Center for American Progress Action Fund

AP PHOTO/RICH PEDRONCELLI

Opening the "Front Door" of a Reformed Health Care System

Six Lessons from Medicaid on Promoting Participation in Health Coverage

Victoria Wachino and Karen Davenport August 2009

Center for American Progress Action Fund

Opening the "Front Door" of a Reformed Health Care System

Six Lessons from Medicaid on Promoting Participation in Health Coverage

Victoria Wachino and Karen Davenport August 2009

Introduction

Achieving the goals set by most major health care reform proposals will require eligible, uninsured Americans to enroll in health care coverage. The process of signing up for health coverage will be many Americans' first contact with the new health care system and will shape their initial impressions of it. It is a crucial step because improving quality, managing chronic disease, and controlling costs hinge on enrolling people and maintaining coverage so they can access needed care, and so that providers and insurers can manage that care. And if health care reform includes a requirement that all individuals obtain health insurance, promoting participation will help people obtain coverage and avoid any penalties that may be imposed if they fail to do so.

Congress and the Obama administration can draw on more than a decade's experience increasing participation in the Medicaid program—the federal/state health and long-term care program for low-income people—as they build the "front door" through which people enter a new health care system. State and the federal government efforts have focused on increasing enrollment of eligible children in Medicaid and the Children's Health Insurance Program, which together currently cover nearly 45 million children, as well as ensuring Medicaid participation by other eligible groups.

Efforts to boost enrollment have been successful: participation has grown from 66 percent to 78 percent of Medicaid and CHIP-eligible children, and overall Medicaid participation rates are higher than those of many other means-tested programs.[1] Under health care reform, though, participation rates will need to be substantially higher to help people comply with coverage mandates. More work remains to be done, but Medicaid's experience offers important lessons about what works and what does not work in promoting participation in health coverage.

Most of the major health care reform proposals under consideration in Congress envision three layers that will provide health coverage, within an overall approach that is likely to require both individuals to obtain and employers to provide health insurance. The first layer generally covers the lowest-income Americans by offering Medicaid to people who are currently eligible, as well as expanding coverage to some people who are currently not eligible. The second layer provides subsidies to uninsured people of modest means with incomes above the proposed Medicaid eligibility levels. These individuals would purchase insurance through a common purchasing mechanism referred to as an "exchange" or "gate-

way" in most proposals. CHIP may provide coverage to some children in this group. The third layer is a reformed version of the nation's current system of employer-based coverage, potentially including a requirement that employers offer coverage. Medicaid's experience promoting enrollment applies primarily to the layers of the new system that serve low-income people: expanded Medicaid coverage of the lowest income groups and subsidized coverage in the exchange.

Many of the health care reform proposals under discussion in Congress contemplate linking the process of enrolling in coverage with selecting an insurance plan through the exchange. Yet it can be challenging to provide beneficiaries with information that clearly explains that they must choose a plan, illustrates differences between plans, and provides accurate information about participating providers.[2] Presenting information so that consumers can make informed decisions is not addressed in this paper but is likely to be a significant challenge in implementing any health care reform plan.

Medicaid's experience yields six key lessons on ways that policy design, enrollment processes, and outreach can promote participation in a reformed health care system:[3]

1. Eligibility structures must be uniform and simple to understand.
2. Different coverage "layers" should work together seamlessly.
3. The application and enrollment process should minimize the burden on applicants.
4. The renewal process must be simplified.
5. Marketing should be used to help build public awareness of new programs, but is not enough to sustain participation gains.
6. Hands-on outreach and assistance is critical, especially for low-income populations.

