the Uninsured (October 2000). Retrieved from: <https://kaiserfamilyfoundation.files.wordpress.com/2000/10/2213.pdf>.
- ³ Susan R. Williams and Margo L. Rosenbach, “Evolution of State Outreach Efforts Under SCHIP,” *Health Care Financing Review* 28, no. 4 (Summer 2007). Retrieved from: <http://www.mathematica-mpr.com/publications/pdfs/evolutionstate.pdf>.
- ⁴ Ian Hill, “Charting New Courses for Children’s Health Insurance,” *Policy and Practice of Public Health Services*, 58(4) (December 2000), 30-38.
- ⁵ Ian Hill, Corinna Hawkes and Mary Harrington, “Final Cross-Cutting Report on the Findings from Ten State Site Visits: Congressionally Mandated Evaluation of SCHIP,” Mathematica Policy Research (December 2003). Retrieved from: <http://www.mathematica-mpr.com/publications/PDFs/schipcongresstenstate.pdf>.
- ⁶ Donna Cohen Ross and Ian Hill, “Enrolling Eligible Children and Keeping Them Enrolled,” *The Future of Children*, Vol. 13, Number 1, (Spring 2003).
- ⁷ Genevieve Kenney, Allison Cook and Lisa Dubay, “Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children?” *Timely Analysis of Immediate Health Policy Issues* (December 2009). Retrieved from: <http://www.urban.org/publications/411981.html>.
- ⁸ Surveys of parents spanning the 15 period since the enactment of CHIP in 1997 show that while knowledge of the program and Medicaid has increased, misperceptions about eligibility and lack of knowledge about how to apply remain barriers for many eligible low income children.
- ⁹ Michael Perry, “Parent’s Views of CHIP and Medicaid: Topline of Findings from a Survey of Low-Income Parents,” (November 2011). Retrieved from: <http://insurekidsnow.gov/professionals/CHIP-Medicaid-Survey-Topline.pdf>.
- ¹⁰ “Medicaid/CHIP Participation Rates.” Retrieved from: <http://www.insurekidsnow.gov/professionals/reports/index.html>.
- ¹¹ Genevieve Kenney et al., “Medicaid/CHIP Participation Rates Among Children and Parents,” Urban Institute (December 2012) Retrieved from: <http://www.urban.org/publications/412719.html>.
- ¹² Ibid.
- ¹³ Ibid. 7.

