Eligible but Not Enrolled: How SCHIP Reauthorization Can Help

Timely Analysis of Immediate Health Policy Issues
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Summary

More than six in 10 uninsured children qualify for Medicaid or the State Children's Health Insurance Program (SCHIP) but are not enrolled.[1] Although controversy surrounds many aspects of SCHIP reauthorization, leaders across the political spectrum agree on the need to cover these children.

Achieving that goal may not be easy. Child health coverage programs now reach 79 percent of their target population—more than any other traditional, means-tested program.[2] Since the enactment of SCHIP in 1997, states have intensively pursued a decade of outreach efforts and streamlining of application procedures, with positive results—but non-traditional methods may now be required to reach the remaining children who qualify for coverage but are not enrolled.

In recent years, Medicare has significantly exceeded traditional programs in covering a high percentage of individuals who qualify for need-based subsidies. Federal officials achieved this result through innovative strategies that provide low-income seniors with assistance based on data accessible to public agencies. Such strategies significantly reduce families' need to complete forms before obtaining help. For child health programs to move substantially beyond current enrollment levels, SCHIP reauthorization will need to offer states the flexibility to use similar data-driven methods like those Medicare now employs to help low-income seniors. Among additional required steps, SCHIP reauthorization will also need to provide enough federal resources to pay for coverage of eligible children.

The Importance and Challenge of Enrolling Uninsured, Low-Income Children Who Qualify for Health Coverage

More than six in 10 uninsured children qualify for Medicaid or SCHIP but are not enrolled. Most are low-income children who qualify for Medicaid.[3] Despite disagreement on many aspects of SCHIP reauthorization, leaders across the political spectrum have expressed a commitment to reaching these children.

Unfortunately, achieving this objective will not be easy. In 2005, the Government Accountability Office (GAO) concluded that no traditional, means-tested program enrolled more than 75 percent of eligible individuals (Figure 1). Since then, researchers at the Department of Health and Human Services (HHS) released new estimates indicating that Medicaid and SCHIP cover 79 percent of the combined programs' target population—namely, eligible children who lack private health insurance.[4]

Since the enactment of SCHIP in 1997, states have undertaken extensive outreach efforts[5] and substantially simplified the process of enrolling in child health coverage.[6] After a decade of this important work, child health programs appear to have reached the high-water mark for participation in traditional, need-based assistance. Using federal policy to move substantially beyond current levels may require non-traditional strategies.

Participation rates are limited despite substantial beneficiary desire for health coverage.[7] Any program that requires families to complete application forms and document eligibility will miss the eligible people who either do not apply or fail to complete the application process successfully. Many such people are found among almost all populations and with benefits of many different kinds. For example, with retirement savings accounts, only nine percent of eligible individuals enroll in individual retirement arrangements (IRAs) if they must select a fund, complete all required forms, and establish accounts on their own.[8] When an employer arranges a 401(k) retirement savings account and proffers forms that new employees must complete to enroll, 33 percent join. If new employees are placed in 401(k) accounts unless they complete forms to "opt out," 90 percent enroll.[9]

Innovative Enrollment Strategies Implemented by Medicare

To reach the remaining uninsured children who qualify for Medicaid and SCHIP, policy-makers may need to borrow strategies from other programs that have greatly exceeded traditional take-up rates through automatic enrollment mechanisms that largely or entirely dispense with the need for consumers to complete applications. As with default enrollment into 401(k) accounts, seniors have long been enrolled into Medicare Part B unless they complete forms opting out of coverage. As a result, 95.5 percent of eligible seniors participate.[10]

