BEST PRACTICES TO IMPROVE TAKE-UP RATES IN HEALTH INSURANCE PROGRAMS

Final Report

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August 18, 2008

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Executive Summary

The number and percentage of Americans without health insurance has been increasing annually. Between 2001 and 2006, the proportion of uninsured Americans increased from 14.1 percent to 15.8 percent. Increases in the number and proportion of Americans who lack health coverage are due in part to the continued erosion of employer-sponsored health insurance. The decline in coverage through the workplace has been paired with an increase in the proportion of Americans receiving coverage through public programs. States have been particularly active over the last several years in expanding coverage through the Medicaid and SCHIP programs. Three states also had enacted and implemented comprehensive health care reform and 14 others were developing comprehensive approaches to health care coverage as of August 2008. On the federal level, President Bush introduced his Affordable Choices initiative in his January 2007 State of the Union address.

Even with expansions, participation rates in public programs targeting the uninsured are low; data from national surveys show that a substantial proportion of the individuals who lack health insurance coverage, particularly children, may have qualified for public programs. Thus an examination of how to best implement outreach, enrollment, and retention efforts is warranted. The findings are relevant for existing health insurance programs as well as new proposals to expand coverage, such as the Administration's Affordable Choices initiative.

This report reviews the extensive literature on methods to improve take-up rates for health insurance coverage. The purpose of this review is to take into account the strength of the evidence presented in studies regarding take-up. This report, therefore, based its findings on previous studies that presented data rather than opinions. The literature review also focused on articles pertaining to strategies to promote take-up, rather than to program participation barriers; and it is limited to interventions, rather than program design or policies that may affect take-up. Although there is little causal evidence among the studies reviewed, some strong correlations are reported. The discussion below presents conclusions from the available literature regarding five topics of particular interest: effective take-up strategies, cost-effectiveness of the strategies, effective strategies for special populations, relevant lessons for the Affordable Choices Initiative, and recommendations for future research.

Effective strategies

Based on a careful analysis of all of the articles reviewed, two predominant findings emerge regarding efforts to promote successful take-up in health insurance programs. The first is that individuals are more likely to enroll in insurance programs and maintain their coverage when extensive personal assistance, geared to the needs of the individual, is available. The second major finding is that simpler enrollment and renewal processes increase the likelihood that individuals will obtain and retain coverage. Studies of publicity campaigns find much weaker evidence of effectiveness. In gauging the success of assistance efforts, the amount and type of assistance provided appears to be relevant as is the source of assistance. Individuals are more likely to seek and accept help from organizations and individuals that they trust and that provide culturally or linguistically appropriate assistance.

Cost-effectiveness of strategies to improve take-up

The literature reviewed does not include rigorous analysis of cost-effectiveness and the data on the cost-effectiveness of various strategies to increase take-up are not conclusive. There is some evidence to suggest that well-targeted rather than broader efforts are more likely to be successful and cost-effective. In discussions of findings, several researchers note that efforts to increase insurance coverage can be seen as good investments. This is particularly true for health care providers, who stand to benefit from additional compensation from insurers if their patients are insured. Also, the administrative savings associated with simplifying enrollment and renewal processes were documented in some articles. Discussions also highlighted the issues that local initiatives to increase coverage may be difficult to sustain without a consistent source of support.

Strategies for special populations

The literature does not provide definitive information about strategies for take-up that are particularly effective for populations living in rural or urban areas. There are indications from the literature that efforts to increase take-up are likely to be more successful if applicants and enrollees have the opportunity to receive assistance from trusted sources who speak the language they are most comfortable speaking and who are familiar with their culture. There is also some evidence that publicity about programs will be more effective if other languages as well as English are used.

Lessons for new coverage initiatives

One important lesson for any new initiative to increase health insurance coverage, such as the Affordable Choices initiative, is that outreach activities are crucial early on to introduce people to the new benefit, but publicity alone will not ensure that individuals seek and successfully enroll in coverage. Also, simple enrollment and renewal processes will be helpful in ensuring that uninsured individuals obtain and keep coverage. Furthermore, there is a good deal of evidence that without the availability of assistance, efforts to publicize programs or simplify enrollment will not be as effective as in efforts where assistance is available. Although face-to-face meetings should not be required, all applicants and enrollees should have the option of receiving comprehensive assistance comprising not only assistance completing applications and obtaining documentation if it is required, but also providing follow-up.

If the nature of a new initiative differs in design from current insurance programs and options, then it will be important to provide adequate training about the new initiative as well as about existing programs and their relationship to the new initiative for those who may be assisting applicants. Much of the literature on increasing take-up rates pertains to the low-income population. If coverage expansions include individuals with higher incomes then it may be necessary to consider who the new target population would view as a trusted source for information and assistance. Finally, with any new initiative there is a need to provide sufficient funding not only to help with the initial enrollment, but also to sustain activities to ensure that individuals who are eligible for coverage obtain and retain it successfully.

Recommendations for further research

The original intent of this project was not to develop recommendations about evaluation techniques, but in the course of reviewing resources for inclusion, the strengths and weaknesses of the research that has been done to date on this topic have become evident. Therefore, this

report includes some recommendations regarding future research to improve the availability and quality of information on the topic of take-up. Specifically:

- Conduct more quantitative research;
- Use meaningful outcomes, such as numbers actually enrolled, to measure success;
- Make meaningful comparisons using baseline data that show usual enrollment patterns; prior to an intervention or enrollment patterns for comparable groups;
- Invest in simple routine measurement so that baseline data will be available for comparison;
- Take exogenous factors such as changes in economic conditions or program regulations into account; and,
- Include measures of cost-effectiveness.

Conclusion

Policy changes to expand health insurance coverage are more likely to succeed if they are accompanied by efforts to ensure that optimal take-up of benefits occurs. This concept is generally recognized and there are many examples of activity on the federal, state, and local levels geared to increasing enrollment in public programs for children, families and the elderly. Yet, program participation rates generally are lower than expected even as a substantial portion of the uninsured population is eligible for public insurance programs. Thus, there is a need to understand how to best promote uptake. A review of the literature on this topic indicates that individuals are more likely to enroll in insurance programs and maintain their coverage when extensive personal assistance is available. Also, simpler enrollment and renewal processes are advantageous for both applicants and those who assist them, and contribute to higher enrollment rates. More rigorous research is needed, however, to understand more about the efficacy and particularly the cost-effectiveness of different approaches.

