

INCREASING ACCESS TO HEALTH INSURANCE FOR CHILDREN AND FAMILIES: INNOVATIVE HEALTH PLAN OUTREACH AND ENROLLMENT EFFORTS



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INTRODUCTION

The U.S. Census Bureau estimates that the number of people who are without health insurance fell from 47 million in 2006 to 45.7 million in 2007. This decline in the number of uninsured was due to an increase in the number of people covered by government programs. Additionally, after two years of increase, the number of uninsured children under age 18 decreased from 8.7 million in 2006 to 8.1 million (or approximately 11 percent of children) in 2007.¹ The reauthorization of the Children's Health Insurance Program (CHIP)^a in February 2009 will provide coverage for an additional four million uninsured children by 2013 and continue to provide coverage for seven million children. President Obama also lifted a prior directive limiting middle-class families' abilities to enroll in the public program. Under the restrictions, states had to enroll at least 95 percent of poor children eligible for public insurance before they could begin covering children in families with incomes above 250 percent of FPL. Additionally, these higher-income children had to be uninsured for a year before they could enroll. These modest improvements will contribute to the ability of public programs to reduce the number of uninsured in the United States, however, access to affordable health insurance coverage continues to elude many Americans and remains an important public policy concern.

The majority of the uninsured have incomes below 200 percent of the federal poverty level (FPL), however, the uninsured are present in all socio-economic categories including moderate and even higher incomes. This heterogeneity of the uninsured illustrates the need for multiple approaches to extending insurance coverage. Outreach for public programs can reach low-income families, while the creation of affordable private market solutions can target moderate- and higher- income persons who are not eligible for public coverage.

Trends in the sources of health insurance coverage within families must also be considered when developing strategies to increase access to health insurance for children and families. Families are increasingly combining health insurance coverage from multiple sources – both public and private – as a result of the decline in the numbers receiving employer-sponsored insurance (ESI).² As the unemployment rate continues to rise, even fewer families will have access to ESI going forward. Research also suggests that enrollment rates among children in public programs increase when their parents are also eligible, pointing to the need for less restrictive eligibility requirements for adults.³

Outreach and enrollment strategies are recognized as critical to increasing access to health insurance for the uninsured. Experience from the Robert Wood Johnson Foundation's Covering Kids and Families initiative suggests that outreach efforts are most successful when they are conducted by organizations that are trusted by community residents, accessible and convenient to the targeted population, and coordinated with outreach efforts of state government and community organizations.⁴ Despite these general guidelines, however, data are generally lacking to identify the specific outreach activities that are most effective at increasing enrollment.⁵

Since outreach and enrollment efforts frequently involve multiple sectors across the health care system and the community, health plans and their foundations can play a significant role. Efforts to conduct outreach and improve enrollment are pervasive throughout health plan business and philanthropic activities. In this paper we will examine innovative health plan efforts to increase enrollment in Medicaid and CHIP as well as to create and market more

^a The Children's Health Insurance Program Reauthorization Act of 2009 indicates that the Children's Health Insurance Program should be referred to as CHIP rather than SCHIP, which was commonly used previously. In this report we use CHIP and SCHIP interchangeably to represent CHIP.

affordable private insurance coverage options. We will also examine the increasing role of health plan philanthropic foundations in efforts to promote access to insurance.

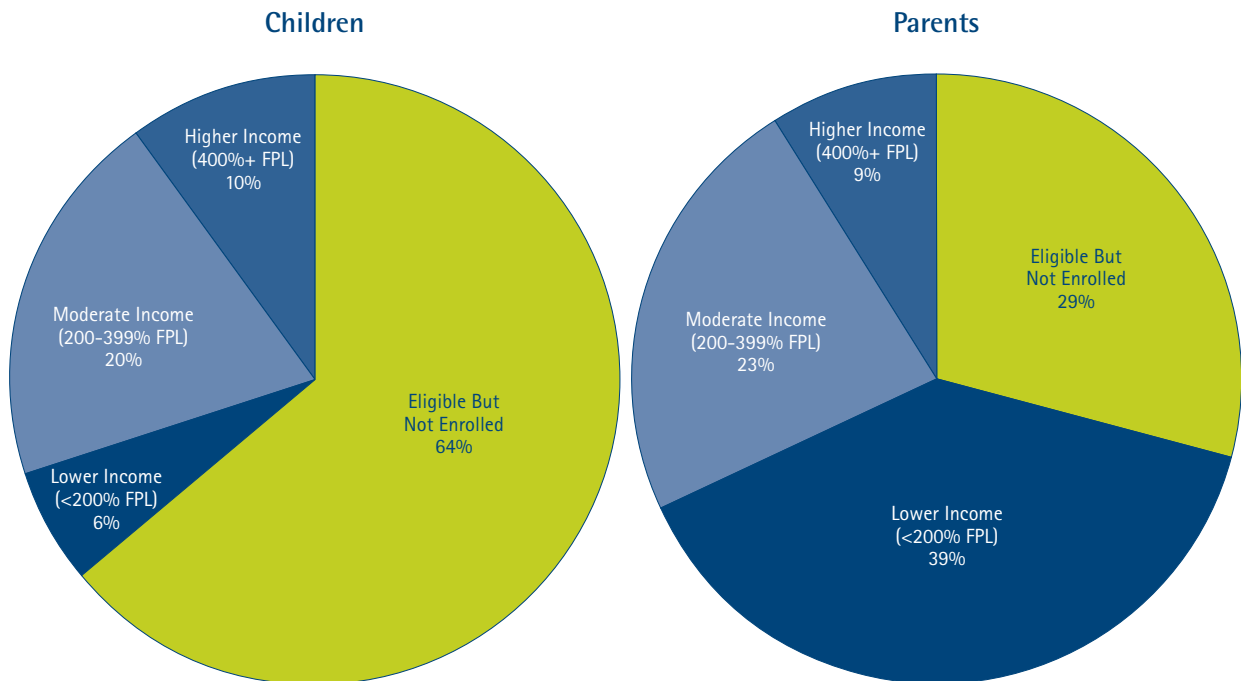
HEALTH PLAN EFFORTS TO IMPROVE MEDICAID/SCHIP OUTREACH AND ENROLLMENT

Twelve million people – or approximately one of every four non-elderly uninsured persons – were eligible for public health insurance programs in 2006 but not enrolled. This group is primarily composed of low-income children and parents due to the eligibility focus of public programs. In fact, 64 percent of uninsured children (6.1 million) were eligible for Medicaid or SCHIP but not enrolled (Figure 1). Parents' eligibility for public programs is more restrictive than for children, so only 29 percent of uninsured parents (3.6 million) were reachable through current public programs but not enrolled.⁶

People who are eligible for public programs may fail to enroll in them for a number of reasons, necessitating the use of multiple types of outreach and enrollment efforts. Some people may be unaware of the programs, not know how to enroll, or have difficulty with the enrollment process. Others may be hesitant to participate due to stigma surrounding "welfare" programs, concern that enrolling would affect immigration status, or distrust of the medical system or governmental programs in general.⁷ To address these issues, much outreach activity is aimed at educating the public about available public programs and assisting with enrollment.