1. Eligibility structures must be uniform and simple to understand

Simple eligibility structures are easier for people to understand and help promote participation. Medicaid eligibility, which varies by state, has historically required an individual to qualify under one of many different eligibility categories, some of which are quite narrow. This complex mix of rules regarding a person's family structure, age, disability status, and income level creates confusion and leads to underenrollment. It also places administrative burdens on families and governments. Parents of children who are eligible for Medicaid or CHIP but are not insured often describe being uncertain about whether or not their children are eligible for coverage.[4] More than 40 percent of parents in one survey reported that they did not apply for coverage on behalf of their children because they were not aware of the programs, did not think their children qualified, did not have enough information about the program, or faced bureaucratic obstacles.[5]

Broadening eligibility beyond traditional narrow eligibility categories increases participation among people who were already eligible for coverage prior to a coverage expan-

sion.[6] The clearest example of this occurred after CHIP implementation began in 1997, when enrollment of already-eligible children in Medicaid increased substantially.[7] Since then, enrollment of previously eligible children has grown in a number of states that have expanded children's coverage. Illinois, for example, implemented a program in 2005 covering all children in the state, and has credited its ability to convey a universal message that *all* children are eligible for health coverage as being central to its success in enrolling kids. About 70 percent of children who enrolled in the program after the Illinois coverage expansion were already eligible for Medicaid or CHIP under the pre-existing eligibility rules but had not enrolled.[8]

The Medicaid experience also suggests that having all members of a family enrolled in the same insurance program promotes participation. Complex eligibility rules currently mean that different children in the same family can be eligible and ineligible for public coverage, or enrolled in two different programs—one in Medicaid, the other in CHIP. This contributes to family confusion about eligibility policies and puts administrative burdens on families, depressing enrollment. A June 2009 study found that this complexity discourages eligible people from enrolling: States with more complex Medicaid and CHIP eligibility structures have significantly higher rates of uninsured, eligible children.[9] Simpler, broader coverage has the opposite effect: a significant body of research shows that expanding health coverage to parents, for example, can increase enrollment among already-eligible children in Medicaid and CHIP.[10]

Implications for health care reform

Creating simple, uniform eligibility thresholds under health care reform would convey a clear public message about who is eligible for coverage, which would promote enrollment. Simple, uniform eligibility rules reduce the likelihood of misunderstanding and uncertainty about whether or not a person qualifies for coverage. They are also easier and less costly for states and the federal government to administer. This applies to subsidies as well as direct coverage: Creating simple-to-understand rules about the qualifications that people must meet to obtain a subsidy to purchase coverage will promote enrollment. An individual mandate will also clearly be a powerful incentive for people to obtain coverage.

In contrast, having a number of narrow eligibility categories creates structures that are difficult to navigate, cause confusion on the part of the target population, impose unnecessary administrative burdens, and reduce enrollment. The number of different eligibility categories should therefore be minimized or eliminated, potentially by establishing a single, clear income threshold that would operate across states, replacing the current, wide variation in state eligibility policies. Keeping family members together in the same program is also crucial to promoting enrollment.

2. Different coverage "layers" should work together seamlessly

The different components of coverage in health care reform may operate relatively autonomously, but their eligibility systems should work together seamlessly. People need to see and experience a unified enrollment process, especially between public and subsidized exchange coverage, instead of being required to navigate separate pathways into and out of each coverage component.

Medicaid and CHIP provide insight into the challenges posed by requiring individuals to navigate different programs. Most states have separate Medicaid and CHIP programs, and children often fall between the cracks that these different rules create, especially in states where Medicaid and CHIP establish different sets of eligibility rules and schedules. Families may apply for one program but be eligible for the other; children whose family income changes may need to move between one program and the other; and children's eligibility rules change as they age, meaning that some children move from Medicaid to CHIP as they grow up. Different Medicaid and CHIP application and renewal processes, rules, and requirements—such as requiring families to separately apply to each program, rather than automatically transferring a family's application from Medicaid to CHIP or vice versa when they are initially denied coverage—mean that children sometimes fail to obtain the coverage they need, or erroneously lose coverage although they remain eligible for it.

Ensuring that separate programs work in a unified manner is central to enrolling eligible people, although recent evidence suggests that unifying processes across separate programs is not as effective as having a unified, easy to understand program in the first place.[11] Nearly 90 percent of states with separate Medicaid and CHIP programs now use one application for both programs.[12] States have also moved toward making the two programs' eligibility rules consistent.