Introduction

The number and percentage of Americans without health insurance has been increasing annually. There were 47 million uninsured Americans in 2006, compared to 39.8 million in 2001. On a percentage basis, the number of uninsured Americans increased from 14.1 percent to 15.8 percent during the same time period.[1]

Among the uninsured, 36 percent come from households with incomes below 100 percent of the federal poverty level (FPL) and a total of 81 percent have incomes below 300 percent of FPL. In 2006, some 20 percent of the non-elderly uninsured were younger than 19, young adults between the ages of 19 and 34 comprised 39 percent of the uninsured, 31 percent were aged 35 to 54 and 9 percent of the uninsured were in the age group 55 to 64.[2]   Insurance status also varies by race and ethnicity. In 2006, more than one third of Hispanics – 36 percent – were uninsured, compared to 22 percent of blacks, 17 percent of Asians and 13 percent of whites.[3]

Among the non-elderly uninsured in America, 71 percent come from households with at least one full-time worker. Another 11 percent come from households with at least one part-time worker. Increases in the number and proportion of Americans who lack health coverage are due in part to the continued erosion of employer-sponsored health insurance; only 60 percent of firms offered health coverage to at least some employees in 2007, compared to 69 percent of firms in 2000.[4] Suggested reasons for the decline include a shift of workers to smaller businesses, which are less likely to offer health insurance coverage than larger firms, and a shift of the cost of insurance from employers to employees, which may prompt some workers to drop coverage.[5]

The decline in coverage through the workplace has been paired with an increase in the proportion of Americans receiving coverage through public programs. In 2001, almost 23 percent of children ages 18 and younger received coverage through Medicaid or the State Children's Health Insurance Program (SCHIP); that percentage rose to 27 percent by 2006. Employer-sponsored insurance, covered 64.4 percent of children in 2001; by 2006, the percentage had fallen to 59.7 percent.[6]

States have taken a number of actions to expand health care coverage for low-income children and some parents through the Medicaid and SCHIP programs by increasing income eligibility limits to levels above the minimum: 133 percent of FPL for pregnant women and children younger than age 6 and 100 percent of FPL for children ages 6 to 19.[7] In 2007, forty-five states covered children in families with incomes of 200 percent FPL or higher. At least 18 states have expanded their Medicaid or SCHIP programs to cover parents with incomes at 100 percent of FPL or higher.[8]   Some expected state expansions have not or will not occur, however, as two reauthorization bills that would have expanded the SCHIP were vetoed by President Bush in 2007. Instead, Congress passed an 18-month extension of the program with some additional funding through March 2009. In addition, an Administrative directive from August 2007 regarding SCHIP expansions affected policies and plans in states to offer coverage to children from families with incomes greater than 250 percent of FPL.[9]

Some states have moved beyond Medicaid and SCHIP expansions towards comprehensive health care reforms. A review of state activity indicates that as of August 2008, three states had enacted

and implemented comprehensive health care reform and 14 others were developing comprehensive approaches to health care coverage.[10] In 2005, Maine implemented a subsidized health insurance program called DirigoChoice, which offers coverage to individuals, self-employed workers and small businesses. Maine paired this program with an eligibility expansion of the state's Medicaid program.[11] The Massachusetts Health Care Reform plan has an individual mandate, which requires all adult residents to purchase health insurance. At the same time, employers with 11 or more employees are required to offer coverage, or pay an annual "Fair Share" contribution. Premium subsidies are available to low-income, uninsured individuals.[12] Vermont established the Catamount Health Plan to provide coverage for uninsured adults.[13]

On the federal level, President Bush introduced his Affordable Choices initiative in his January 2007 *State of the Union* address. Affordable Choices would provide states with the option to subsidize private health insurance to cover uninsured residents. It would use redirected funds that are otherwise paid to hospitals and other health care institutions for care of the uninsured or underinsured.

For a new or existing program to be successful in improving health insurance coverage, the question of how to maximize take-up rates is a vital one to consider to ensure that all eligible uninsured targeted for the program are enrolled.. The topics of effective outreach, enrollment, and retention practices to improve take-up rates have received a great deal of attention over the past several years as states, the federal government, foundations, health plans, and community organizations have mounted campaigns and tried new procedures to increase enrollment for children and families in SCHIP and Medicaid programs. Significant activity has also occurred with respect to the Medicare Savings Programs (MSP), the Medicare Part D program, and the Low-Income Subsidy for Part D. These practices to improve take-up focus increasing program participation by reducing barriers to participation.

Program participation

The emphasis on improving take-up rates or program participation is logical in considering any policy to expand health insurance coverage given that large numbers of individuals in the US are uninsured and that a substantial proportion of those who are uninsured is eligible for public health insurance programs but not enrolled. There is ample evidence of low participation rates in public programs of all types.

- An analysis of data from the March 2005 Current Population Survey indicates that 74 percent of all uninsured children are eligible for Medicaid and SCHIP. Given the nature of public health insurance programs, parents and childless adults are much less likely to be eligible for public coverage. Still, eligible parents and childless adults account for 28 and 18 percent of the uninsured, respectively.[14]

- Traditionally, participation rates in public programs that pay Medicare premiums and some cost-sharing for low-income Medicare beneficiaries (QMB and SLMB) have been low. The U.S. Government Accountability Office reported in 1999 that 43 percent of beneficiaries eligible for the QMB and SLMB programs were not enrolled.[15] In 2004, the Congressional Budget Office estimated that 33 and 13 percent of eligible Medicare beneficiaries were participating in the QMB and SLB programs, respectively.[16]

- Data from the Centers for Medicare and Medicaid Services show that only 37 percent of eligible Medicare beneficiaries, who must apply in order to receive the Part D Low-Income Subsidy, were receiving the subsidy at the start of 2008 (two years after it became available).[17]

- An analysis of data from national surveys conducted by the U.S. Government Accountability Office shows that participation rates vary and fall short of full enrollment, with rates that range from about 50 to more than 70 percent for federal entitlement programs and from less than 10 to more than 50 percent for federal non-entitlement programs.[18]

Barriers to program participation

A substantial body of research that identifies barriers to participation has been published, though very little of it contains quantitative information. Frequently cited barriers to participation by children and families in Medicaid and SCHIP include a lack of information (or incorrect information) about the benefit or how to enroll; the complexity of the application and renewal processes; and difficulty getting to public benefits offices.[19] Reluctance to participate in public programs and the stigma associated with receiving public benefits are cited as barriers in some studies, but others indicate that stigma is not a factor in decisions about whether to participate in public programs.[20]

The importance of reaching individuals and assisting them with enrollment has long been recognized as part of efforts to overcome program participation barriers. Also, there is acknowledgment that efforts to assure that the renewal process works well are essential to ensure that coverage initiatives will continue to be successful. Research indicates that millions of children leave Medicaid and SCHIP each year and become uninsured despite their continued eligibility. A large proportion of individuals who apply for public coverage have already participated in public programs. Often the coverage gap is short – one to three months – suggesting that the gap is the result of administrative factors rather than changes in families' circumstances during that period. Still, those families are counted among the uninsured, and generally do not have coverage during the gaps.[21]

Over the years, the federal government has provided substantial funding for program outreach, which includes initiatives to publicize programs and streamline the application and enrollment processes. President Bush's budget for FY2009 included $450 million in outreach grants for the SCHIP program.[22] Congress approved new funds for efforts to reach the population eligible for the Medicare Part D subsidy.