More recently, the Medicare Modernization Act of 2003 allowed

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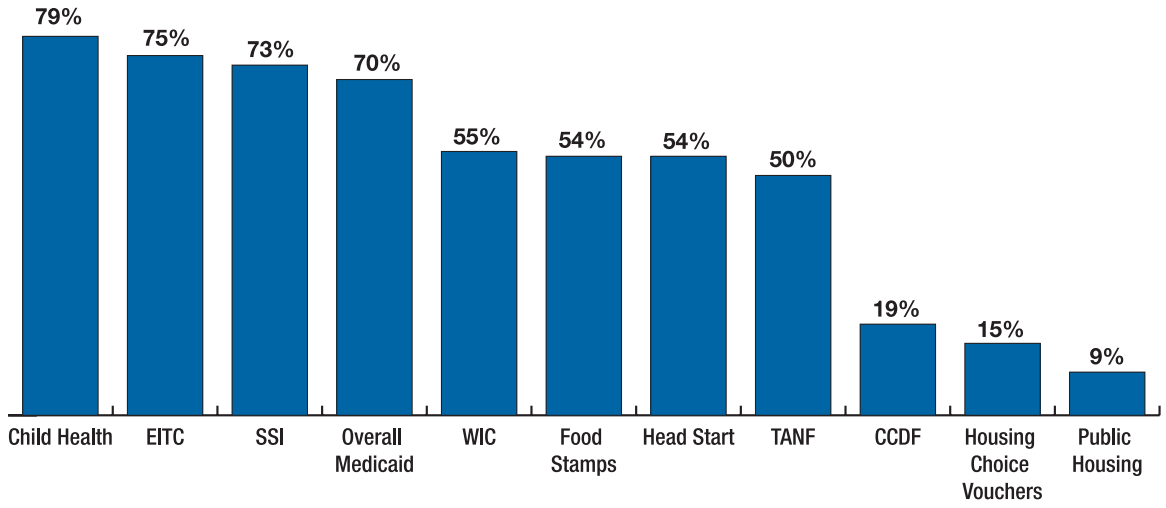
FIGURE 1: Participation Rates for Various Means-Tested Programs (Highest Population-Wide Estimate for Each Program)



Sources: Hudson and Selden 2007 for child health; GAO 2005 for the other programs.

Notes: (1) For most programs, GAO listed a range of participation estimates. This table shows the high end of each range. (2) For every program taken from the GAO analysis (i.e., for all programs except child health listed in the chart), GAO supplied the most recent estimates available in 2005, when the GAO report was published. (3) "Child health" means Medicaid and SCHIP coverage for children, excluding privately insured children from the pool of eligibles for purposes of calculating participation rates. (4) EITC is the Earned Income Tax Credit. (5) SSI is Supplemental Security Income. (6) WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. (7) TANF is Temporary Assistance for Needy Families. (8) CCDF is the Child Care and Development Fund.

Medicare to pursue enrollment strategies that use government-accessible data to determine eligibility, requiring application forms only when such data are insufficient. For example,

➤ Beginning this year, federal subsidies for Medicare Part B premiums are being means-tested, based on federal tax information two years in the past. As a result, *every Part B beneficiary obtains a default income determination and a corresponding premium subsidy*, without completing application forms. If income declined during the intervening years, beneficiaries can apply for larger subsidies. If income increased, subsidies are unaffected.

➤ Medicare beneficiaries receive automatic low-income subsidies (LIS) for Part D prescription drug coverage if they obtained Medicaid the previous year. As a result, less than six months after LIS began, 74 percent of eligible individuals received subsidies, predominately based on data matches with Medicaid agencies rather than new applications.[11] At comparable early points in their development, more traditional means-tested programs reached substantially lower proportions of eligible households. After two years, food stamps helped only 31 percent of eligible individuals, for example;[12] and after even five years, SCHIP (without access to Medicare-type innovative enrollment strategies) reached only 60 percent of eligible children.[13]

Medicare's recent success contrasts dramatically with earlier efforts to help low-income seniors. For decades, Medicare Savings Programs (MSPs) have helped pay Medicare premiums and out-of-pocket costs for low-income beneficiaries. However, MSPs require traditional applications with state Medicaid offices. As a result, fewer than 33 percent of eligible seniors enroll[14]—a participation rate substantially bested by recent Medicare innovations.