Research suggests that poor retention of previous program enrollees is responsible for a large number of the people who are eligible but not enrolled in public coverage. In 2006, one third of uninsured children had Medicaid or SCHIP coverage during the previous year.⁸ Through "inreach" activities, such as encouraging timely renewal for current enrollees who may lose coverage, health plans can aid in the retention of currently

FIGURE 1: UNINSURED CHILDREN AND PARENTS BY ELIGIBILITY AND FAMILY INCOME



Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

enrolled individuals and increase the likelihood that a child will maintain public health insurance coverage.

States often play a large role in outreach and enrollment activities for their public programs. Title XXI of the Social Security Act, which created SCHIP, provided states with federal matching funds for activities designed to find and enroll uninsured children in Medicaid or SCHIP. The amount of SCHIP funding that states can use on administrative activities, including outreach, is limited to 10 percent of their total SCHIP spending.⁹ States also are required to describe their outreach efforts and progress in annual reports to the Centers for Medicare and Medicaid Services. Partnerships between the state and local entities are prevalent in outreach activities, and health plans frequently team with community groups who perform outreach and enrollment. The national recession has created large state budget deficits and some states are seeking to close those gaps by reducing or eliminating funds dedicated to outreach and enrollment activities or by cutting back benefits altogether. The CHIP reauthorization legislation took action to protect outreach and enrollment activities by allocating \$100 million for grants to increase enrollment of children in CHIP and Medicaid, particularly among Native Americans, and by waiving the 10 percent cap on CHIP payments for outreach activities targeted at this group.¹⁰ In order to not lose the momentum gained by the reauthorization and expansion of CHIP, partnerships, such as those described in this section, will be an integral part of enrolling and retaining eligible children in light of these state funding cutbacks.

Blue Cross and Blue Shield of Florida

Blue Cross and Blue Shield of Florida (BCBSF) is a nonprofit mutual insurance company based in Jacksonville. In its health business, BCBSF serves more than 4 million members and has a 30 percent share of the Florida health insurance market. Expanding access to health insurance for children and families is a logical extension of BCBSF's mission of providing affordable products for as many Floridians as possible.

In 2007 more than 70 percent of the approximately 548,000 uninsured children in Florida were eligible for free or subsidized coverage through KidCare, the state's network of public programs for children.¹¹ One of the

primary barriers to enrollment for these children is the complex administrative structure of KidCare. KidCare has four different programs, each with its own separate administration:¹²

- 1) MediKids (SCHIP): uninsured children ages one through four;
- 2) Healthy Kids (SCHIP): uninsured children ages five through 18;
- 3) Children's Medical Services Network: uninsured children with special health care needs up through age 18; and
- 4) Medicaid: qualifying children up through age 18.

Florida KidCare checks to determine eligibility for each program and refers the application to the appropriate program. The application is valid for 120 days after receipt by KidCare and if a child is not enrolled during this time, parents are notified that they must re-apply if they are still interested.

BCBSF is a Healthy Kids provider and administers the program in 19 counties, providing coverage for more than 15,000 children. Florida Healthy Kids is a quasi-public organization providing affordable health insurance to more than 200,000 Florida children. In the enrollment application, parents are required to provide documentation of income, citizenship, and the number of children in the family. The enrollment process can be completed in approximately 45 minutes with the help of an eligibility worker. Parents must reenroll their children every 12 months or they will be dropped from the program. Members can also be dropped due to nonpayment of the premiums. In this situation, the member must complete the entire enrollment process again.

Florida is well aware of the effect its complex enrollment process has on families. After a series of regulations made enrollment in Florida Healthy Kids more difficult, Florida's SCHIP enrollment decreased by 39 percent (nearly 128,000 children) from June 2004 to June 2005.¹³ This decline was driven by the removal of passive renewal and continuous enrollment. Families were now required to submit a renewal form and could do so only during two open enrollment months. In addition, the

state instituted an enrollment cap and eliminated the waiting list, which meant that eligible families who submitted forms on time could still be denied enrollment and would not be contacted later if a spot opened up.¹⁴ In light of this decline in enrollment, the state took steps last year to streamline the system and improve outreach. BCBSF was an active participant in these state efforts to facilitate enrollment and retention.

BCBSF is also a member of the Florida Covering Kids and Families Coalition (part of the national initiative of the Robert Wood Johnson Foundation), which is a public/private partnership of community, regional and state organizations and KidCare community coalitions that aims to enroll as many children as possible in Florida KidCare. As part of the Coalition, BCBSF conducted 1,000 back-to-school events in 57 of Florida's 60 counties during late summer and early fall of 2007 – extending well beyond the markets in which they currently operate. Application forms were provided and eligibility workers were available on-site to assist with the paperwork. As a result of these back to school events, 42,000 applications were completed and sent to the state for processing. These new applications resulted in 33,000 KidCare enrollments, which was the largest increase ever seen in the state over only a few months. As of February 2008, the remaining 9,000 applications were still being processed. Through the Coalition, BCBSF continues to discuss with the state how to streamline the KidCare system in order to make it more efficient. Florida serves as an example of how state eligibility and enrollment policies impact enrollment and retention; and how health plans can play a critical role in improving access – both by reaching out to eligible children and advocating for simplified regulations.

WellPoint Inc.'s State Sponsored Business

WellPoint's State Sponsored Business (SSB) division seeks to improve the lives of the underserved and uninsured people in our country. The division serves nearly two million members in 13 states, making it one of the nation's largest Medicaid managed care companies. SSB helps people in need find quality health-care coverage through programs such as Medicaid, State Children's Health Insurance Program (SCHIP), Aged, Blind, or Disabled (ABD), and other publicly funded programs. WellPoint's SSB works closely with numerous community and civic organizations to

educate residents about the availability of Medicaid and to expand outreach and accessibility for Medicaid enrollment among eligible families and children.

Through a model rooted in service in the communities where its members live, SSB achieves personalized service and community involvement with members and providers. The community resource model is a vital link between Medicaid and other publicly funded health care programs and those members who are eligible to benefit from these programs. Local staff conduct outreach programs in low-income neighborhoods and provide members with convenient access to information on public programs and assistance with enrollment. Additionally, SSB staff offer training on member benefits, plan orientation, claims and billing, pharmacy policies and electronic processing. SSB participates in numerous outreach events throughout the year including: community and school health fairs; minority expos; state, federal and local conferences; conventions; and new member orientations.

The local staff has strong community connections to help remove obstacles that can prevent a person from accessing services. At times, those barriers are related to language and culture. SSB's bilingual representatives are able to help non-English speaking individuals understand the services available. Sometimes they arrange transportation for members who have no other way to see a doctor. Often members are contacted by phone, mail or in-home visits to help assure their needs are addressed.

This community emphasis is strengthened through programs that reach members where they live. Through its van program in California, for example, SSB outreach personnel travel throughout the state to offer education and on-site application assistance to prospective members. Eligibility for public programs is determined at the state and county level, so van personnel help facilitate the enrollment process, but do not assess eligibility. The vans travel to schools, clinics, fairs and other community events to help eligible families sign up for their health care coverage.