OUTREACH, ENROLLMENT AND RETENTION – IMPLICATIONS FOR THE ACA

- ¹⁴ Eugene Lewit, “Successfully Navigating the CHIP State-Federal Relationship and Challenges to State Implementation,” *First Focus* (February 2014). Retrieved from: <http://www.firstfocus.net/sites/default/files/ACA%20Briefs%20-%20Federal-State.pdf>.
- ¹⁵ Cathy Kauffman, interview with author, March 31, 2014.
- ¹⁶ Leslie Foster, Adam Dunn, and Maggie Colby, “Health-e-App Public Access: A New Online Path to Children’s Health Care Coverage in California: Findings From HeA PA and Implications for ACA Implementation,” *Mathematica Policy Research* (October 2013). Retrieved from: <http://www.mathematica-mpr.com/Health/health-e-app.asp>.
- ¹⁷ Maggie Colby, “Health-e-App Public Access: A New Online Path to Children’s Health Care Coverage in California. Outreach to Low-Income Families During the First Year of HeA PA,” *Mathematica Policy Research* (May 2013). Retrieved from: http://www.mathematica-mpr.com/publications/PDFs/Health/Health_E_App_ib5.pdf.
- ¹⁸ *Ibid.* 9.
- ¹⁹ Genevieve Kenney, Jennifer Halper, and Frank Ullman, “Most Uninsured Children Are in Families Served by Government Programs,” *Urban Institute* (December 2000). Retrieved from: <http://www.urban.org/publications/309302.html>.
- ²⁰ Nonetheless, schools over the years have been popular venues for outreach to expand children’s coverage, with a focus increasingly on outreach campaigns during the back to school period in late summer and early fall.
- ²¹ A more recent Urban Institute report published in 2007, <http://www.urban.org/publications/411981.html>, found that despite the substantial reduction in the number of uninsured children since the first report was released, 66% of low-income families with uninsured children participated in other means-tested public programs. Free and reduced school lunch still had the highest rate of participation (53%), followed by WIC (32%), Food Stamps (16%) and disability (13%) (not included in the 2000 report).
- ²² Sheila Hoag et al., “CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings,” *Mathematica Policy Research* (December 2013). Retrieved from: http://mathematica-mpr.com/publications/pdfs/health/ELE_fnlrpt.pdf.
- ²³ Interestingly, although the data show that uninsured low-income children are much more likely to be in families participating in free and reduced school lunch than in SNAP, only one of the eight states included in the evaluation used school lunch information in their ELE initiatives, while six states used information from SNAP.
- ²⁴ Maureen Hensley-Quinn, Mary Henderson and Kimm Mooney, “State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future,” (December 2012). The Robert Wood Johnson Foundation: State Health Assistance Network.
- ²⁵ Joint Legislative Audit and Review Committee of the Virginia General Assembly, “A Review of Selected Programs in the Department of Medical Assistance Services” (January 2002), (January 2002). Retrieved from: <http://jlarc.virginia.gov/reports/Rpt275.pdf>.
- ²⁶ Benjamin D. Sommers, “From Medicaid to Uninsured: Drop-Out Among Children in Public Insurance Programs,” *Health Services Research* 40.1 (2005): 59-78. 3.
- ²⁷ Kate Lewandowski, “Churn Toolkit: Policy Approaches to Reducing Churn,” *Community Catalyst* (March 2014). Retrieved from: <http://www.communitycatalyst.org/resources/publications/body/policy-approaches-to-reducing-churn.pdf>.
- ²⁸ Trish Riley et al., “Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment,” *National Academy of State Health Policy* (February 2002). Retrieved from: http://nashp.org/sites/default/files/SCHIP_lose_or_leave.pdf.
- ²⁹ Ian Hill and Amy Westfall Lutzky, “Is there a Hole in the Bucket? Understanding SCHIP Retention,” *The Urban Institute* (May 2003). Retrieved from: http://www.urban.org/UploadedPDF/310792_OP-67.pdf.
- ³⁰ Tricia Brooks, “The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP,” *Georgetown University Health Policy Institute* (February 2009). Retrieved from: <http://ccf.georgetown.edu/wp-content/uploads/2012/04/The-Louisiana-Experience.pdf>.
- ³¹ *Ibid.* 25.
- ³² Beth Morrow and Julia Paradise, “Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges,” *The Henry J. Kaiser Foundation* (August 2010). Retrieved from: http://www.nastad.org/Docs/090434_8090.pdf.
- ³³ Ian Hill, Brigitte Courtot and Margaret Wilkerson, “Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act,” *The Robert Wood Johnson Foundation* (October 2013). Retrieved from: <http://www.urban.org/UploadedPDF/412917-Reaching-and-Enrolling-the-Uninsured.pdf>.
- ³⁴ Jocelyn Guyer, Tanya Schwartz and Samantha Artiga, “Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion,” *Kaiser Commission on Medicaid and the Uninsured* (November 2013). Retrieved from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf>.
- ³⁵ In addition, within a year, states need to evaluate fast track enrollees using the new Medicaid income eligibility rules.

OUTREACH, ENROLLMENT AND RETENTION – IMPLICATIONS FOR THE ACA

³⁶ Ibid, 34.

³⁷ Quoted in Jocelyn Guyer et al., 34

³⁸ Martha Heberlein et al., “Medicaid Coverage for Parents Under the Affordable Care Act,” Center for Children and Families at Georgetown University (June 2010). Retrieved from: <http://ccf.georgetown.edu/wp-content/uploads/2012/08/Medicaid-Coverage-for-Parents.pdf>.

³⁹ Center for Children and Families, Georgetown University Health Policy Institute, “Medicaid Expansion: Good for Parents and Children,” (January 2014). Retrieved from: <http://ccf.georgetown.edu/wp-content/uploads/2013/12/Expanding-Coverage-for-Parents-Helps-Children-2013.pdf>.

⁴⁰ David Goren, “More than One Million Latinos Enrolled in Exchange or Medi-Cal in Six Months,” California Healthline, (April 18, 2014). Retrieved from: <http://www.californiahealthline.org/capitol-desk/2014/4/more-than-one-million-latinos-enrolled-in-exchange-or-medical-in-six-months>.