Adapting Medicare's Innovative Enrollment Methods to Children

To reach many more eligible children than in the past, Medicaid and SCHIP may need automatic enrollment methods like those employed by Medicare. For example, states could be allowed to enroll children, without requiring new application forms, so long as:

➤ Another means-tested program has already found that the family is poor or near-poor (so-called "express lane eligibility"); or

➤ Government-accessible information shows the family has low enough income for the children to qualify for Medicaid or SCHIP. Such information could include wage data from recent calendar quarters,[15] supplemented by older tax records showing other forms of income.[16]

Citizenship or satisfactory immigration status would also need to be documented. This could be done by providing intensive application assistance to help families gather documents and complete forms. Although this approach can be effective,[17] it is costly.[18] As a less expensive way to facilitate substantially increased enrollment of eligible children, citizenship and satisfactory immigration status could be shown electronically. Citizenship can often be demonstrated through data matching with birth certificate records and Social Security

records.[19] Citizenship and immigration status could likewise be demonstrated through "express lane eligibility," incorporating other agencies' findings made through federally mandated procedures[20] that apply to Medicaid, welfare, and certain other programs.[21]

Program Integrity and Administrative Efficiency

The National School Lunch Program (NSLP) uses similar auto-enrollment strategies, providing children with free lunches based on data matches with other benefit programs. This increases the number of eligible children who receive assistance while lowering operating costs and reducing the percentage of ineligible children who enroll.[22] Similar gains in efficiency and program integrity could result from the approaches discussed here.

Even if they strengthen program integrity, however, data-driven approaches to children's health insurance would indirectly cause several minor expansions in effective eligibility criteria:

➤ Even if another program has found that a child is poor enough to qualify for Medicaid or SCHIP, that program may use a different methodology for evaluating income, such as the definition of household. Disregarding such differences would have little impact on total eligibility, however. Among the most generous non-health benefits, several food programs help families with *gross* incomes up to 185 percent of the federal poverty level (FPL). SCHIP typically reaches at least 200 percent FPL in *net* income, which is calculated by deducting from gross income various work expenses, child support payments, etc. Few if any families will be found (a) by nutrition programs to have *gross* income below 185 percent FPL and (b) by SCHIP to have *net* income above 200 percent FPL.

➤ If eligibility is based on income data housed in government databases, some children will receive health coverage even though family income rose between the period covered in the data and the time of the child's application for health coverage. However, most income fluctuation for low-income families results from changed wages and hours of employment.[23] Accordingly, using recent wage data to help determine income may greatly reduce mismatches between eligibility data and current circumstances.

In exchange for these small eligibility expansions, the policies described here could (a) greatly increase enrollment among children who qualify under current rules; (b) cut administrative costs; and (c) relieve families of the need to complete largely redundant application forms.[24] Policy-makers have made similar trade-offs in the past. For example:

➤ With subsidies for Medicare Parts B and D, each beneficiary is assigned a single, unchanging income level throughout the calendar year. That level is based on income one and two calendar years in the past, for Parts D and B, respectively, even if, since that time, income rose enough that the beneficiary would otherwise be disqualified from subsidies.

➤ Medicaid beneficiaries automatically receive LIS for Medicare part D, even though LIS would otherwise disqualify some Medicaid recipients. Notably, LIS is limited to seniors with assets below specified levels, but some states provide certain types of Medicaid to low-income seniors without taking assets into account.[25] Nevertheless, HHS found that eligibility for Medicaid and LIS is "substantially the same,"[26] so these Medicaid recipients automatically receive LIS.

➤ With Medicaid, SCHIP, NSLP, and WIC, states are currently allowed (or required, in the case of NSLP) to provide children with one year of continuous health coverage and nutrition assistance, based on income at the time of the application, even if changes in family circumstances would otherwise make some children ineligible at points during the year.