Private organizations have also sponsored efforts to increase enrollment in public benefits programs. The Robert Wood Johnson Foundation, for example, has supported a national multi-year campaign, the *Covering Kids and Families* initiative, focused on reducing the number of eligible but uninsured children and adults in the United States. The *State Solutions* initiative, funded by the Robert Wood Johnson Foundation and the Commonwealth Fund, provided grants to states in an effort to improve enrollment in the Medicare Savings Programs. State SCHIP and

Medicaid programs have already exercised a number of options to make the application and renewal processes easier, though there is substantial variation among states.[23]

Policymakers have long recognized that to succeed, any new initiative to expand coverage must include strategies to promote take-up, but they need guidance to help them understand which strategies work best. Despite the high level of activity on the part of some national, state, and local organizations to increase enrollment, few efforts have been accompanied by rigorous evaluations. Little definitive information is available to indicate which methods for improving take-up are most effective or most cost-effective.

Purpose of this study

This report reviews the extensive literature on methods to improve take-up rates for health insurance coverage. Originally conceived as a meta-analysis, the purpose of this review is to take into account the strength of the evidence presented in studies regarding take-up. Thus, this report based its findings on previous studies that presented data rather than opinions. The literature review also focused on articles pertaining to strategies to promote take-up rather than to program participation barriers, and it is limited to interventions rather than program design or policies that may affect take-up. Although there is little causal evidence among the studies reviewed, some strong correlations are reported. Many of the methods to improve take-up discussed in this report are appropriate for expansion policies and coverage approaches like the Affordable Choices Initiative. The discussion below presents conclusions from the available literature regarding five topics of particular interest: effective take-up strategies, cost-effectiveness of the strategies, effective strategies for special populations, relevant lessons for new coverage program initiatives, and recommendations for future research.

Methods

This project makes a systematic assessment of the available literature on methods to overcome participation barriers and increase participation rates in health insurance programs. The research seeks to answer four key questions:

1) What types of outreach, enrollment and retention strategies have proved most effective in ensuring that uninsured individuals have public or private coverage?
2) Which outreach, enrollment and retention strategies are particularly cost-effective?
3) Which outreach, enrollment and retention strategies are particularly effective for special populations (those living in urban and rural areas, those whose first language is not English, and those whose cultural background or practices are different from the majority of program participants)?
4) What lessons are particularly important to consider with regard to new programs to expand coverage, such as the Affordable Choices Initiative?

Initially, the project was to feature a meta-analysis with the goal of providing evidence-based take-up best practices. To that end, a literature review, which involved the creation of a database, was developed. The methods used to construct the database and conduct the literature review are described in a preliminary report (see Appendix).[24] The completed literature review

catalogued resources on the basis of populations featured in the research, types of take-up strategies and activities studied, and the study methods used. The resources gathered were then reviewed to determine which should be included in the next phase of the project and what form the next phase should take. Based on the literature review findings, modifications to the meta-analysis approach were proposed for several reasons:

- The review indicated that the number of methodologically rigorous studies on the topic of interest is small. A variety of evaluation approaches are used in the research, with case studies being the most popular. Only four of the studies in the database are sufficiently rigorous in design to allow the authors to draw conclusions about the causes of outcomes. They control for exogenous influences with randomized samples, quantitative models or the use of control and comparison groups.

- In studies of a non-clinical nature it is difficult to control for exogenous factors that may affect outcomes. Many studies did not sufficiently address this concern, making it difficult to determine whether the observed effects were caused by the intervention or by other factors. Results from studies that do and do not control for exogenous variables are not comparable.

- Although there is a substantial body of literature, there is not enough uniformity to support a meta-analysis. For example, other researchers report that they have encountered difficulties when they attempt to collect outcomes data on SCHIP enrollment. They note that states have a difficult time producing outcomes data and that there is considerable variation in how states define, collect and organize outcome measures.[25]

- Comparison among the studies is complicated by the fact that they generally do not evaluate a single strategy. Most often, when there is a policy decision to make an effort to increase take-up, many activities occur simultaneously. This reality makes it difficult to conduct definitive outcome-based research and to make comparisons among studies.

Past efforts to synthesize research on take-up strategies support the conclusions presented here.[26] A systematic literature review was proposed and accepted as an alternative means to use the best available evidence to help answer the research questions. This strategy-specific review examines the literature pertaining to each of four strategies for increasing take-up rates:

       1) provide special assistance for applicants and enrollees
       2) publicize benefits
       3) simplify the enrollment process, and
       4) simplify the renewal process.

The methods used to construct the database ensure that it provides a rich source of reliable information. Strong consideration was given in the initial review of the literature to the quality of the research. The articles included in the database present evidence rather than opinions. The collection of articles is focused on strategies to promote take-up, rather than on program participation barriers. It is also limited to interventions, rather than program designs or policies that may affect take-up. Although there is a dearth of causal evidence among the studies, some strong correlations are reported.

There are 84 articles in the database categorized according to whether they pertain primarily to the four strategies under review. The most popular strategy examined in the articles is the provision of special assistance for applicants or enrollees followed by efforts to publicize benefits and then enrollment and renewal strategies. A few of the articles provide general overviews of take-up strategies. The results reported here are based on a review of the 84 articles in the original database. Also, articles that are relevant to the topic were added to provide newly available information and some context as the report was prepared. In reporting the findings, the type of data on which they are based is also reported to provide an indication of the relative strength of the findings. In drawing conclusions, greater weight is given to the findings from more rigorous studies. The report also includes recommendations regarding future research to improve the availability and quality of information on the topic of take-up.

Findings

Based on a careful analysis of all of the database articles, two predominant findings emerge regarding efforts to promote successful take-up in health insurance programs. The first is that individuals are more likely to enroll in insurance programs and maintain their coverage when extensive personal assistance, geared to the needs of the individual, is available. The second major finding is that simpler enrollment and renewal processes increase the likelihood that individuals will obtain and retain coverage. Studies of publicity campaigns find much weaker evidence of effectiveness. Each of these findings is discussed in detail below.

Although the cost-effectiveness of take-up strategies is very important to consider, the research on this topic is sparse. The articles in the database do not include rigorous analysis of cost-effectiveness, but several do discuss cost. The discussion below includes all of the references to cost in the articles.