A federal "screen and enroll" requirement would require states to screen all children who apply for CHIP for Medicaid eligibility and enroll a child in Medicaid if that child is determined to be eligible for it. This would ensure that all eligible children receive Medicaid's benefits and cost-sharing protections.[13] In contrast, the recent implementation of the Medicare outpatient drug benefit demonstrates the issues that can arise when misaligned program eligibility rules inhibit coordination, resulting in lost opportunities to enroll eligible individuals. Part D's different income thresholds, income determination methodologies, and asset tests made it extremely difficult for the Social Security Administration and state eligibility offices to "screen and enroll" elderly and disabled individuals between the Part D "Extra Help" benefit and the Medicare Savings Programs.[14]

Virginia recently implemented a policy to better integrate Medicaid and CHIP eligibility. The state offers multiple entry points for people seeking to enroll their children in health coverage. Virginia's "No Wrong Door" policy allows applicants for Medicaid and CHIP to submit one application for either program at eligibility locations that have historically

served just one of the two programs. When this change and other simplifications took effect, Virginia's quarterly enrollment increased 43 percent.[15] The federal government could apply and extend a program like Virginia's No Wrong Door approach by allowing people to apply for coverage at many different locations, including provider offices, libraries, unemployment offices, and motor vehicle departments.[16] People will want the ability to apply through several different methods, such as applying online, over the phone, through mail in applications, or through applications submitted in person, including to application assistors working on site at different locations.[17]

Unifying eligibility processes is likely to be even more important—and challenging—in a reformed health care system than it has been in Medicaid and CHIP. The new system will probably cover many more adults than Medicaid and CHIP now cover, and adults are more likely to experience instability in coverage. The working poor and individuals whose jobs are not steady are especially likely to have changing incomes, which drives movement from one part of the coverage system to another.[18]

It will be critical to coordinate program eligibility policies, including application processes, rules regarding how income and assets are treated, and renewal timing between public programs and subsidies for exchange coverage. A degree of coordination will need to take place with employer coverage, as well. The need for coordination should inform the decision about whether one or several entities perform eligibility determinations, as well as the selection of what organization or organizations will determine eligibility.

Implications for health care reform

Separate, related coverage components—such as Medicaid and subsidized coverage through the exchange—should operate as seamlessly as possible from the standpoint of people trying to navigate the programs. Seamlessness includes ensuring that the programs' eligibility ground rules are the same—especially rules about how income is counted in determining eligibility. Aligning rules for coverage subsidies and Medicaid will help minimize confusion. Seamlessness should also apply to the enrollment process, minimizing the need for people to navigate between Medicaid and subsidized Exchange coverage.

A key component of a seamless system is using one simple, unified application that eligibility agencies can employ to determine which type of coverage an applicant is eligible for. Massachusetts' use of a single application form for several different programs in its health care reform plan, for example, helped promote enrollment growth.[19] Making sure that people who are not eligible for Medicaid coverage are automatically redetermined for subsidized exchange coverage—and vice versa—could also prevent unnecessary coverage losses. Establishing "No Wrong Door" policies that encourage people to apply for public or exchange coverage at the same time at convenient locations can promote enrollment by avoiding having people try to determine on their own which program they are eligible for and where to go to enroll.

3. The application and enrollment process should minimize the burden on applicants

The experience in Medicaid and CHIP over more than a decade clearly demonstrates that making the application process easy for beneficiaries to navigate is critical to promoting program enrollment. Many states have reduced the complexity of the application and enrollment process for children and families. Their experience demonstrates that these programs can increase enrollment by simplifying and clarifying application forms, minimizing income documentation requirements, eliminating asset tests, presumptive eligibility, and permitting remote rather than in person application. Many of these strategies also reduce administrative costs. Medicaid and CHIP's history also demonstrate that charging low-income families premiums depresses enrollment[20].