SCHIP Reauthorization

With SCHIP reauthorization under active consideration, federal policymakers have an opportunity to provide states with the resources and tools needed to greatly exceed prior enrollment levels. At a minimum, SCHIP grants must increase above current levels enough to finance SCHIP coverage for eligible children.[27] In addition, federal resources, perhaps in the form of incentive payments, need to compensate states for the cost of covering additional eligible children through Medicaid, for which federal matching payments are much less generous than under SCHIP. States also need the flexibility to document citizenship through methods other than those mandated by the Deficit Reduction Act of 2003, which have reduced enrollment by eligible children.[28]

For states to use Medicare-type innovative strategies in reaching eligible children, SCHIP reauthorization also needs to do the following:

➤ Create a new option for so-called "express lane eligibility," through which states may disregard technical differences in eligibility methodologies and grant health coverage based on the findings of other means-tested programs;

➤ Provide improved access to eligibility-related data;

➤ Allow states to initiate eligibility determinations based on data showing that particular children are uninsured and appear eligible for coverage;

➤ Give states the option to cover children whose citizenship or legal immigration status is shown by electronic evidence; and

➤ Offer federal funding to modernize obsolete information systems needed for data-based strategies to operate efficiently.

Conclusion

While many aspects of SCHIP reauthorization are controversial, almost universal support is voiced for covering uninsured, low-income children who qualify for Medicaid or SCHIP. To reach that goal, states need sufficient federal resources to pay for covering these eligible children as well as new flexibility to give children the benefit of modernized Medicare enrollment methods that have proven so effective with America's seniors.

[1] Dubay, L., J. Holahan, and A. Cook. 2007. "The Uninsured and the Affordability of Health Insurance Coverage." *Health Affairs* 26(1): w22–w30; Hudson, J. L., and T.M. Selden. 2007. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs*, Web Exclusive, August 16.

[2] Government Accountability Office (GAO), 2005. "Means Tested Programs: Information on Program Access Can Be an Important Management Tool." GAO-05-221. Washington, DC: GAO.

[3] Dubay et al. 2007, op cit.; Hudson and Selden 2007, op cit.

[4] Hudson and Selden 2007, op cit., calculations by Dorn, 2007.

[5] Williams, S.R., and M.L. Rosenbach. 2007. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review* 28(4): 95–108.

[6] Dorn, S. 2006. "Automatically Enrolling Eligible Children Based on Other Agencies' Findings: Federal Policy Issues." Alliance for Health Reform presentation, June 16.

[7] Kenney, G., J. Haley, and A. Tebay. 2004. "Awareness and Perceptions of Medicaid and SCHIP Among Low-Income Families with Uninsured Children: Findings from 2001." Washington, DC: The Urban Institute; Kenney, G., 2003. "Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children Is High." Washington, DC: The Urban Institute.

[8] Sailer, P., and S. Holden 2005. "Use of Individual Retirement Arrangements to Save for Retirement — Results from a Matched File of Tax Returns and Information Documents for Tax Year 2001." In *Special Studies in Federal Tax Statistics: 2004* , 4th ed., edited by J. Dalton and B. Kilss (25–32). Washington, DC: Internal Revenue Service.

[9] Laibson, D., 2005. "Impatience and Savings." *National Bureau of Economic Research Reporter* Fall: 6–8.

[10] Remler, D. K. and S.A. Glied. 2003 "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health* 93(1): 67–74.

[11] U.S. Department of Health and Human Services (HHS). 2006. "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage." Press Release, June 14. Washington, DC: HHS.

[12] Government Accountability Office (GAO). 2007. "Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals Is Limited." GAO-07-858T. Washington, DC: GAO.

[13] Selden, T. M., J.L. Hudson, and J.S. Banthin. 2004. "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002." *Health Affairs* September/October: 39–50.

[14] Federman, A.D., B.C. Vladeck, and A.L. Siu. 2005. "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program." *Health Affairs* January/February: 263–270.