Assistance: extensive and individual

Applicants and enrollees who receive assistance with the enrollment or renewal processes are more likely than others to obtain or retain coverage. The types of organizations that provide enrollment assistance and the settings in which the assistance is provided vary. Most commonly, state agencies, community organizations, and health care providers offer assistance. Some providers are motivated to help uninsured patients sign up for health insurance to reduce the amount of uncompensated care that they provide. Emergency rooms and community health centers are among the most common sites where individuals receive assistance with benefit applications. Individuals with a variety of titles provide enrollment assistance. For example, they may be called "enrollment facilitators, specialists or coordinators," "caseworkers," "outreach workers," "intake workers," or "community workers." In gauging the success of assistance efforts, the amount and type of assistance provided appears to be relevant as is the source of assistance. Individuals are more likely to seek and accept help from organizations and individuals that they trust, and that provide culturally or linguistically appropriate assistance.

Extensive assistance

The most successful assistance efforts guide individuals through the complete enrollment or renewal process. They not only inform people about insurance options and make program applications available, but also assist in completing the application, gathering any documents that must accompany the application, help submit the application, and follow up with the individual to ensure that the application has been processed successfully in a timely manner or to provide more assistance if problems arise after the application has been submitted.[27] Individual, one-on-one assistance is often involved. A number of the more rigorous studies in the database support these conclusions.

- In a <u>randomized, controlled study</u> of program take-up among uninsured children in Boston, families were assigned to a control group that received the standard Medicaid and SCHIP outreach, or to a bilingual, community-based case manager. Case managers provided information about available programs, help parents complete necessary paperwork, and submit applications to state agencies. They also worked to troubleshoot applications and to expedite coverage determinations with state agencies. Families that worked with case managers were more likely to obtain health insurance coverage (96 percent, compared to 57 percent) and to be insured continuously (78 percent compared to 30 percent) than families in the control group that did not receive case management services. On average, families in the case management group received insurance coverage within three months; families in the control group, however, waited more than four months to receive coverage.[28]

- Another <u>controlled study</u> showed a difference in enrollment for parents who received intensive one-on-one counseling and follow-up regarding health insurance at WIC sites in New York City for public health insurance benefits and those who did not. The number of parents who reported that their child was enrolled in New York's SCHIP, the Child Health Program, rose from 12 to 16 percent at the intervention sites, compared to an increase of two points, from 8 to 10 percent, at comparison sites. Medicaid enrollment at the intervention sites increased slightly, but declined at the comparison sites, a trend consistent with the rest of the state at the time.[29]

- A <u>controlled study</u> of a Social Security Administration (SSA) pilot project to increase enrollment in the Medicare Savings Programs also showed the value of providing assistance. The study compared six different models; in each model, seniors received letters indicating that they might be eligible for the benefit. They then received varying types of assistance such as eligibility screening by SSA workers or AARP volunteers, initial eligibility determinations conducted by SSA staff when widows and widowers reported the death of a spouse to the SSA office, or having Medicaid eligibility workers available at SSA offices. The most intensive "application model" had SSA employees complete beneficiaries' applications, compile the necessary documentation, and forward completed applications to the state Medicaid agency for review. At the end of the project, the application model had the greatest impact on enrollment, leading to 26 additional enrollments for each 1,000 letters mailed. Other models were much less effective, producing a range of 7 to 20 additional enrollments per 1,000 letters mailed.[30]

- The Choice regional health network in Olympia, Washington employs access coordinators who chaperone clients through the system to get needed health and social support. Comparative enrollment data from the state showed that 98 percent of Choice-assisted applications result in enrollment, compared with 40 percent of applications from individuals who attempt to enroll on their own. In addition, 96 percent of those enrolled with help from the Choice program retained coverage three years later compared with 40 percent of those who enrolled independently.[31]

- A comparison of enrollment patterns in three Virginia counties concluded that the greater than expected enrollment increase in one of the counties was likely tied to the intensity of the school-based outreach. Local schools identified uninsured children, made referrals to coverage programs, and followed up with families that did not apply.[32]

Other studies provide evidence based on enrollment data following interventions to provide extensive assistance, though it is not possible to determine from the studies what the results would have been without the intervention.

- A study of Medicaid and SCHIP enrollment among New York City children between September 2000 and February 2001 found that community-based organizations were more effective at enrolling uninsured children than managed-care organizations. New York began funding community organizations to help uninsured families enroll in June 2000, with a special emphasis on groups that could provide appropriate linguistic and cultural assistance. Staff at the community-based organizations are trained to help families fill out applications and assemble documents. They track submitted applications. The marketing staff at managed care organizations can also assist with enrollment, but their efforts generally are not as thorough. The research shows that 80 percent of parents who worked with community-based organizations obtained coverage for their children through Medicaid or Child Health Plus compared to 60 percent of those who worked with managed-care organizations. The community-based organizations had a lower denial rate, 8 percent, compared to 14 percent of applications submitted by managed care organizations. The authors suggest that the community-based organizations' roles in their communities may explain the better coverage outcomes, as compared with the broader, less targeted outreach practiced by the managed care organizations.[33]

- Starting in 1997, three community health centers in South Carolina hired local residents to work as geriatric coordinators with older, rural African Americans. At the end of the three-year project, 54 percent of clients were linked to benefit programs for which they were eligible, including the Medicare Savings Programs, SSI, and Veterans Administration benefits.[34]

- In 2004, callers to the Health Coverage Tax Credits (HCTC) call center received extensive assistance with the HCTC application process from state officials in Virginia. (HCTC credits are available to some workers whose jobs have been displaced by international trade). Officials contacted eligible individuals who had consented to receive help, confirmed the status of applications and trouble-shot issues with the IRS. Ultimately, more than 90 percent

of the callers from Virginia who gave permission received help paying for health coverage through HCTC or another source.[35]

The approval rate for applications submitted is a different measure associated with assistance. The Children's Defense Fund (CDF) spearheaded a project in New York that was successful in that 97 percent of applications submitted to Medicaid and Child Health Plus were accepted. There was no control group in this study, but the acceptance rate is high relative to other acceptance rates reported in the literature. Some 25 volunteers from Columbia University were based at community-based organizations, including a Head Start, a health clinic, and several social service organizations. They helped families complete applications and compile necessary documents. The volunteers were certified to complete a Medicaid face-to-face interview, which is required in New York. Families could complete the entire enrollment process at the volunteer site, which spared them a trip to the Medicaid office. The CDF reviewed applications for eligibility, completeness, and documentation before they were forwarded to Medicaid or SCHIP. Volunteers also followed up with families with incomplete applications, either by phone or by mail.[36]

Finally, there is some evidence from the more descriptive literature to suggest that providing assistance is an important element of efforts to improve take-up.