WellPoint believes that one of the best ways to help vulnerable populations is to increase awareness of the health and social services available. For instance, SSB's marketing call center receives more than 100,000 calls per year and assists nearly 46,000 prospective members with

their inquiries. The SSB marketing call center conducts new member orientation calls to welcome members to its plan, explain benefits and answer new member questions. Representatives explain the importance of choosing a primary care physician and coordination of their medical care. The marketing call center also explains SSB's supplemental benefits, which include health education classes, a 24-hour nurse help line and asthma, diabetes, prenatal and obesity programs.

Through its outreach and enrollment activities, WellPoint SSB strives to meet the holistic needs of Medicaid members. For example, in an effort to ensure that all children get the immunizations that are critical to keeping them healthy, SSB helped sponsor Nevada Childhood Immunization Week, resulting in the successful immunization of more than 5,000 at-risk children from across the state.

In 2008 SSB participated in more than 200 events in Northern California alone to promote awareness and

enrollment of State-sponsored programs. Involvement in community events that improve the overall health of the community is key to successfully reaching this population.

Highmark

Governor Edward G. Rendell's Cover All Kids initiative aims to provide health insurance coverage to every child in Pennsylvania. To achieve this goal, SCHIP eligibility was expanded to 300 percent of FPL with some cost sharing required for families between 200 and 300 percent of FPL. Families with incomes above 300 percent of FPL can buy into the program and pay full cost. In an attempt to prevent crowd out of private coverage, there is a waiting period of six months for children in families with incomes between 200 percent and 300 percent of FPL. Eight health insurance companies, including Highmark, provide coverage under SCHIP,

BLUECROSS BLUESHIELD OF TENNESSEE

Governor Phil Bredesen's initiative, Cover Tennessee, aims to provide affordable health insurance options for all Tennesseans. CoverKids, Tennessee's SCHIP product, was launched on March 26, 2007, for children under age 19 in families with income up to 250 percent of FPL who are not eligible for Medicaid or TennCare.¹⁵ The state estimates that there are about 80,000 to 90,000 uninsured children in families with incomes less than 250 percent of FPL, of which approximately half are Medicaid eligible.

BlueCross BlueShield of Tennessee (BCBST) is the insurer for CoverKids and conducts outreach and enrollment activities in partnership with the state. The state initiated a media campaign using television, radio and print sources. The state also produces brochures, posters and application forms for distribution. BCBST's outreach is focused on educating community members by organizing events where they provide information and offer state-produced brochures on the program. Specific venues include school events where parents are present and health care providers' offices. Previously BCBST worked with state health councils from individual counties, however, the council system is no longer in place due to recent budget cuts in the state. Additionally, BCBST has partnered with the Chamber of Commerce to educate small businesses.

Despite numerous outreach activities, Tennessee fell short of meeting Gov. Bredesen's goal of enrolling 40,000 uninsured children in CoverKids by 2009.¹⁶ This appears to be partly due to failure by existing members to renew their coverage. BCBST and the state of Tennessee will continue partnering to develop strategies to increase retention of current enrollees and to continue to enroll uninsured children who are eligible for CoverKids.

with premiums varying among the insurers. Highmark is continually the largest contractor in the state in terms of enrollment in SCHIP.

Highmark's mission is to provide access to affordable, quality healthcare, enabling individuals to live longer, healthier lives. In accordance with this mission and to spread awareness about the Cover All Kids campaign and Highmark's SCHIP premiums, Highmark distributed 13,000 brochures and 10,000 applications to almost 2,000 partners. Highmark partners include an extensive list of community organizations, many of which focus on reaching African American and Hispanic populations. Notable organizations include the NAACP, YMCA Black Achievers Program, Estamos Unidos de Pennsylvania, the Governor's Advisory Committee on African American Affairs, and the Governor's Advisory Committee on Latino Affairs, in addition to African American and Latino business owners.

SCHIP information was also mailed to 76 schools/districts, resulting in more than 55,000 brochures being sent home with students or mailed directly to their parents. Highmark also conducted outreach to 31 domestic relations offices to educate staff about SCHIP availability and application processes. Since health insurance is frequently an issue during family separation and custody disputes, there is great utility in sharing information regarding how separated families can apply. Additionally, a new pilot program was created with summer camp programs in South Central Pennsylvania to provide SCHIP information to families. Participating camps included those from the YWCA, YMCA, and Big Brothers/Big Sisters.

Highmark also worked internally to elevate the issue of the uninsured through the "Family and Friends" initiative for Highmark employees. The goal of the initiative was to educate employees about SCHIP, adultBasic (a program offering low-cost coverage to individuals 19 through 64), and Highmark direct pay products that might be attractive to the uninsured so that they could then identify family and friends who would benefit from Highmark's social mission and products. Almost 500 employees attended 17 "Family and Friends" presentations. Highmark is dedicated to increasing enrollment in SCHIP and continuing to partner with the state to achieve the Governor's goal of providing health insurance coverage to every child in Pennsylvania.

HEALTH PLAN PHILANTHROPIC FOUNDATIONS AND COMMUNITY COVERAGE EFFORTS

The creation of CHIP, and its recent reauthorization and expansion, foster opportunities for more children, and in some states, adults, to access health coverage. Private philanthropic organizations, including health plan foundations, have stepped forward and offered financial support to further government efforts and ensure that all eligible children are targeted and benefiting from the program. Foundation support for outreach and enrollment activities will continue to be vital in the near future as some states reduce or eliminate funding for these types of activities due to state budget shortfalls.

To guide other foundations in their grantmaking for outreach and enrollment efforts, the California Endowment has recently published a report describing the myriad components of initiatives designed to identify and enroll persons eligible for public coverage.¹⁷ These components include: eligibility assessment, outreach, enrollment and retention, utilization, networking, policy analysis and systemic change, and program management and evaluation.

In this section we present examples of three health plan foundations actively involved in outreach and enrollment activities to reduce the number of uninsured children across the country. Their efforts, both through their direct activities and through the activities of the community-based organizations that they fund, cover many of the components identified by the Endowment. For example, foundations are identifying and funding effective local organizations, supporting media campaigns, convening grantees for networking and training opportunities, supporting policy analysis and working with grantees to develop relevant evaluation measures.

Foundations' efforts are making an impact. An analysis of the source of applications for the Los Angeles Healthy Kids Program (the local SCHIP program) reveals that clinics and health centers, community-based organizations, and media-based hotlines are the top three sources of applications.¹⁸ In producing this report, we found that these are the very types of initiatives that foundations are funding. Specifically, foundations are funding community-based centers for uninsured

individuals to receive direct access to health care services, community-based social service organizations to conduct outreach and assist individuals in enrollment, and public access to information and service hotlines.

Blue Cross Blue Shield of Massachusetts Foundation

Blue Cross Blue Shield of Massachusetts (BCBSMA) established Blue Cross Blue Shield of Massachusetts Foundation (BCBSMAF) in 2001 as an independent philanthropic entity. BCBSMA provided an initial contribution of \$55 million and continues to contribute to the Foundation generating a current endowment of approximately \$108 million. Foundation activities fall under three closely coordinated branches: 1) grantmaking, 2) policy research, and 3) capacity-building programs for nonprofit Massachusetts health care organizations. Over time, information from the grantmaking operations have informed BCBSMAF's policy work.