Georgia, for example, experienced significant enrollment growth after it began accepting applications through both mail and the Internet, allowed beneficiaries to self-attest their income, improved coordination between Medicaid and CHIP, and simplified the renewal process.[21] Eligible people have conversely lost coverage when states have made enrollment and renewal policies more restrictive. For example, 150,000 children in Texas lost coverage after the state made its CHIP enrollment and renewal practices more restrictive in 2003.[22] States can also realize administrative savings from simplification efforts, like Oklahoma did after it stopped requiring people applying for Medicaid coverage to meet an asset test.[23]

Some states are also making significant progress toward using electronic applications and automating the enrollment process. Many states make applications available online, and a small but growing number can process applications electronically. The growing use of electronic enrollment and renewal has simplified the process for beneficiaries, generated administrative savings for states, and helped make it more likely that beneficiaries receive care in appropriate settings.[24]

Automated enrollment is a longstanding practice in Medicare. States are moving toward deeming individuals eligible for Medicaid by using information from other means-tested programs, such as the supplemental nutrition assistance program and the National School Lunch Program, or state tax records, though this approach is still emerging.[25] States more frequently use databases and data sharing technology to verify eligibility elements, minimizing burdens on people applying for coverage. The CHIP reauthorization law recognizes the success of simplification efforts and the potential of using new processes such as automated enrollment by providing new flexibility to states that adopt them, coupled with performance incentives for states that use them to increase children's enrollment.

The entity or entities that enroll people in health coverage under a reformed health care system must make enrolling all eligible people in health coverage a primary goal, and ensure that its organizational culture thoroughly supports enrollment. Louisiana provided extensive orientation to its eligibility caseworkers to emphasize the importance of provid-

ing health coverage and made caseworkers accountable for promoting enrollment and renewal of coverage.[26] Some states are moving away from organizational cultures that focus on keeping ineligible people out of coverage and toward cultures that promote helping all eligible people get the coverage they need.

Implications for health care reform

The health care reform enrollment process should employ simple, clear applications that minimize burdens on people applying for coverage and subsidies. Requirements to document income, assets, and citizenship should be kept to the minimum needed to ensure eligibility, and technology should be used to modernize and simplify verification. Employing online applications and automatic enrollment processes can make applying for Medicaid coverage easier and could help people apply for subsidized coverage.

The agency that is charged with enrolling people in health care coverage also needs to establish clear coverage goals and ensure that its organizational culture and processes support them. That means adopting personnel practices—from staff orientation and education to pay and promotion criteria—that reward staff for successfully enrolling and retaining the population that the program aims to serve. Finally, the organizations responsible for enrollment will need sufficient resources to handle what may be a very high volume of applications as health care reform is implemented.

4. The renewal process must be simplified

Once people are enrolled in health coverage, it is essential that they maintain that coverage for as long as they are eligible. Having people "churn" on and off of health coverage will frustrate broad health care reform goals of improving quality, managing chronic disease, promoting prevention, and controlling costs. It is difficult for insurers and providers to manage care and measure quality when people lose coverage, even if they regain it within a short time period.[27] The government and providers also incur additional costs when people churn off and on coverage.[28]

Renewal processes should support a broad goal of making coverage stable. Failing to design renewal processes to promote continuous coverage can leave insurance programs vulnerable to backdoor coverage losses. Some states have found, for example, that most children who lose Medicaid and CHIP coverage over the course of a year subsequently re-enroll.[29] When Washington state restricted renewal policies for its Children's Medical Program in 2003, enrollment fell by more than 30,000 children. But children's enrollment rebounded to previous levels when the state reinstated simplified renewal policies.[30] More than four in ten children nationwide who are eligible for, but unenrolled in, Medicaid and CHIP were enrolled in one of these two programs during the previous year.[31] Most children who lose coverage do so for procedural reasons, not because their eligibility has changed.

