Retention and Reenrollment of Children in SCHIP and Medicaid*

Summary
States and the federal government have made considerable progress in implementing the State Children’s Health Insurance Program (SCHIP), according to the U.S. General Accounting Office. Given the complex planning required for a program of this magnitude and the limited time provided for implementation, state enrollment numbers are on target. More than half of the states have reached their one-year anniversary of program operation. In the early phases of implementation, states concentrated on initial enrollment and outreach. Now they are turning their attention to reenrollment and determining how this process affects families.

Reenrollment presents both challenges and opportunities for states. They want to ensure that more families acquire and maintain health insurance coverage for their children. States with stand-alone children’s health insurance programs have the additional task of coordinating with Medicaid.

In June 1999, the National Governors’ Association Center for Best Practices convened a group of states with stand-alone SCHIP programs that had been operating for at least one year to discuss challenges and successes in reenrollment.

State Children’s Health Insurance Program
States have been expanding Medicaid eligibility levels for the past decade, and Title XXI of the Balanced Budget Act of 1997 authorizes them to further increase eligibility levels for infants and children under SCHIP. SCHIP provides states with approximately $4.8 billion annually to provide or purchase health insurance for uninsured children. The Congressional Budget Office estimates that under SCHIP, 2.8 million uninsured children who are not eligible for Medicaid will be covered; another 660,000 uninsured children will be enrolled in Medicaid as a result of SCHIP outreach efforts. Potentially eligible children are those below age nineteen who are living in families with incomes between a state’s Medicaid income eligibility requirement and 200 percent of the federal poverty level.

States have three options for implementing SCHIP. They may design and develop a separate state insurance program, expand their current Medicaid program, or combine the two approaches. As of September 3, 1999, fifty-two states, commonwealths, and territories, including the District of Columbia, have received approval from the Health Care Financing Administration to implement SCHIP. Fourteen states have designed new children’s health insurance programs, fourteen states are using SCHIP funds to design new programs while simultaneously increasing Medicaid eligibility for
children, and twenty-seven states have expanded Medicaid eligibility for children. Nineteen states also have received approval for expansions or changes through amendments to their SCHIP plans.

States’ top priority for SCHIP has been to reach and enroll eligible children. They have used the early implementation phases to ensure accessibility and understanding of their programs by simplifying application forms, conducting innovative outreach campaigns, and forming partnerships with community-based organizations. States are now faced with maintaining their achievements through the reenrollment process, which presents its own challenges.

**Challenges and Opportunities of Enrollment**

States with separately designed insurance programs have the added requirement of coordinating these programs with Medicaid. This challenge becomes especially apparent during reenrollment. States’ ability to retain enrollees in either the SCHIP program or Medicaid depends on a well-designed reenrollment process. The experiences of eight states that have reached their one-year anniversary of SCHIP operation reveal some common challenges and innovative strategies to make the reenrollment process easier for families.

**Stages in the Reenrollment Process**

Each stage of the reenrollment process is important for both the state and the family. Typical stages of this process include:

- notification;
- reapplication;
- eligibility redetermination;
- client tracking and application; and
- measurement of reenrollment and retention.

A family’s ability to navigate the reenrollment process depends, in large part, on the design and flow of the stages. Coordination between SCHIP and Medicaid adds to the complexity of the process. Two programs with different rules, requirements, locations, and staff must learn to “talk” to one another.

**Notification**

When and how the state communicates with families to inform them of the need to reenroll in the program is a critical beginning point to the process.

**Finding and Challenges**

- States have found that there is a critical time window for notification. If a notice is sent out too early, considerable letter or phone followup is needed.
- The form of the notification also is important. It must be clear and concise and include instructions, deadlines, and a number to call for help.
- When children in the same family are enrolled in different programs with different eligibility timetables, the notification process can become confusing. Notices for the separate programs are sent out at different times and often have different requirements. With separate programs, states must decide which program will send out the reenrollment notice and what information will be communicated to the family.
Best Practices

- **Connecticut** has found that an initial notification letter, followed by phone calls if the family does not respond, has been helpful in keeping children enrolled.

- **New Hampshire**’s premium coupon book has an extra page after the tenth-month payment to remind families to save pay stubs for their upcoming reenrollment.

- States with common administrative systems, such as **Massachusetts**, have the most success in facilitating family reenrollment. Common eligibility timeframes between SCHIP and Medicaid can be a starting point for simplification efforts.

- States with identical marketing materials, including reenrollment notices and letters with matching logos, maintain a more consistent message. A family on Medicaid may only recognize the name under which the program is marketed, rather than “Medicaid.”

Reapplication

Most states are moving toward simplifying their reenrollment forms, much like they have simplified their initial enrollment forms. Some states also are combining Medicaid and SCHIP forms to the extent possible.