Leader in Health Reform Efforts

In the years leading up to the passage of Massachusetts's groundbreaking health reform law in 2006, BCBSMAF played a critical role in gathering and analyzing the data needed to craft the 2006 law. Under the auspices of its Roadmap to Coverage initiative, BCBSMAF commissioned The Urban Institute to analyze what the state was currently paying to cover its uninsured residents; what it would cost to implement a near-universal health plan; and potential ways in which such a plan could be implemented. Beginning in 2004, BCBSMAF released 13 reports and policy briefs that influenced and informed policymakers and lawmakers working to cover the uninsured in Massachusetts.

Support of Outreach and Enrollment Efforts

Since its establishment, BCBSMAF has funded grantees to enroll uninsured individuals in the state's Medicaid program. Providing those funds has made BCBSMAF a significant player in efforts to enroll residents into public health insurance coverage, supplementing the often sporadic state efforts in this area. In 2005 Governor Romney proposed reinstating previously halted state funding for outreach and enrollment activities and made maximizing enrollment in Medicaid a priority. In July 2005 the state legislature approved

\$500,000 to be distributed in the form of grants to community organizations conducting outreach and enrollment activities. In that same year, BCBSMA sought to enhance the state's efforts and contributed \$250,000 to the Foundation's existing outreach and enrollment grant budget of \$400,000, resulting in a total BCBSMAF distribution of \$650,000 for outreach and enrollment.

With the passage of the state's health reform law in 2006, legislators included \$3 million to fund outreach and enrollment activities. BCBSMAF, meanwhile, continued to make outreach and enrollment grants totaling \$400,000. While the state grants focused solely on enrollment for Medicaid and Commonwealth Care and Choice programs, BCBSMA also included outreach and enrollment for prescription drug plans for seniors and the state health safety net fund. However, due to the national recession and a state budget deficit, Governor Patrick announced in January 2009 that \$3.5 million in outreach and enrollment grants would be eliminated in the 2010 budget. That change would make BCBSMAF the primary source of funding support for outreach and enrollment activities in the state.¹⁹

Connecting Consumers with Care (CCC) is BCBSMAF's major funding vehicle to support comprehensive outreach and enrollment. Total CCC funding for 2007 was \$490,000 (exceeding the initially budgeted funding level). Individual grants ranging from \$15,000 to \$25,000 have been awarded to a mix of community-based organizations, community health centers, and select hospital-based programs.

The program has two goals: a) enroll eligible residents in appropriate coverage programs, and b) ensure that the outreach and enrollment workers are professional and well-trained. To achieve these goals, BCBSMAF looks for grantees that:

- 1) work closely with and understand the needs and characteristics of the populations they serve;
- 2) are familiar with MA Medicaid online Virtual Gateway portal and paper applications; and
- 3) have relationships with local primary care physicians serving Medicaid beneficiaries so new beneficiaries can be quickly connected to the health care system.

With more than 42 coverage plans available in Massachusetts, outreach and enrollment professionals are critical for connecting residents with the right plan to suit their needs and circumstances. To ensure grantees have all the information necessary to assist their communities, BCBSMAF regularly organizes technical assistance events such as in-person conferences to educate grantees and exchange information between the foundation and grantee staff.

Moreover, professionals have valuable field experience that can help state officials understand the practical impact of reforms, the implementation challenges, and possible ways to address these challenges. Recognizing the value of these insights, BCBSMAF has worked to open communication between state government and the outreach and enrollment professionals. In June 2006, for example, BCBSMAF organized a technical assistance session to explain the state's new reforms and gather grantee concerns about the coming changes. The concerns and suggestions raised at this session were developed into a briefing document that was distributed to state decision makers. In November 2006 BCBSMAF engaged the Executive Director of the newly formed Massachusetts Commonwealth Health Insurance Connector Authority to participate in an open-dialogue meeting with outreach and enrollment professionals. At this session the grantees demonstrated their commitment to being a resource to the community and pointed out some forms of health coverage in Massachusetts of which the Connector was not yet aware.

Lessons Learned

BCBSMAF is dedicated to sharing information about the success of its funded programs. In 2007 to strengthen evaluation of funded programs, the Foundation changed grantees' reporting requirements from bi-annual to monthly. Reports collect both quantitative data, such as volume of visitors and numbers enrolled, and qualitative data, such as best and worst experiences working to enroll clients, providing valuable information to BCBSMAF about the progress of health care reform and its impact on grantees' communities. Those monthly reports are then summarized by the Foundation, and those summaries are distributed to grantees and state decision makers.

BCBSMAF-funded organizations have had a great impact on enrollment. Collectively, grantee organizations report

that they are seeing around 8,000 to 10,000 individuals a month. By August 2007, the overwhelming number of new health insurance applications had created a backlog within the state Medicaid screening process. Grantee reports consistently listed that backlog as a barrier to access; applications were lingering in the system for as long as six to eight months. Based in part on the data from the monthly report summaries, concern over the problem grew. After it was publicly reported in the *Boston Globe*, senior state health officials restructured the screening process for applications in order to increase screening capacity.²⁰

The Foundation's work has helped to build capacity among grantees. Some organizations were initially completing about five electronic enrollments per month. BCBSMAF provided technical assistance and helped grantees use the online enrollment system. The resulting decrease in processing time enabled a higher volume of enrollments.

BCBSMAF grantees' unique organizational assets, such as established relationships with specific subgroups of the uninsured population, have contributed to their successful enrollment efforts. Two organizations that worked closely with non-English speaking residents were able to build upon their understanding of the relevant cultural norms to allay clients' fears about providing their personal information and connect them with health care. Other organizations engaged local businesses. One example is a Safe Shops Initiative, a Boston Public Health Commission program originally funded by the U.S. Centers for Disease Control and Prevention that focused on reaching 19–31 year old males who commonly lack insurance. The Foundation has funded this effort for two years, supporting its staff as they travel to Boston area auto body shops to educate employees (mostly young males) about insurance options and to screen and enroll employees on-site.

The population of BCBSMAF grantees has evolved since the state health reform initiative. In 2007, BCBSMAF increased available funding and received double the number of applicants. Of the 24 selected grantees, 11 were new, and 13 were renewals. This year some grantees have "graduated" from simple outreach and enrollment activities to case management under a separate three-year funding program. These grantees have already enrolled most of their target population

and are now focused on ensuring beneficiaries are receiving the best care possible.

Future

The Foundation is currently involved in long-term strategic planning discussions around the issue of outreach and enrollment. One idea under consideration that will enhance its funding efforts is to introduce more technological innovations, such as providing grantees with laptops to enroll residents in the field. BCBSMAF remains fully committed to the outreach and enrollment of uninsured state residents. "We will not abandon our Connecting Consumers with Care grant program until we know the state is in it for the long haul and we have built a good infrastructure," shared Phillip Gonzalez, Director of Grantmaking.

WellPoint Foundation

WellPoint Foundation (WLPF) is a private, nonprofit foundation funded by WellPoint, Inc. (WellPoint). The Foundation, established in 2000, is one of the largest corporate foundations in the United States with net assets of about \$150 million. WLPF operates primarily in the 14 states covered by WellPoint, providing funding for programs at the state, local and national levels. Efforts to reduce the number of uninsured comprise one of the Foundation's two Signature Programs. The other Signature Program ("Healthy Generations") supports programs to improve specific state public health measures.