Recognizing the risk of significant falloff in coverage during the renewal process, one third of all states guarantee children one year of continuous eligibility regardless of changes in family income in Medicaid and more than half do so in CHIP. Continuous eligibility and annual coverage renewals have helped increase enrollment of eligible children.[32] Some states have also made the Medicaid and CHIP renewal process easier for families by providing for "administrative" renewal, which minimizes the need for beneficiaries to supply new information at renewal. Pennsylvania ensures that information transfers automatically between Medicaid, CHIP, and a health program for low-income adults at application and when an individual loses eligibility for one of the three programs, which promotes continuous coverage between programs.[33]

Implications for health care reform

Minimizing the burdens that the renewal process places on individuals—including reducing the frequency of renewals, limiting documentation requirements, and automating the renewal process—will promote continuous coverage. Coordinating renewals between different coverage components in the health care reform system can prevent loss of coverage, as some people are likely to move back and forth between employer coverage, subsidies for purchasing coverage through the Exchange, and public programs. Establishing a single annual enrollment or renewal period across programs, automating and sharing renewal information across programs, and using a single renewal application that could be, like the initial application, submitted at one of many locations, would help promote coordination.

5. Marketing should be used to help build public awareness of new programs, but is not enough to sustain participation gains

Marketing can promote awareness of programs among the public, stakeholders, and policymakers. This should include advertising, promotional materials, and public education campaigns. Building public awareness of programs is key: A 2003 survey of Medicare beneficiaries showed that nearly 80 percent of low-income seniors who were eligible for—but not enrolled in—targeted programs that provide Medicaid coverage to pay for required Medicare premiums and cost-sharing were not aware that the programs existed.[34] People who have recently lost their jobs as a result of the recession, making them or their family members newly eligible for Medicaid or CHIP, have also reported that they were not aware that they might qualify for these programs.[35]

States, the federal government, and outside organizations employed marketing as CHIP was implemented in the late 1990s to build public awareness and understanding of the new program. Evidence is mixed regarding the effect of marketing on increasing participation in Medicaid and CHIP. Some states reported that marketing helped increase enrollment, but some evaluations found that there is limited evidence that marketing increased

program participation.[36] States marketed the program to build public awareness during the early years of implementation, but moved away from marketing as the program matured and toward more intensive, community-based outreach and application assistance.[37] This suggests that marketing may be most effective at the outset of a new program, but that its effectiveness may diminish over time relative to community-based assistance. There is clear evidence, however, that establishing broad, easily understood eligibility criteria helps market programs and enroll eligible people. It is difficult to market narrow, confusing eligibility categories.

Implications for health care reform

Despite mixed evidence, marketing a new national health care program may help increase public awareness of it, especially at the program's inception. Massachusetts launched a significant effort to publicize its reform plan as it was implemented, driven in part by a firm, shared commitment to promote coverage by the state, providers, and consumer groups. Enrollment in Massachusetts' health care reform plans was dramatic in the months following health care reform implementation, though the degree to which this enrollment surge can be attributed to marketing and public education is not clear. Establishing easily understood eligibility rules is vital to helping market public programs. Although any returns from marketing programs may diminish over time as programs mature. Sustaining participation over time requires additional interventions, including outreach.

6. Hands-on outreach and assistance is critical, especially for low-income populations

Hands-on, community-based assistance to help people understand public programs and apply for coverage is an established means of increasing participation in Medicaid and CHIP. Community groups, schools, and providers have helped people navigate the enrollment process in Medicaid and CHIP.[38] States like California and Illinois have employed paid application assistors to help families understand and complete application and renewal forms; this assistance has helped families successfully complete applications and enroll in coverage.[39] In Boston, a broader case management approach for uninsured Latino children that began in 2002 increased the probability that participating families enrolled in the Medicaid and CHIP programs from 57 percent to 96 percent by 2004.[40]

Application assistance has also helped low-income seniors enroll in "Medicare Savings Programs," through which Medicaid pays Medicare premiums and cost sharing for some low-income Medicare beneficiaries.[41] Community-based application assistance helps some beneficiaries navigate the application process, surmount language or cultural barriers, and overcome any sense of distrust on the part of potential beneficiaries. It can be especially important in helping to enroll minority populations, people with limited English profi-

ciency, and immigrant groups. Community-based organizations with experience working with target populations were central to Illinois' success enrolling children in its universal children's insurance program.[42] Seniors enrolled in Medicaid and organizations that promote enrollment in the Medicare Discount Drug Card both emphasized the importance of having personal assistance with the enrollment process for these two programs.[43]