- In a Congressionally mandated evaluation of SCHIP, which surveyed state program administrators on the most effective means of outreach, 34 percent identified face-to-face local outreach, followed by paid media ads (17 percent) and school-based outreach (12 percent).[37]

- A project designed to increase the enrollment of eligible Kaiser Permanente members in the Medicare Part D Low-Income Subsidy concluded that the availability of immediate application assistance when members call for information was a promising and relatively low-cost enrollment strategy.[38]

- A small study in Ohio concluded that the process of making a referral from a health clinic to a health insurance program was not sufficient by itself to ensure that eligible children would apply for and receive coverage.[39]

- A case study from Illinois showed that efforts to increase enrollment in Illinois' SCHIP, KidCare, may have been more successful if more assistance had been available. An attempt to reach a large pool of potentially eligible households in a convenient location placed outreach staff in employee cafeterias for hotel and hospitality workers. More than 1,000 employees were screened over an 8-month period, but fewer than 150 parents submitted applications. Researchers concluded that workers did not have enough time during their lunch breaks to have productive meetings with outreach staff; that employees who took forms home had difficulty completing them; and that the perception that KidCare was a "welfare" program kept some employees from signing up in front of their peers.[40]

Assistance from health care providers

The literature suggests that efforts to promote enrollment are more likely to be successful if those needing assistance feel comfortable working with those providing assistance. Health care providers are generally also known and trusted entities. In a 2002 national survey of recent SCHIP enrollees, respondents indicated that the most important sources of information about SCHIP were health care providers (22 percent), public agencies (20 percent), informal networks (18 percent), and children's schools (17 percent). A variety of sources were cited by the remaining 23 percent of respondents.[41]

There is strong evidence that the involvement of health care providers can have a positive impact on children's enrollment in public insurance programs. Families trust providers to give them good advice about health care.[42] Also, the health care setting is a logical place to ask people about their health insurance coverage and to provide assistance. Since families who do not have health insurance may go to the emergency room or to a local clinic to receive care, emergency departments and clinics are viewed as locations that provide an opportunity to enroll uninsured children.[43]

- A multivariate analysis of data from the National Health Interview Survey examined the influence of multiple variables, particularly the use of community and migrant health centers, on the probability that eligible children would be insured. Initially the researchers hypothesized that families who could access low-cost or free health care through a health center might be less likely to enroll their children in health insurance. Instead, they found that the presence of community or migrant health centers increased the probability of Medicaid enrollment.[44]

- Another multivariate analysis of data from the nationally representative Medical Expenditure Panel Survey concludes that more frequent contact with clinicians in an office setting or in hospital outpatient departments is associated with a lower risk for losing public health insurance.[45]

- In a pilot study in a Michigan emergency room department, the parents of uninsured children were given information and an application for Medicaid and SCHIP by an on-site case manager. She later contacted the participating families to confirm their insurance status, and also to offer assistance to those families having difficulty with the application process. On follow-up, which used phone interviews and a review of state records, 44 percent of the children whose parents were given applications obtained coverage, and 31 percent confirmed that the emergency room intervention was responsible.[46] A later multi-site controlled experiment used the same intervention. Some 42 percent of parents who received applications reported that their children were insured after 90 days, compared to 28 percent of parents who did not receive applications.[47]

Approval rates for applications are less rigorous measures, but still give some information about the success of health care providers and health plans in assisting patients with their insurance applications. Some 84 percent of applications were successful in an experiment involving enrollment workers stationed in a Michigan hospital emergency department. The workers identified uninsured children and collected information and consent from families for enrollment

in public insurance programs. Researchers concluded that the program was reasonably efficient and cost-effective, as the reimbursements the hospital received from the public programs Medicaid and MIChild increased enough to accommodate the additional staffing costs of enrollment assistance.[48]

Enrollment data provide some information about other health-related efforts. A rural county in Alabama conducts annual school-based health fairs to identify uninsured children and then helps parents apply for public coverage. Data compiled by the school system showed a 6.6 percent decrease in the number of uninsured children within the county school system over a six-year period compared to decreases of 3.5 percent and 3.1 percent in Alabama and the United States, respectively.[49]

Findings from interviews, surveys, and case studies also provide some evidence of the efficacy of assistance from trusted sources. Grady Hospital in Atlanta coordinated six staff members and Spanish-speaking volunteers to help patients apply for Medicaid, food stamps, and WIC. They reported increased Medicaid enrollment among pregnant women, and that the time required for the application process decreased, from 45 days to 30 days.[50]

Linguistically and culturally appropriate assistance

Enrollment and renewal efforts that are tailored to individuals' needs are more likely to be successful. The most common means of tailoring assistance is to try to accommodate populations whose first language is not English. The desirability of one-on-one counseling, particularly for reaching groups that may be culturally different from the majority, is often cited. A controlled study from California shows that new monthly Medicaid enrollment increased among Asian and Hispanic children for families that had access to bilingual application assistors from existing community organizations, compared to children from families in the same neighborhood who did not have access to bilingual assistance.[51]

Observations from interviews, surveys, and case studies also provide some insight regarding linguistically and culturally appropriate assistance.

- After completing site visits to 10 states, researchers reported that they were often told that one-on-one direct contact is best for reaching ethnic groups and that the contact should be with a person the parent trusts, such as a religious leader.[52]

- Qualitative reviews of local outreach efforts in Arizona and California conclude that repeated personal contact is important in successfully reaching and enrolling children in public health insurance programs, that culturally appropriate approaches are necessary, and that having bilingual outreach workers is helpful.[53]

- One conclusion from a study of efforts to increase insurance coverage, as well as the use of immunization clinics and primary care services, is that outreach programs must be staffed by ethnically and culturally sensitive people in order to be effective.[54]

- Interviews with mothers in a California community of predominantly low-income immigrant families most (76 percent) reported that community organizations provided very useful help with children's insurance enrollment.[55]

Surveys also show that applicants are more comfortable working with individuals who speak their language. For example, a survey of Boston-area families enrolled in a state-sponsored health insurance program indicated that those with limited English proficiency were more likely than other enrolled families to have received assistance with enrollment. Medical providers were an important source of information and assistance.[56] A survey of enrollees in New York City's Disaster Relief Medicaid, implemented in response to the 9/11 attacks, found broad satisfaction with that program's accommodations for applicants with limited English skills. Chinese and Hispanic applicants particularly appreciated that they were able to fill out the program's application with someone who spoke their language.[57]

Generally, the focus of discussions about culturally appropriate methods is on particular racial or ethnic groups, but the literature suggests that it is important to consider the best way to reach other groups, including those that traditionally may not have participated in public programs.