WellPoint's interest in expanding access to health care is two-fold. First, as a health care organization, the company seeks to provide health insurance to optimize individuals' health and well-being. Second, it recognizes lack of health insurance as a business problem as well as a social problem: failure to address health problems early results in increased health care costs to consumers and society and drives up the costs of health insurance premiums.

WellPoint's strategic plan provides specific targets for reducing the rate of uninsured in states where the company operates. While WellPoint is focusing on moderate to higher income uninsured people who are not eligible for public coverage, WLPF focuses its funding and programs on the 12 million individuals

below the Federal Poverty Level who are eligible for public programs.

Following this vision, WellPoint announced a company-wide Uninsured Initiative in January 2007 with three major components:

- 1) Affordable benefit plans,
- 2) Public policy lobbying (state and federal levels), and
- 3) WLPF funding commitment of \$30 million over three years.

In addition, an Uninsured Task Force comprised of key associates throughout the company was appointed to lead WellPoint's uninsured efforts. During 2007, the task force conducted extensive research to identify community-based programs with the greatest potential to reduce the number of uninsured. As a result, WLPF approved \$10.6 million (of the \$30M commitment) to support organizations providing health-related services, including eligibility and enrollment assistance, to low-income, ethnically diverse and underserved communities with predominantly uninsured populations. These grants accounted for 46 percent of the Foundation's total 2007 grant budget (\$23 million).

In February 2008 the task force recommended funding three organizations:

- 1) Foundation for Health Coverage Education (FHCE),
- 2) The CoverMe Foundation, and
- 3) Prevention Partners

From 2004 through 2007, WLPF was the primary funder of FHCE with a total contribution of \$1.33M. FHCE is a California-based nonprofit organization that provides education and services to assist uninsured individuals in obtaining coverage. FHCE operates a 24/7 call center and produces and disseminates printed Health Coverage Matrices that outline state specific public and private insurance options for individuals. Individuals can call FHCE operators who will guide them through their insurance options, determine whether they are eligible for public programs, and refer them to the appropriate

agency to apply for coverage. Individuals can also access state-specific information on the FHCE website at www.coverageforall.org. Over the four years of WLPF funding, FHCE's outreach efforts have shown value, reflected in increased call volume and hits to the FHCE website. In 2008 WLPF approved two additional grants totaling \$112,000 to continue funding the FHCE call center.

The other two organizations – The CoverMe Foundation and Prevention Partners – are both working to identify uninsured individuals eligible for government programs and helping them get enrolled.

The CoverMe Foundation (CMF) is the nonprofit arm of MedAssist, a national company that specializes in eligibility and enrollment assistance. Through outreach at community events, national public relations, advertising, mailings, a nationwide call center, and referrals from SCHIP, School Lunch Programs, FHCE, Prevention Partners, and WellPoint network physicians, CMF identifies and guides uninsured individuals to enroll in coverage. Once an uninsured individual is identified, CMF conducts comprehensive eligibility screening to determine which coverage type is best suited to an individual's personal circumstances. For public programs, CMF will provide hands-on counseling and instruction through the application process and ongoing assistance as individuals access public benefits. For individuals not eligible for public coverage, CMF provides education and means to access other free or discounted medical resources. In the first year, WLPF will provide up to \$2.5 million to CMF with total funding dependant on their success in enrolling uninsured individuals. WLPF expects CMF to enroll approximately 39,000 individuals each year.

Prevention Partners' outreach model utilizes churches as a safe site to bring health education, awareness and services to the uninsured populations in underserved communities. The program provides direct access to on-site health care services, such as screening tests, education, and access to medical follow-up and treatment. In addition, on-site enrollment specialists from the CoverMe Foundation assist individuals in completing applications for appropriate public programs. The populations impacted are predominantly African American and Hispanic. WLPF provided \$1.2 million in funding for one year. The goal is to secure 9,264 enrollees in five of WellPoint's major markets.

WLPF monitors the progress of current grantees as they seek to reach WellPoint's goal of reducing the number of uninsured. At the start of each funding cycle, WLPF and each grantee jointly establish metrics upon which the program will be evaluated. Evaluation reports submitted at the completion of a grant period assist WLPF in determining the impact of their grants.

The Blue Foundation for a Healthy Florida

The Blue Foundation for a Healthy Florida (TBF) is a private, nonprofit philanthropic affiliate of Blue Cross and Blue Shield of Florida. The Foundation's mission is to enhance access to quality health-related services for Floridians with an emphasis on the uninsured and underserved. TBF's current grantmaking focus is on community health clinics and outreach programs.

TBF's funding philosophy is to support community-based organizations for one to three years to assist them in becoming established and implementing programs. The Foundation believes that following the initial support and training, the projects should be able to continue without TBF's financial support.

In recognition of the fact that many uninsured children in the state are eligible for public programs, each Foundation project related to children and families includes a screening and education component to increase awareness of, and enrollment in, public coverage.

Two TBF projects are implementing significant outreach and enrollment activities. In Hillsborough County, TBF provides funding to St. Joseph's Children's Advocacy Center for Project PATH (Providing Access to Healthcare). The project includes a mobile van providing health care services, offered by the Mobile Medical Outreach Clinic, and on-site eligibility screening for public health insurance coverage. The Center targets underserved and uninsured residents in Hillsborough County, and the van represents an important vehicle through which these populations can access health care services. A nurse practitioner and dental hygienist staff the van, providing immunizations, well-child care, screenings, teeth cleaning, child development resources, and eligibility screening. Project PATH will reach at least 350 children over the course of the two years of funding.

A second project in Miami Beach targets the local Hispanic community. TBF funds a mobile dental health van that travels to Title I schools²¹ to conduct eligibility screenings and provide health services to low-income, primarily Hispanic children. Last year van staff screened 2,200 children, of whom 240 were eligible for public programs. Specialists assisted families in completing and submitting forms to enroll children in these public programs. In addition, children visiting the van received dental health services, including screenings, cleaning and minor procedures, and as of last year, vision screening. TBF is committed to increasing enrollment in public programs through their funded programs; any project funded related to kids and families has both an eligibility screening and education component.

HEALTH PLAN EFFORTS TO INCREASE AFFORDABLE PRIVATE INSURANCE OPTIONS

Although the total number of uninsured children in the U.S. declined slightly in 2007, public coverage increased, primarily for low-income children. However, in 2007, almost 40 percent of all uninsured children were in families with incomes above 200 percent of FPL.²¹ Public coverage for these families is limited, and despite the lifting of a directive to allow more states to enroll higher-income children in public programs, state budget deficits are expected to keep most states from expanding their programs to cover this population. Therefore, private market options will still be critical to this population. Nationally, approximately 60 percent of children receive health insurance coverage as dependents through employer-sponsored insurance (ESI).²³ Therefore changes in the private insurance market affect children's and families' access to health insurance. Decline in ESI coverage in recent years has led to an increase in the number of uninsured children among middle-income families (particularly among those with incomes between 200 and 399 percent of FPL).²⁴ Additionally, there have been larger declines in ESI coverage for children than adults at all income levels, which suggests that dependent coverage is eroding.²⁵ These trends point to a need for alternative insurance products for the non-group markets that are affordable for middle-income families and can fill the gap between public programs and ESI coverage that currently exists in the U.S.