Implications for health care reform

Hands-on outreach and application assistance performed by trusted community organizations, including sufficient funding dedicated to these activities, will be needed to help people apply for and enroll in health coverage and to navigate the process of applying for subsidies. Assistance will be especially important for promoting enrollment of people with very low incomes and members of minority populations.[44] Community-based outreach played a key role in implementing health care reform in Massachusetts as part of a strategy that made sure on-the-ground community assistance translated broader marketing efforts into actual enrollment.[45] Hands-on assistance should supplement other methods of increasing participation, such as marketing campaigns, and should be ongoing rather than time-limited. If under health care reform individuals are asked to select plans when they enroll in coverage, as is the case in Massachusetts, community-based assistance could be designed to support people with both enrollment and plan selection.

Conclusion

Very high enrollment in a range of insurance options will be crucial to the federal government meeting the coverage, quality, and cost goals set out by any health reform legislation. Medicaid's experience promoting enrollment for more than a decade demonstrates that no single approach can work alone. Instead, a range of strategies that work together to minimize burdens on families—simplified application processes, renewal requirements that promote continuous coverage, providing intensive outreach and assistance by trained and trusted community organizations, and program marketing—can effectively promote participation in health coverage.

Two policies must underpin these strategies. First, the agency that enrolls people in coverage must commit to successfully enrolling people in coverage through staff education and performance incentives. Second, the different programs that provide health coverage must work closely and deliberately in concert so that they appear as one seamless, unified program to people applying for coverage.

Endnotes

1 Jocelyn Guyer and Dawn Horner, "The Last Piece of the Puzzle: Providing High-Quality, Affordable Health Coverage to All Children Through National Health Reform" (Washington: Georgetown University Health Policy Institute Center for Children and Families, May 2009); Robert Nelb, "Effortless Enrollment: Using Existing Information to Automatically Enroll Families in Medicaid and SCHIP" (Washington: Brookings Institution Hamilton Project, May 2009).

2 See Joan Alker and Jack Hoadley, "Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes," "Jesse Ball Dupont Fund, May 2007; and Samantha Artiga, "Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status," "Kaiser Family Foundation, October 2008.

3 Much of the evidence supporting the lessons laid out in this paper was presented in Victoria Wachino and Alice Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children," National Academy of State Health Policy, February 2009.

4 Julia Paradise and others, "Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage," "Kaiser Family Foundation, January 2009; Michael Perry and Julia Paradise, "Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Families," Kaiser Family Foundation, May 2007.

5 Genevieve Kenney and Jennifer Haley, "Low-Income Uninsured Children With Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?" *Pediatrics*, 119, no. 1 (2007).

6 Maureen Hensley-Quinn, "On the Spot with Illinois: Working Toward Reaching and Enrolling All Children and Adolescents," National Academy of State Health Policy, October 2008; Arjun and Guyer, "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children."

7 Margo Rosenbach and others, "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report," "Mathematica Policy Research, 2007.

8 Arjun and Guyer, "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children.".

9 Julie Hudson, "Families with Mixed Eligibility for Public Coverage: Navigating Medicaid, CHIP, And Underinsurance," *Health Affairs*, 28(4) (2009), w697-w709.

10 Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *Health Services Research* 38, no, 5 (Fall 2003) 1283-1302; Leighton Ku and Matthew Broaddus, "Coverage of Parents Helps Children, Too" (Washington: Center on Budget and Policy Priorities, October 2006).

11 Hudson, "Families with Mixed Eligibility for Public Coverage: Navigating Medicaid, CHIP, And Underinsurance,"

12 Donna Cohen Ross and Caryn Marks, "Challenges of Providing Health Coverage to Children and Parents in a Recession: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing in Medicaid and SCHIP in 2009" (Washington: Kaiser Family Foundation, January 2009).

13 Donna Cohen Ross and Ian Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 12, no. 1, (2003).

14 Laura Summer, Testimony before the Special Committee on Aging, United States Senate, May 22, 2008, available at http://aging.senate.gov/events/hr195ls.pdf; Medicare Rights Center, Letter to Jo Ann Barnhart, May 3, 2005, available at http://www.medicarerights.org/pdf/ImprovingPartDLowIncomeSubsidy.pdf. http://www.medicarerights.org/pdf/ImprovingPartDLowIncomeSubsidy.pdf

15 Embry Howell and others, "Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice," Covering Kids and Families Final Evaluation Report for The Robert Wood Johnson Foundation, July 2006.