- With the implementation of SCHIP in 1998, California certified a variety of organizations as "enrollment entities," including schools, hospitals and clinics, faith-based organizations, and commercial insurance brokers, agents, and tax preparers. An analysis of <u>application approval rates</u> through June 2002 reveals that insurance brokers and tax preparers played an important role in serving individuals on the higher end of the income eligibility threshold, a group that traditionally has been hard to reach and who might not be familiar with the mechanics of applying for a public benefits program. The applications submitted by brokers had the highest acceptance rate of all types of entities, at 44 percent. [58]

Simplification of Applications and Renewals

The literature on strategies to improve take-up is full of examples of efforts to simplify the enrollment process for programs. Since attempts to increase take-up rates cannot succeed if individuals who have coverage lose it, efforts to simplify the eligibility re-determination process for public programs are also needed to help keep people insured. The strategies featured in the literature most often are:

- **Simplify application and renewal forms.** Simplified forms reduce the probability of error on the part of the applicant, and may also shorten the time needed to process the application or renewal. Programs that do not use a resource test as a condition of eligibility need less information for applicants and therefore can use simpler forms. A survey of 18 states conducted to examine the Medicaid application process reports that most states recognize the value of a simplified application process not just for the applicant but also for the eligibility worker.[59]
- **Eliminate requirements for face-to-face interviews** so that enrollment and renewal can be conducted by phone, by mail, or online and travel to offices is not required.
- **Allow applicants and enrollees to make self-declarations** about financial and other circumstances. Recognizing that applicants and enrollees may have difficulty providing documents related to employment, identity, income or assets, some states allow

applicants to simply attest that their application is truthful without providing documentation.

- **Use data on file** to verify income or other eligibility information. To lessen the burden of documentation, some states verify an individual's eligibility through existing sources, such as records for other benefit programs, tax rolls, wage records or other accessible information.
- **Establish 12-month continuous eligibility periods** to guarantee coverage regardless of changes in financial or other circumstances during the year.[60]
- **Conduct "passive" renewals** that use the data provided in an initial application to fill out a renewal form, send it to enrolled families, and ask them to return the form only if there are changes that would affect their eligibility status.
- **Send renewal reminders** to enrollees.

A structured examination of states' experience with process changes in Medicaid and SCHIP concludes that certain other practices contribute to improvements in program retention as well. They include: telephone renewals; telephone reminders to return renewal forms; making calls to verify financial information provided by the family; automated referrals from one program to the other; treating forwarding addresses as valid addresses and attempting to re-contact families; verifying addresses at each contact; listing county and worker names so that renewal cards can quickly be directed to the correct worker for follow-up; highlighting key lines in letters; and revising letters to make them more user-friendly.[61]

For the most part, rigorous evaluations of simplification strategies have not been conducted. Generally, the literature on particular simplification efforts is descriptive, providing detail about the substantial amount of activity in states to streamline the enrollment and renewal processes. The strongest evidence that certain strategies and policies may be effective comes from program enrollment data. It can be particularly difficult to analyze the relative efficacy of individual activities in situations where a multi-faceted approach is used to simplify enrollment and retention. The types of available data and the findings related to comprehensive efforts and specific activities are discussed below.

Specific activities to simplify enrollment and renewal

A number of the studies in the database report data on <u>enrollment, retention, and insurance rates</u> to show that a particular intervention may have had an impact. Most also compare the new measure to similar, previous, or expected measures. Comparisons are helpful, though none of the comparisons presented here are strong enough to show definitively that a particular activity was the cause of the change in enrollment or coverage. Findings for particular activities are summarized below.

Among the simplification strategies, those that **allow self-declaration and use existing data** for verification or to identify and enroll individuals are frequently studied.

- An analysis, using data from the March 2001 Current Population Study, concluded that Medicaid and SCHIP enrollment increased by 3.5 percentage points in states where applicants could self-declare their income.[62]

- In 2002, Texas instituted new policies so that families could mail in Medicaid recertification forms rather than coming in for a face-to-face interview and could make declarations about the value of their assets rather than having to submit additional documents for verification. The renewal rate increased from 73 to 78 percent in the first nine months following the simplification efforts. At the same time, the proportion of cases denied for failure to return requested information dropped from 12.8 to 1.7 percent. (It is important to note that improvement in these areas may have been mitigated somewhat by new renewal requirements implemented at the same time as the simplifications: a requirement that parents attend an orientation session and that they get recommended check-ups for their children or else appear for a face-to-face renewal session).[63]

- For a pilot program that provided coverage to uninsured children in the Volusia County, Florida school system, children who were determined eligible for the school lunch program were simultaneously deemed eligible for subsidized coverage under Healthy Kids. Researchers found that the total number of months for which students were uninsured in area public schools was reduced substantially.[64]

- Medicaid and the Food Stamp Program in New York City share a common administrative system, which allows staff to identify children whose families receive food stamps but who are not enrolled in Medicaid. The city sent letters to these households explaining that, unless families opted out of child health coverage, their children would be evaluated for their Medicaid eligibility and possibly enrolled. More than 15,000 children were enrolled in Medicaid as a result of this campaign; only two percent of the families contacted chose to opt out of coverage.[65]

- A negative effect on enrollment was documented in Wisconsin following a policy change to replace self-declaration of income with a requirement that applicants to the state's BadgerCare insurance program have their employers fill out forms verifying the applicant's income and insurance status. State officials reported that the new requirement accounted for 5 percent of applications denied and 14 percent of the BadgerCare renewals that were terminated. Researchers hypothesized that requiring employer verification was a barrier to coverage, particularly given the short period of time within which forms had to be returned.[66] At its peak, the difference between expected and actual enrollment was nearly 30,000 enrollees.[67]

Methods to **simplify renewal** are also the subject of a number of studies.

- Louisiana implemented changes to simplify renewal including the use of available data to verify information as well as the use of telephone renewals and reminders. Between June 2001and April 2005, the proportion of children who lost coverage at renewal for Medicaid decreased from 28 to 8 percent and the proportion of children with gaps in coverage decreased from 18 percent to just 5 percent.[68] Over a two-year period, the proportion of Medicare Savings Program cases closed at renewal declined from more than 7 percent to 4.5 percent. Estimates indicate that the use of the simpler renewal process saved the state millions of dollars in administrative costs.[69]

- In Washington State, Medicaid retention rates for children who also had food stamps improved dramatically after a procedural change that allows caseworkers at Community Service Offices to automatically perform a Medicaid review when a family comes in for a food stamp eligibility review.[70]

- Arkansas implemented phone renewals and phone follow-up for incomplete renewals for Medicaid and SCHIP. The state also aligned the redetermination dates for food stamps and the health insurance programs. The proportion of cases closed for failing to renew decreased from roughly 25 percent to roughly six percent over a two-year period.[71]

- Disenrollment rates in Florida, where passive renewal was used, were reported at five percent, much lower than the rates in other states.[72]

- Pennsylvania requires managed care plans that provide SCHIP coverage to send renewal notices 90 and 60 days before a child's coverage is due to end, as well as a "last chance" renewal notice sent to families who have not responded to previous notices. At least one company, Keystone Health Plan East, goes further by having staff call families who have not responded to the 60-day renewal notice, and by including renewal reminders in the plan's quarterly newsletter, which is sent to the families of all enrolled children. In 2005 the plan's director of operations reported that 85 percent of its enrollees responded to the letters and phone calls.[73]

In an effort to encourage stable insurance coverage, most states have established **12-month enrollment periods** rather than shorter periods and there is some information on the efficacy of this in the database.