Young adults (19–24) are one of the fastest growing segments of the uninsured population in the U.S. Lack of insurance for this age group is primarily due to young adults aging out of a parent's policy, but can also be attributed to the fact that many entry-level jobs do not offer health insurance. As of 2006, 31 percent of all young adults were without health insurance.²⁶

The non-group private insurance market offers options for the more than 20 percent of Americans who are not offered or cannot afford ESI and who are ineligible for public programs.²⁷ New products are continually emerging that target the young adult population and other groups that have not traditionally purchased private health insurance. Insurers are also using non-traditional methods and innovative marketing techniques to expand enrollment in individual products. This section outlines some of these methods.

Horizon NJ Health

Horizon NJ Health, a wholly owned subsidiary of Horizon Blue Cross Blue Shield of New Jersey, was established in 1993 as a Medicaid Managed Care Organization for the publicly insured. Horizon NJ Health (Horizon) has a 45 percent market share serving more than 358,000 members.

New Jersey has made great strides in recent years to improve access to health insurance for all residents. The state anticipates that tens of thousands of new families will enter into NJ FamilyCare (the state's SCHIP program) as a result of the bill signed in July 2008 by Governor Corzine, which mandates insurance coverage for children in the state and raises eligibility for parents in NJ FamilyCare from 133 percent to 200 percent.²⁸ This new legislation augments the Family Health Care Act implemented in 2005 that expanded the eligibility for children and some parents for NJ FamilyCare and created the framework for a new buy-in program, NJ FamilyCare ADVANTAGE, for families not eligible for traditional NJ FamilyCare.

NJ FamilyCare covers children and some adults with incomes up to 350 percent of FPL, and the new NJ FamilyCare ADVANTAGE buy-in program allows the

FIGURE 2: NJ FAMILYCARE ADVANTAGE PREMIUM

Number of Children in Family	Premium Cost per Month
1	\$137
2	\$274
3 or more	\$411

Source: Horizon NJ Health. Available at: http://www.horizonnjhealth.com/members_nj_familycare_advantage.asp; accessed 4/8/08.

purchase of a very similar benefit package for children in families with incomes above the 350 percent of FPL. In an attempt to prevent crowd out of private coverage, the program requires that enrollees cannot have been covered by another type of insurance for the six months prior to enrollment unless they lost their Medicaid or traditional NJ FamilyCare eligibility. The monthly premium is based on the number of children in the family and families with more than one child must enroll all of their children (Figure 2). Certain benefits may also require a co-payment to the provider.

Unlike the rest of NJ FamilyCare, the ADVANTAGE program receives no state or federal funding. It is a private program that is offered by health plans through a contract with the state. Following the passage of the Family Health Care Act, the state contacted five Medicaid Managed Care organizations in New Jersey regarding their interest in participating in the new buy-in program. Of these, Horizon NJ Health was the only plan that has elected to offer the new buy-in program, which became operational on January 1, 2008. While the new program is initially anticipated to operate at a loss, Horizon decided to participate because it is in line with its mission of providing access to quality health care.

Prior to the launch of the buy-in program, Governor Corzine held a press conference to announce it and

generate awareness of the program across the state. In turn, people began to call Horizon asking how to enroll. Horizon kept information on file from these callers in order to follow-up with interested residents after the program was fully implemented.

Horizon and state agencies continue to work in partnership to promote enrollment into the NJ FamilyCare ADVANTAGE program. The State has committed to include information on the buy-in program in the letters they send to individuals who will be losing their eligibility for traditional NJ FamilyCare or are not eligible because their income is above 350 percent of FPL.

Horizon has based its outreach activities on market research, drawing on information from consumers through the Consumer Assessment of Healthcare Providers and Systems. Horizon also sought feedback from its members and community health advisory committees. These advisory committees meet monthly and include voluntary representatives from community organizations and health plan members. Information from these sources was consolidated to guide the development of activities that would be most successful in reaching the target population.

Horizon's limited license marketing representatives who currently market for traditional NJ FamilyCare are now also promoting the ADVANTAGE program. Initial

outreach activities included the establishment of a toll free NJ FamilyCare ADVANTAGE hot line and mailing applications to close to 300 families with children believed to be eligible. As of August 2008, 119 members have been enrolled in the plan. When members are enrolled, they receive a welcome call from Horizon and an information kit for new members. Horizon's experience has shown that this personalized welcome call will assist members in understanding their benefits, rights and responsibilities.

Horizon focuses much of its outreach efforts on grassroots organizations and activities. This focus is partly due to the high advertising costs in New Jersey, but also because the plan's previous experience has found grassroots outreach to be the most effective means of reaching the uninsured population across the state. Outreach activities are achieved by partnering with community-based organizations, faith-based organizations and schools. These organizations often are better able to overcome barriers and can effectively identify, inform and help enroll uninsured individuals. Horizon has mobile vans that participate in various health fairs and other community events, and Horizon employees assist with enrollment at these events. Horizon participated in 215 events in 2007 and plans to participate in more than 250 in 2008.

Blue Cross and Blue Shield of Florida

Blue Cross and Blue Shield of Florida's (BCBSF) mission to provide affordable products for Floridians extends beyond its efforts to increase the number of children and families enrolled in public coverage. BCBSF has sought to fill the gap left by the decline in employer-sponsored insurance by offering a wide array of individual health insurance products directly to Floridians. As the insurance industry evolves to become more consumer-centric, BCBSF has also moved beyond the traditional means of health insurance sales, entering a new frontier for insurers – the retail marketplace.

The first Florida Blue retail store opened in a Jacksonville mall in February 2007. Since then, a second store has opened in South Florida. BCBSF decided to adopt a retail focus in order to demystify the process of

obtaining health insurance for consumers. The direct access and outreach into the community afforded to BCBSF by the retail store location allows for more visibility and opportunities to advertise their suite of individual products, while interacting directly with consumers on an individual basis. The idea of developing a retail store experience for purchasing health insurance came out of focus groups conducted by BCBSF. This research indicated that consumers desired individualized assistance with the cumbersome process of understanding and selecting health insurance. The desire for face-to-face interaction was especially apparent in Florida's multi-cultural markets in the southern part of the state. Therefore, the stores are staffed by bilingual customer advocates who greet customers as soon as they enter the store, providing a VIP or concierge experience to every person by personally leading them through their options for obtaining health insurance.