16 Guyer and Horner, "The Last Piece of the Puzzle: Providing High-Quality, Affordable Health Coverage to All Children Through National Health Reform."

17 Paradise, "Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage."

18 Laura Summer and Cindy Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies" (Washington: The Commonwealth Fund, June 2006).

19 John E. McDonough and others, "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* 27(4) (2008) w285-w296.

20 Genevieve Kenney and others, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003" *Inquiry* 43 no. 4 (Winter 2006/2007): 345-361.

21 Wachino and Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children.".

22 Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage to Children and Families," "Kaiser Family Foundation, October 2004.

23 Vernon K. Smith and others, Eliminating the Medicaid Asset Test for Families: A Review of State Experiences (Washington: Kaiser Family Foundation, April 2001).

24 Beth Morrow, "Emerging Health Information Technology for Children in Medicaid and SCHIP Programs," The Children's Partnership and Kaiser Commission for Medicaid and the Uninsured, November 2008; and Beth Morrow with Dawn Horner, "Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices," The Children's Partnership and Kaiser Commission for Medicaid and the Uninsured, May 2007.

25 Stan Dorn, "Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP" (Washington: The Urban Institute, National Academy for State Health Policy, and Robert Wood Johnson Foundation, April 2009).

26 Summer and Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies."

27 Ibid.

28 Ibid.

29 Ibid.

30 Ibid.

31 Benjamin Sommers, "Why Millions of Children Eligible for Mediciad and SCHIP Are Uninsured: Poor Retention Versus Poor Take-up," *Health Affairs* 26 (5) (September/October 2007).

32 Rosenbach and others, "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report"; and Angela Merrill and Margo Rosenbach, "SCHIP and Medicaid: Working Together to Keep Low-Income Children Insured," (Mathematica Policy Research, 2006).

33 Morrow, "Emerging Health Information Technology for Children in Medicaid and SCHIP Programs."

34 Susan G. Haber and others, "Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Beneficiary (SLMB) Programs," Centers for Medicare and Medicaid Services, October 2003.

35 Michael Perry and others, "Turning to Medicaid and CHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees" (Washington: Kaiser Family Foundation, December 2008).

36 For a more comprehensive discussion of the evidence regarding marketing's impact, see Wachino and Weiss, 2009, pp. 36-38.

37 Rosenbach and others, "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report.".

38 Perry and others, "Turning to Medicaid and CHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees."

39 Jennifer Kinchloe and E. Richard Brown, "The Effect of County Outreach Environments on Family Participation in Medi-Cal and Healthy Families" (UCLA Center for Health Policy Research, July 2007); Hensley-Quinn, October 2008.

40 Glenn Flores and others, "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116(6) (December 2005).

41 Laura Summer, "Increasing Participation in Benefit Programs for Low-Income Seniors" (The Commonwealth Fund, May 2009).

42 Hensley-Quinn, "On the Spot with Illinois: Working Toward Reaching and Enrolling All Children and Adolescents."

43 Ibid.

44 Hensley-Quinn, "On the Spot with Illinois: Working Toward Reaching and Enrolling All Children and Adolescents,"; Flores and others, "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children"; Perry and Paradise, "Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Families."

45 McDonough and others, "Massachusetts Health Reform Implementation: Major Progress and Future Challenges."

The Center for American Progress Action Fund transforms progressive ideas into policy through rapid response communications, legislative action, grassroots organizing and advocacy, and partnerships with other progressive leaders throughout the country and the world. The Action Fund is also the home of the Progress Report and ThinkProgress.

Center for American Progress Action Fund

1333 H STREET, NW, 10TH FLOOR, WASHINGTON, DC 20005 • TEL: 202-682-1611 • FAX: 202-682-1867 • WWW.AMERICANPROGRESSACTION.ORG