- Enrollment data from Washington state show a sharp decline following a policy change to replace a 12-month continuous eligibility for Medicaid with a 6-month eligibility period, and then an increase after the former policy was restored two and a half years later.[74]

- A study of enrollment patterns in five states concluded that one of the factors most responsible for Oregon's having the least stability of coverage was that it was the only one of the five to require that Medicaid enrollees renew coverage every six rather then 12 months.[75]

On-line applications are common for private insurance, but less so in public programs. There is some evidence that these may make enrollment easier for some individuals.

- When the option of an online application was introduced for Georgia's Medicaid and SCHIP programs, applicants were asked to complete a voluntary survey at the end of the online application. Some 23 percent reported that they would not have applied that month without the online option. The majority of survey respondents (61 percent) said that they had filled out the application at home, suggesting that the Medicaid-eligible population has sufficient access to computers for online applications to be useful.[76]

- In the private sector, a study of one firm found that 70 percent of its employees enrolled in health benefits online, including a substantial portion of those who lacked Internet access at work.[77]

- A study of Blue Cross Blue Shield North Carolina's Buy Online program for individual insurance – which allows individuals to be screened, submit an application for review, and purchase individual health insurance online – reported that the number of individual insurance applications received increased 25 percent since the program was implemented and that the processing time for applications was reduced from a few weeks to a few days.[78]

Finally, there is some discussion about **simplifying applications and the application process** in the descriptive literature.

- A review of state efforts to help individuals obtain Health Care Coverage Tax Credits concludes that high take-up requires simple application procedures that involve filing a single form.[79]

- Arizona simultaneously simplified its application for the Medicare Savings Programs (MSPs) and eliminated its requirement for a face-to-face interview. The state also eliminated the asset test for Medicaid and the Medicare Savings Programs and increased its in-person outreach efforts. Enrollment in the MSPs rose by 29 percent after these changes were implemented.[80]

- Georgia reported a 42 percent increase in enrollment among pregnant women and children after it shortened its Medicaid application in 1993. This change took place in the context of welfare reform, when Medicaid enrollment might otherwise be expected to decline.[81]

- Perhaps the most striking example of the positive impact on enrollment of a simplified application process comes from articles about the Disaster Relief Medicaid program that operated in the months following the 9/11 attacks on the World Trade Center. In the four months following, nearly 350,000 people used a very simple process to enroll in the program.[82]

Comprehensive efforts to simplify enrollment and renewal

A variety of policy changes or activities can be used to simplify enrollment and renewal. Each deserves consideration, but it is important to note that if implemented individually they may not make a significant difference in enrollment. For example, a multivariate analysis of the March 2001 Current Population Study concluded that on its own, elimination of the face-to-face interview did not appear to influence enrollment.[83]

- The value of providing more comprehensive assistance is also evident from studies that examine initiatives comprising of many different activities. A multivariate analysis, which used data from the California Health Interview Survey as well as administrative program data, examined the individual effects of different factors on children's enrollment in California's public insurance programs and concluded that a mass media campaign to encourage enrollment had no effect on enrollment. Researchers noted that the media

campaign utilized a "one-size-fits-all" approach, and that it failed to accommodate "California's tremendous diversity." They also reported that money spent within counties on more personal efforts – such as application assistors and outreach through community organizations and schools – did increase the odds that children would enroll in Medi-Cal and Healthy Families.[84]

Enrollment and insurance coverage data suggest that each of the initiatives described below, using a combination of activities, had a positive impact on program participation.

- The number of uninsured children in Arkansas decreased from 19 percent in 1996 to 10 percent in 2003. This change occurred as the state, in partnership with an advocacy group, implemented a comprehensive set of activities designed to increase enrollment in ARKids, which comprises both the Medicaid and SCHIP programs. The enrollment process was simplified: the requirement for families to apply at the Medicaid office was eliminated so that applications could be submitted by mail. Self-declaration of income was accepted as was alternate methods to verify income by the state. Also, information that families supply when they apply for Food Stamps could be used to determine eligibility for ARKids. Re-enrollment could be done over the phone. Training was conducted so that local organizations could assist families with their applications. Head Start programs and Community Health Centers were particularly active. Americorp/VISTA volunteers helped staff community sites. A marketing campaign included print materials, TV and radio spots and the distribution of products with the program logo and information, such as tray liners at local McDonalds, pens and pencils, shirts, hats, band-aid holders, book marks, erasers, coloring books, Frisbees and book covers. School nurses and school coaches (individuals who were known and trusted by families) were also recruited to help publicize the program.[85]

- The Children's Health Initiatives in Santa Clara and San Mateo counties in California were designed to increase enrollment in three public insurance programs for children: Medi-Cal, Healthy Families (the state SCHIP program), and Healthy Kids (a new county-based program). A simple application form was developed. Local media advertized the program and information was provided at community events and in schools. An in-reach campaign identified uninsured children through the county's health care system, community clinics and the social service system, and enrollment assistors provided one-on-one help for families. In addition, a full-time application assistor in each county examined school lunch applications to screen children for program eligibility and contact and assist parents whose children might be eligible. Substantial numbers of children enrolled in the new county-based programs. The initiative also led to large enrollment increases in the established programs with enrollment for Medi-Cal and Healthy Families increasing 28 percent more for children in Santa Clara County than for a comparison group.[86] Researchers have suggested, based on key informant interviews, that the higher application success rates achieved by county-based programs relative to the state-sponsored Medicaid and SCHIP programs in California may have occurred because of efforts to inform families at hospitals, public clinics, and community health centers about the availability of expanded health insurance coverage for low-income families. Also, because the application forms are simpler, less documentation is required, and more assistance and follow-up with families occurs for the county program.[87]

Some researchers report that when applications are completed without assistance, they are more likely to contain errors or to lack necessary documentation. This suggests that alternate methods of submitting applications should ideally be paired with simpler applications and adequate assistance for enrollees. <u>Descriptive data</u> from several states support this point.