All BCBSF products, including health, dental, life insurance and long-term care options, are sold through these stores for both the Medicare market and for the under-65 buyer. One of the lowest-cost products currently available in the store is Go Blue, which includes coverage for routine health care needs such as physician office visits, dental care, prescription drugs and lab services, with a premium of \$50 a month. Under this product, the plan will pay a maximum of \$50 for each visit and the member pays the balance. All lab services are covered in-network and the plan will pay between \$5–15 towards each prescription filled by a network pharmacy. The store provides tools and websites to help consumers understand health costs. BCBSF expects the retail store to attract a large number of the growing population of uninsured young adults since this age group is responsible for significant mall traffic. While data for this specific age group are unavailable, initial data for 2007 indicated that of all applications received through the retail store, close to half (44 percent) of applicants have been uninsured for six months or longer. The initial data from the first quarter of 2008 indicates a slightly higher percentage (48 percent) of applicants have been uninsured for six months or longer.²⁹

BCBSF has also invested in television, billboard and print advertising for the store, but expects to generate

much business through word of mouth advertising as satisfied customers share their experiences with friends and family. BCBSF is also considering placing a kiosk in the stores to help those eligible for public programs to apply for coverage on the spot. As they look to the future of retail insurance sales, BCBSF plans to open two additional retail stores shortly and is considering adding kiosks in additional locations across the state. Another insurer in Florida, Aetna, also recently embraced the retail store model by opening a store in south Florida, indicating the insurance industry may continue to reach out to consumers in the places they frequent most often, while providing individualized health insurance enrollment services.

WellPoint

As stated earlier in this report, WellPoint's overall strategy for addressing the uninsured problem has been to segment the uninsured according to the reasons they do not have coverage and to develop strategies for insuring these populations. One way that WellPoint is doing this is by developing new products targeted to particular market segments that typically have a higher rate of uninsurance. In its work, the company identified a need for a product targeted to meet the needs of uninsured young adults. WellPoint categorized this population as the "young invincibles" – those who either do not see the

FIGURE 3: TONIK PLANS

Benefits	Thrill Seeker	Part Time Daredevil	Calculated Risk Taker
Annual Deductible	\$5,000	\$3,000	\$1,500
Doctor Visit <i>Deductible waived</i> Copay covers all services received in office, including x-ray, lab, etc.	\$20 4 visits/year	\$30 4 visits/year	\$40 unlimited visits
In/Outpatient Hospital	\$0 after deductible		
Prescription Drugs (Generic Only)	\$10		
Dental	\$25 Deductible \$0 Cleanings, Exams, X-rays 20% Fillings		
Vision	\$50 for Exams, Glasses, Contacts		

Source: Northrup S. Presentation at Academy Health National Health Policy Conference, Washington, DC, February 4, 2008; "Young and Uninsured: Closing the Gap for the Invincible and the Ineligible."

value of health insurance or cannot afford it. Through extensive market research to better understand the desires and financial constraints of this age group, WellPoint developed the product TONIK.

There are three separate plans within TONIK: Thrill-Seeker, Part-Time Daredevil and Calculated Risk-Taker. Figure 3 details the co-pays and deductibles for each plan as of August 2008. Focus group research indicated that young adults want comprehensive benefits, including medical, vision and dental; simplified online enrollment; straightforward, conversational communication; automated payment; and instant, downloadable and customized identification cards. TONIK provides all of the above and is currently offered in six states under the TONIK brand offered by Anthem Blue Cross (California), Anthem Blue Cross and Blue Shield (Nevada, Colorado, Connecticut and New Hampshire) and Blue Cross Blue Shield of Georgia. Under the UniCare brand the product is offered in two additional states (Texas and Illinois), where the product is called Sound.

As of 2007, approximately 78 percent of TONIK's more than 80,000 enrollees were previously uninsured.³⁰ The success of TONIK in enrolling previously uninsured young adults can be attributed to the innovative and nontraditional outreach and marketing of the product. For example, in California, Anthem Blue Cross, a WellPoint health plan, has used brand-launching events linked to extreme sports, such as extreme ski presentations and beach volleyball events. TONIK also has a website specifically developed for the 19–29 year old audience and the plan is also investing in online marketing with banner ads on websites visited by this age group. This active outreach through brand launching events was important to product enrollment in California. Recognizing the differences in the geographic markets, when rolling TONIK out on the East Coast, the marketing was focused more on online marketing instead of event marketing.

WellPoint continues to invest in focus groups as a mechanism for understanding the needs of the uninsured population and seeks to develop products and outreach activities that will contribute to their mission of reducing the rate of uninsured. They expect young adults to continue to be a priority population

for new products as this demographic group frequently cycles in and out of health insurance coverage.

Blue Cross Blue Shield of Massachusetts

In 2007 following the Massachusetts health reform efforts, private health plans were permitted to offer plans to individuals and families with incomes 300 percent of FPL and higher through the Massachusetts Health Insurance Connector's Commonwealth Choice program. Blue Cross Blue Shield of Massachusetts (BCBSMA) responded to a state request for proposals to offer a product for 18–26 year olds who cannot obtain health insurance through their employers. BCBSMA is now one of six private health plans to offer a Young Adult Plan (YAP), which is a low-premium, cost-sharing product, available with or without a pharmacy benefit; deductibles and co-pay requirements vary by plan. The BCBSMA plan — Essential Blue Young Adult — is the only one of the six not to have an annual benefit maximum. Details on the BCBSMA YAP are provided in Figure 4.

While the state is responsible for enrollment in Essential Blue YA and all other Commonwealth Choice plans, each health plan conducts outreach and marketing for its products. BCBSMA outreach efforts for Essential Blue YA focus on advertising and email campaigns. The plan also hired a "brand ambassador" for the product, who takes a branded vehicle to events where the target age group is present, such as concerts and auto shows. Additional outreach for all Commonwealth Choice plans was conducted in 2007 through a \$3 million advertising campaign, funded by the Commonwealth Connector, tied to the Boston Red Sox, and featured on the New England Sports Network. *Cover Your Bases — Connect to Health* was an integrated communications campaign targeting men age 19 to 39, since this age group represents the majority of uninsured in the state. The campaign included television and radio advertising that ran during Red Sox games, as well as print ads in community, ethnic and college newspapers. Additional outreach planned for 2008 through the Commonwealth Connector includes partnerships with ZipCar, colleges and universities, and web outreach, including social networking sites.

FIGURE 4: BCBSMA YOUNG ADULT PLAN

Benefits	Essential Blue YA with Rx	Essential Blue YA without Rx
Annual Deductible	None	None
Doctor Visit	All visits (including one GYN exam per calendar year) Tier 1 ¹ provider: \$10 Tier 2 provider: \$50	All visits (including one GYN exam per calendar year) Tier 1 ¹ provider: \$10 Tier 2 provider: \$50
In/Outpatient Hospital	Tier 1 provider: 30% coinsurance Tier 2 provider: 60% coinsurance	Tier 1 provider: 30% coinsurance Tier 2 provider: 60% coinsurance
Prescription Drugs	Retail (up to 30 day supply): \$15 Generic \$30 Preferred Brand \$50 Non-preferred Brand Mail Order (up to 90 day supply): \$30 Generic \$60 Preferred Brand \$150 Non-preferred Brand	No coverage
Dental	30% co-insurance for in-network providers (maximum benefit is \$250 a year)	30% co-insurance for in-network providers (maximum benefit is \$250 a year)
Vision	Routine exam (one every 24 months) Tier 1 provider: \$10 Tier 2 provider: \$50	Routine exam (one every 24 months) Tier 1 provider: \$10 Tier 2 provider: \$50

¹ Tiers for the Essential Blue YA product are based on proprietary agreements with providers.