[15] For a description of data available from state workforce agencies, see Stone, C., R. Greenstein, and M. Coven. 2007. *Addressing Longstanding Gaps in Unemployment Insurance Coverage*. Washington, DC: Center on Budget and Policy Priorities. For a description of data available from the National Directory of New Hires, to which other means-tested programs (but not Medicaid and SCHIP) currently have access, see Federal Office of Child Support Enforcement 2007. *A Guide to the National Directory of New Hires*. HHS, Federal Office of Child Support Enforcement, Division of Federal Systems. Updated January 23.

[16] The former alternative would benefit only low-income children served by other public programs. The latter could help both low- and moderate-income children.

[17] Flores, G., M.A. Abreu, C.E. Chaisson, A. Meyers, R. C. Sachdeva, H. Fernandez, P. Francisco, B. Diaz, A. Milena Diaz, and I. Santos-Guerrero. 2005. "Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." *Pediatrics* 116(6): 1433–41.

[18] Access to Benefits Coalition. 2005. "Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes." Washington, DC: National Council on Aging.

[19] Ku, L, D. Cohen Ross, and M. Broaddus. 2006. *Documenting Citizenship And Identity Using Data Matches: A Promising Strategy for State Medicaid Programs*. Washington, DC: Center on Budget and Policy Priorities.

[20] These procedures are described in Social Security Act Section 1137(d).

[21] When non-citizen children seek coverage, satisfactory immigration status could be shown through digital confirmation of a valid social security number or a parent's authorization to work legally in the United States. Not only would this require adjustments to federal rules that define the evidence that shows satisfactory immigration status, most immigration data do not currently show how long particular immigrants have been legalized. For non-citizen children, Medicaid and SCHIP require five years of legal residence. To most effectively automate determinations of immigration status, states may also need the option to cover legal immigrant children regardless of prior length of stay. This would allow status as a qualified alien to be documented electronically without expanding eligibility greatly; proposals to grant such flexibility would increase children's Medicaid and SCHIP enrollment by less than 0.5 percent (Ku and Waidmann 2003; CBO 2007; calculations by S. Dorn, 2007).

[22] Gleason, P., T. Tasse, K. Jackson, and P. Nemeth 2003. *Direct Certification in the National School Lunch Program—Impacts on Program Access and Integrity.* E-FAN-03-009. Princeton, NJ: Mathematica Policy Research, Inc.; Cole, N. 2007. *Data Matching in the National School Lunch Program: 2005*, "Volume 1: Final Report," Report No. CN-06-DM. Bethesda, MD: Abt Associates, Inc.

[23] Newman, C., 2006. "Income Volatility Complicates Food Assistance." *Amber Waves* 4(4): 16–21.

[24] Of course, if health coverage were granted based on the findings of other programs, errors by those programs could, in theory, provide health coverage to ineligible children. However, such children are likely to be few. As noted above, real income-eligibility (taking into account the difference between net and gross income) is much more generous for SCHIP than for most other means-tested programs. As a result, only a large error affecting the highest-income participants in other programs would provide health coverage to an otherwise ineligible child. Moreover, standard methods of income verification and eligibility quality control procedures for health coverage could continue to apply, preventing errors and holding states accountable for mistakes.

[25] Nemore, P., 2007. Testimony of Patricia Nemore, Center for Medicare Advocacy, Before the Subcommittee on Health of the House Committee on Ways and Means, May 03.

[26] This statutory standard for deemed eligibility can be found at 42 U.S.C. § 1395w-114(a)(3)(B)(v)(II).

[27] Broaddus, M., and E. Park. 2007. *Freezing SCHIP Funding In Coming Years Would Reverse Recent Gains In Children's Health Coverage*. Washington, DC: Center on Budget and Policy Priorities.

[28] Cohen Ross, D. 2007. *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants.* Washington, DC: Center on Budget and Policy Priorities.

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