Findings and Challenges

- Common data elements between programs simplify the referral process when families’ incomes change and qualify them for a different program.

- States have worked hard to simplify their initial application forms, but many states have yet to address reenrollment forms. Verification requirements, and even the forms themselves, are sometimes more lengthy for reenrollment than for enrollment.

- Mail-in reenrollment capacity is important, especially for families that initially applied through the mail. It can be confusing when families are required to have a face-to-face interview for redetermination.

Best Practices

- Some states are moving toward a preprinted application form. The state’s data system produces a reapplication form with the most recent information the state has about the family. The family is required to return it with changes or approve the listed information. Some states, such as **Florida**, use “passive redetermination,” where the family returns the form only if there are changes.

- **Pennsylvania** requires Medicaid and SCHIP programs to accept each other’s forms. The state also allows individual plans to print applications with plan logos on them, so long as the common data elements are present.

- Some states use community-based organizations (CBOs) to help clients complete application forms. CBOs may be open during nontraditional hours or visit families’ homes (see appendix for further details).

- Some states, such as **New York**, give SCHIP clients the choice of mail-in reenrollment or face-to-face reenrollment assistance through a local social services office or CBO.

- **California** allows families to use a toll-free number to change their address or health plan.
Eligibility Redetermination
If family income has changed, child enrollment may need to shift from Medicaid to SCHIP or from SCHIP to Medicaid. States must decide which program is responsible for a child’s eligibility redetermination.

Findings and Challenges
- Coordination between Medicaid and SCHIP eligibility staff is essential.
- When verification requirements are different for each program, direct referral to the other program is more difficult.
- States with separate eligibility systems and requirements for SCHIP and Medicaid have the added task of collecting the information necessary to determine children’s eligibility for one program versus the other.

Best Practices
- States with a single point of entry for both SCHIP and Medicaid have found it especially helpful in coordinating services and tracking clients between programs. One entity receives all application forms and directs them to the appropriate program, as family income warrants.
- Electronic transfer of information has been essential for some states’ eligibility determination and tracking efforts. Applications move easily from one program to another, and the electronic transfer prevents applications from being misplaced. Other states are striving toward this end, though year 2000 demands and the 10-percent cap on administrative expenditures are proving to be significant impediments.
- Other states, such as Alabama, use courier systems to transfer referral applications between programs.
- Co-location of Medicaid staff with SCHIP enrollment workers also is an effective reenrollment strategy.

Client Tracking and Application
The reenrollment process helps states reconnect with families. It also is a time when families could potentially drop or lose coverage because of insufficient communication or cumbersome processes. Having to refer clients to other programs further complicates this process.

Findings and Challenges
- Common eligibility or data systems between programs enables states to more easily track applicants through the system.
- A followup “loop” or process must be established between Medicaid and SCHIP to ensure that clients stay enrolled in an insurance program.
- Direct contact with families is most successful in maintaining enrollment.
- Common provider networks between programs enable families that must change program enrollment to retain their health care providers.
Some families resist changing their enrollment from SCHIP to Medicaid because of their desire to avoid “welfare.” Many families also perceive Medicaid as an inferior program.

**Best Practices**

- **Connecticut** places followup calls to families forty-five days and fifteen days before their eligibility period ends. A letter is sent thirty days prior to remind families to return the reenrollment form. The state flags the case as a priority if the family is close to the end of its eligibility period.

- CBOs that have contracts with a state may also conduct followup. The state notifies the CBO when the family receives a reenrollment notice, and the CBO often visits that family to offer assistance.

**Measurement of Reenrollment and Retention**

The purpose of measuring reenrollment and retention is two-fold: to learn what is working and how to improve the program and to gather information to share results with the public. States must monitor the program’s operation from a technical standpoint, but they also must communicate with the public about program developments. This ongoing communication is critical to a program’s long-term success. States with more established programs, such as **New Hampshire** and **Florida**, tend to have additional experience in this area.

**New Hampshire**

New Hampshire’s Healthy Kids’ immediate exit survey has been extremely helpful in identifying reasons for termination. The state has found that 95 percent of clients leave the program because they acquire other insurance, mostly employer-based coverage. Families often do not make premium payments because they no longer need insurance. The survey’s simplicity facilitates immediate results.

Healthy Kids also has recognized the need to regularly communicate with the public about the program. Eight to ten simple graphs, including information on enrollment locations and the frequency of and reasons for disenrollment, are updated monthly. Programs results are published in a quarterly newsletter and discussed at quarterly CHIP outreach workgroup meetings, and they will soon be published on the Healthy Kids’ web site.

**Florida**

Florida regularly conducts random satisfaction surveys when families initially enroll. Lasting approximately forty-five minutes, these surveys include inquiries about providers and insurance status. Florida Healthy Kids also surveys enrollees, disenrollees, and people who never enroll. Comparisons among these three groups show program staff where improvements can be made.