Source: "What's a YAP?" Available at: <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Brochures/YAP>; accessed 4/18/08

To date, BCBSMA has been successful in enrolling young adults, most of whom were first-time insurance buyers. However, it is more difficult for the state to measure the overall successful enrollment of uninsured young adults across all options available to this population – Commonwealth Care, Commonwealth Choice, and the expansion of dependent coverage up to age 26. As of June 2008, 8,882 individuals aged 19–26 were enrolled in Commonwealth Choice Young Adult Plans; 41 percent of these individuals were enrolled in Essential Blue's YAP.³¹

In addition to outreach on Essential Blue YA, BCBSMA had a companion campaign from May–December 2007 to promote other new products available directly through BCBSMA. Prior to health reform, BCBSMA offered six health insurance products; currently they are offering over 50 products. This amount of choice has been overwhelming for consumers, so BCBSMA has created a family of products called Get Blue to make it easier to decide and developed outreach activities to help consumers understand product options. Outreach for these products included seminars in malls and hotels, paid online and television advertising, and print marketing materials. BCBSMA also utilized call centers with expanded hours, with many staying open until midnight during the days before the campaign ended. Outreach and education will continue to be vital to the success of both the health reform efforts in MA as well as increasing enrollment in the myriad new health insurance products available to consumers through health reform.

CONCLUSION

The outreach and enrollment efforts detailed in this paper represent a sampling of the types of activities underway across the United States to increase the number of insured children, young adults and families. While each state faces its own unique challenges and circumstances, these examples highlight the capacity and commitment of health plans and foundations, working alone and in collaborations, to reach and enroll uninsured Americans. Despite the lack of evidence in the literature on what constitutes effective outreach and enrollment, health plans are forging ahead and learning what works in their respective communities.

Outreach and enrollment of eligible children and parents in SCHIP and Medicaid relies heavily on partnerships between the state, health plans and community organizations. Health plans have immense resources to drive outreach activities in their communities and work concertedly with state governments and community groups to smooth out the enrollment process. Health plan foundations continue to reflect a commitment to supporting community-based organizations, clinics and health centers that are often working with limited budgets to reach the uninsured, identify options for health insurance, and assist with the enrollment process. Due to the competitive nature of the health insurance industry, health plans are also natural innovators in developing new private products and unique outreach strategies to meet the needs of the evolving marketplace. The unique products developed and marketed specifically to young adults illustrate this innovation, as well as the move towards retail sales of health insurance on a personalized level.

The reauthorization and expansion of CHIP, coupled with the lifting of restrictions on enrolling higher-income children in the program, are steps in the right direction for securing health coverage for more children through public programs. However, state budget shortfalls may reduce funds for outreach and enrollment in the future and limit the ability for states to extend coverage to higher income children through CHIP. The problem of the uninsured in the U.S. will not be solved easily or without the involvement of all stakeholders in the health care system. The efforts detailed in this paper are positive contributions to ameliorating the problem from which others can learn, with the hope that sustained commitment to outreach and enrollment in public and private health insurance will ultimately lead to a decrease in the number of uninsured Americans.

ENDNOTES

- 1 DeNavas-Walt C, Proctor B, Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau Current Population Survey, August 2008.
- 2 Vitnes JP, Schone BS. "Pathways to Coverage: The Changing Roles of Public and Private Sources." *Health Affairs* 2008;27(1):44-57.
- 3 Rosenbaum S. "Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature." GWU/SPHHS for First Focus, June 2007.
- 4 Woolridge J. *Making Health Care a Reality for Low-Income Children and Families*. Mathematica Policy Research Issue Brief, February 2007.
- 5 USC Division of Community Health. *Reaching Out and Reaching In: Understanding Efforts to Identify and Enroll Uninsured Children Into Health Insurance Programs*. The California Endowment: January 2006.
- 6 Schoenman J, Chockley N, Murphy B. *Understanding the Uninsured: Tailoring Different Policy Solutions for Different Subpopulations*. NIHCM Issue Brief, April 2008.
- 7 *Reaching Out and Reaching In: Understanding Efforts to Identify and Enroll Uninsured Children Into Health Insurance Programs*.
- 8 Sommers BD. "Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up," *Health Affairs* 2007;26(5):w560-w567.
- 9 Williams SR, Rosenbach ML. "Evolution of State Outreach Efforts Under SCHIP," *Health Care Financing Review*, Summer 2007;28(4):95-107.
- 10 GovTrack.us. H.R. 2--111st Congress (2009): Children's Health Insurance Program Reauthorization Act of 2009. Available at <http://www.govtrack.us/congress/bill.xpd?bill=h111-2&tab=summary>. Accessed February 13, 2009.
- 11 Herndon JB, Shenkman EA. "The Florida Children's Health Insurance Study 2007." Institute for Child Health Policy University of Florida, 2008.
- 12 Florida Department of Health. "Florida KidCare Instructions" Available at: <http://www.doh.state.fl.us/AlternateSites/KidCare/images/applications/englishapp3-08.pdf>. Accessed April 9, 2008.
- 13 Smith VK, Rosseay D, Marks C. "SCHIP Program Enrollment: June 2005 Update," Kaiser Commission on Medicaid and the Uninsured, 2006.
- 14 "Update on the Florida SCHIP Enrollment Freeze," Kaiser Commission on Medicaid and the Uninsured, July 23, 2004.
- 15 Tennessee Title XXI State Plan Fact Sheet. Available at: www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/TNCurrentFactsheet.pdf. Accessed April 8, 2008.
- 16 Johnson L II. "More Than 16,000 Now in CoverKids; Cover Tennessee Ready to Grow." *Memphis Daily News*, November 27, 2007.
- 17 *Reaching Out and Reaching In: Understanding Efforts to Identify and Enroll Uninsured Children into Health Insurance Programs*.
- 18 Ibid.
- 19 Governor Patrick Outlines Emergency Recovery Plan to Stabilize Budget, Position State for Economic Recovery." Available at: http://www.mass.gov/?pageID=gov3pressrelease&L=1&LO=Home&sid=Agov3&tb=pressrelease&f=090128_budget&csid=Agov3; accessed 2/3/2009.
- 20 Dembner A. "Uninsured Face Health Plan Delays." *The Boston Globe*, August 11, 2007.
- 21 Title I schools are those where children are predominantly from families with incomes <100% FPL.
- 22 Fronstin P. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey*. EBRI Issue Brief, September 2008.
- 23 Holahan J, Cook A. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Kaiser Commission on Medicaid and the Uninsured, September 2007.
- 24 Ibid.
- 25 Ibid.
- 26 *Understanding the Uninsured: Tailoring Different Policy Solutions for Different Subpopulations*.
- 27 Beeuwkes Buntin M, Marquis MS, Yegian JM. "The Role of the Individual Health Insurance Market and Prospects for Change," *Health Affairs* 2004;23(6):79-90.
- 28 State of New Jersey Office of the Governor. "Governor Signs Progressive FamilyCare Legislation." Press Release, July 7, 2008.
- 29 Blue Cross Blue Shield of Florida sources. Retail Store Data, June 2008.
- 30 Northrup S. Presentation at Academy Health National Health Policy Conference, Washington, DC, February 4, 2008; "Young and Uninsured: Closing the Gap for the Inevitable and the Ineligible."
- 31 "What's a YAP?" Available at: <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Brochures/YAP>; accessed 4/18/08.

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