To address consumer stigma associated with Medicaid, Florida also has surveyed people who moved from Healthy Kids to Medicaid because of changes in income. By making the application easier and more user-friendly, Florida has changed attitudes about Medicaid. Twenty percent of enrollees who formerly would not accept Medicaid coverage decided to apply for such coverage for their children.
Federal Barriers to Greater Coordination

States have found that certain laws or regulatory requirements impede their ability to make the reenrollment process as seamless and successful as possible. Provisions that states find problematic include:

- the prohibition on nonstate personnel determining Medicaid eligibility;
- the prohibition on some organizations that serve as single points of entry for state programs granting presumptive eligibility;
- the question of who, other than the family, can pay the family’s premium share; and
- the 10-percent cap on administrative costs, given the extensive system upgrades that are needed.

Resolving these issues would allow for greater simplification and coordination between programs, and families would experience a more seamless system.

Next Steps for States

States are focusing their energies on simplifying the reenrollment process for families, in much the same way that they have simplified the enrollment process. States with stand-alone programs have the added challenge of coordinating the restrictive rules of Medicaid with the state-designed rules under SCHIP. At various stages of the reenrollment process, states may struggle to retain families in programs because of eligibility requirements and administrative procedures.

Some of these problems are easier to resolve than others. In certain cases, states can change aspects of their programs to make reenrollment less complicated. For example, coordinating eligibility timeframes and marketing materials could significantly simplify the process. Other efforts, such as systemic changes that enable programs to easily communicate with one another, will be major undertakings.

States are still in the early phases of program implementation. Many challenges have yet to be addressed and some have not even surfaced. As these programs mature, states will continue to improve their program administration so that more uninsured children acquire and maintain health insurance.

*This Issue Brief was written by Kelly Nicholson, consultant to NGA, and prepared under a cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The comments and recommendations come from SCHIP administrators and state Medicaid personnel who attended a meeting hosted by the National Governors’ Association Center for Best Practices in June 1999.


2 States with eligibility levels set close to or above 200 percent of the federal poverty level prior to June 1, 1997, are allowed to increase eligibility by fifty percentage points.

3 Special thanks to the state representatives from Alabama, California, Connecticut, Florida, Massachusetts, New Hampshire, New York, and Pennsylvania who participated in the June 1999 meeting.
Appendix: Partnering with Community-Based Organizations in the State Children’s Health Insurance Program

States are using community-based organizations (CBOs) to accomplish a variety of tasks under the State Children’s Health Insurance Program (SCHIP). CBOs often contract with states to perform these tasks and are held responsible for specific outcomes. States, including California, Massachusetts, New Hampshire, and New York, have found CBOs to be integral to their programs’ success.

The Role of CBOs
The roles that CBOs perform vary from state to state. A major benefit of using CBOs is their constant presence in the community and their accessibility to families. Often they are the contact point in the community, which promotes ongoing communication and relationship-building. Such relationships are critical when family trust needs to be earned.

California uses CBOs to market its program and help break down cultural barriers, especially in explaining the value of health insurance. The state has 17,000 enrolled entities that are certified as application assistants. These entities can be CBOs, religious organizations, insurance agents, or consulting organizations. California also has a contract with a large public relations firm to develop advertisements and other collateral materials that promote the program.

Massachusetts uses mini-grants with fifty-two CBOs. These organizations can choose to do outreach, application assistance, or both. CBOs have the freedom to design approaches that will best meet the needs of their communities.

New Hampshire uses CBOs to perform “facilitated enrollment.” CBOs assist clients with any questions on the application process or verification requirements.

New York’s CBO pilot sites play a critical role in assisting families with the application process. They also help families choose a health plan upon their enrollment, rather than waiting for families to be enrolled before they choose a health plan. New York has issued a statewide request for proposals (RFP) for other organizations to participate.

Compensation of CBOs
States have used different payment methods for CBOs, including a per-application fee, contracts, and mini-grants.

California reimburses entities on a per-application basis. An enrollment fee is paid for each application that results in enrollment in the Healthy Families program or MediCal. In the future, California plans to allow CBOs to choose between a per-application fee or a contract for reimbursement.

Massachusetts uses a flat payment for its mini-grants to CBOs that qualify through an RFP process. In the upcoming fiscal year, the state will reimburse grants that range from $5,000 to $15,000.

State Requirements and Support of CBOs
Some states encourage collaboration among CBOs to ensure adequate infrastructure. Other states allow single CBOs to apply for grants or contracts.
Most states require CBOs to be open during nontraditional business hours. States such as Massachusetts also hold CBOs accountable through performance measures when their contracts are reviewed.

Massachusetts also convenes monthly meetings of CBOs to share successes and barriers and offer them assistance. CBOs work with outstationed state eligibility workers and other state agency program staff to leverage state resources and maximize their effectiveness.