- In California, which collected data when mail-in applications were first used, some 60 percent of mail-in applications submitted in a 6-month period were completed without the help of an application assistant. Among those mailed-in applications that had to be sent back because of errors, 92 percent were completed without assistance.[88]

- A survey of 336 families found that the proportion of families who said they were satisfied with the enrollment process for Florida's SCHIP was higher for the original process than for the new simpler process, which does not require a face-to-face interview. Those who were satisfied tended to say that the new process was "quick and easy" but those who were not cited "administrative process" problems. The researchers note that families accustomed to the interview process may have had more difficulty understanding and completing applications on their own.[89]

- Data from a study in New York also suggest that policies to promote enrollment can be even more effective if they are part of more comprehensive efforts to enroll individuals. Managed care organizations in New York can obtain immediate, temporary coverage for children who appear eligible, but they report that 40 to 50 percent of the children enrolled through this "presumptive eligibility" process fail to complete their applications by the end of a 60-day grace period and lose that coverage. While presumptive eligibility means that families can meet immediate health needs, this study suggests that intensive assistance may be necessary to help families obtain consistent health care coverage.[90] Similarly, in a pilot study, families of children contacted through the school system about their eligibility for public insurance failed to complete the application process on their own.[91]

Publicity

Prior research suggests that many eligible families simply do not know about health insurance programs or are not aware that they may qualify for benefits. To remedy this, advertising for health insurance programs has included comprehensive media campaigns, television, radio, or print media, and advertisements on public transit or billboards. Another approach is the use of products – objects printed with a program's information that can be easily distributed, like fans in churches, emery boards at nail salons, and tray liners at fast food restaurants. Health fairs and information sessions are common places that people learn about insurance programs. It is also interesting to note that while publicity can be helpful, "word of mouth" is a very common means by which families hear about the Medicaid and SCHIP programs.[92]

- A <u>randomized controlled trial</u> to test the effectiveness of a mail outreach program for SSI benefits targeted to current recipients of Retirement, Survivors, and Disability Insurance concluded that the outreach program increased the likelihood of applying for benefits by a small but significant margin of 4.3 percent.[93]

<u>Enrollment data</u> are reported for several studied related to providing publicity.

- An analysis of enrollment patterns in Georgia's SCHIP program found a strong association between program enrollment and using the public school system to disseminate program information.[94]

- In 1999, Kentucky launched a major media campaign featuring singer Naomi Judd on billboards, informational flyers, and television, radio, and public transit advertisements. The campaign was paired with Back-to-School outreach campaigns, during which family and youth resource centers distributed flyers within communities. Three spikes in enrollment occurred between July 1999 and 2002, each of which corresponded with the media campaign or the Back-to-School campaigns. The latter were deemed so effective that the state continued to sponsor them, even after the state cut back on other outreach activities after 2002.[95]

- A case study of two California counties suggests that one of many possible factors affecting differences in Medi-Cal enrollment growth is higher retention in a county where the marketing department of the predominant public health plan took an active role in promoting retention.[96]

There is some evidence that publicity about programs will be more effective if information is available in languages other than English.

- An analysis of <u>enrollment data</u> suggests that efforts to convey information about Medicaid and to provide assistance with applications had positive impacts on enrollment and that television advertising in English and Spanish had a small but significant impact on enrollment among Hispanic children in California.[97]

- A community health clinic in San Francisco sponsored radio and television advertisements on Chinese-language stations to promote California's Healthy Families SCHIP. These efforts were concurrent with a broader publicity campaign about the program run by the state. A <u>survey</u> of 154 Chinese-speaking parents in San Francisco, taken 4-6 weeks after the clinic's advertisements were aired, found that 32 percent recalled seeing the Chinese television ads, and 15 percent had heard the Chinese-language radio announcements. Only 3 percent of parents identified the broader state publicity campaign as a source of program information.[98]

- Individuals associated with an application assistance program in California saw increased activity after workers used Spanish-language radio talk shows to explain the importance of health coverage.[99]

Cost-effectiveness of take-up strategies

Measures of cost-effectiveness are of particular interest for this project, but very little of the available research pertains to the cost-effectiveness of take-up strategies and none of the research includes rigorous analysis of cost-effectiveness. Every article in the database was examined for any information related to the cost of outreach, enrollment, or retention activities.

A few articles discussed outreach activities in the context of making an investment to increase enrollment.

- An analysis of administrative program data from the state of California for fiscal years 2000 and 2001 examined spending to train certified applications assistors and to fund community-based organizations and schools for outreach and enrollment support and concluded that among children eligible for Medi-Cal, the Medicaid program, the odds of being enrolled increased by 6 percent for each additional dollar spent on outreach per eligible child in the county. Among Healthy Family SCHIP-eligible children, the odds increased by seven percent for each additional dollar spend on outreach per eligible.[100]

- There also are reports in the literature of health care providers concluding that efforts to increase enrollment in public health insurance programs were "reasonably efficient and cost-effective," as the reimbursements that a hospital received for services that would otherwise be uncompensated were large enough to accommodate the additional staffing costs of enrollment assistance.[101] Community health centers saw an increase in new patients and patient visits and in reimbursements when clients were successfully enrolled in programs.[102]

- One study of program take-up in California calculated that a 15 percent increase in Medicaid enrollment would lead to a 2.7 percent decline in avoidable hospitalizations and potentially save $8 million annually in health care costs.[103]

There are some indications in the literature of the cost of providing various types of enrollment assistance. It is important to note, however, that these figures are likely associated with assistance provided using a variety of approaches in many settings to differing numbers and types of people. Therefore, while they can be informative in a general way, they are not comparable and may not be relevant for new programs.

- "Enrollment Entities" in California employ "certified application assistors." In 2004 they received $60 for each successful application and $50 for each successful renewal for the Healthy Families program.[104]

- In Northwest Arkansas, ARKids offered $20 vouchers to area physicians whose offices assisted first-time patients with completing a program application. The payment was not meant to cover all costs but it guaranteed that the physician was paid $20 for the child's first visit, and some expectation that the child would have insurance coverage for subsequent visits. Also, the physician became the primary care case manager for the child once he or she had ARKids coverage.[105]

- A county in Ohio that contracted with a human resources development firm to conduct presentations and provide application assistance to workers at several hundred small firms in the Cleveland area estimates that outreach costs averaged $157 per enrollee.[106]

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- A study of various outreach methods used to reach and enroll seniors and younger individuals with disabilities in benefit programs concluded that the average cost of enrolling an individual in the Medicare Part D low-income subsidy was $100.[107]

Discussions of the cost of different strategies conclude that providing one-on-one assistance is expensive relative to other activities because of the labor intensity, but these are not accompanied by assessments of the relative effectiveness of methods.[108] Well-targeted efforts are more likely to be successful and cost-effective. Preliminary research designed to identify the population to be reached and to determine what portion of a target population needs coverage is essential to help assure that limited resources are spent most effectively.[109]

Findings from the literature illustrate the importance of understanding the particular circumstances associated with cost estimates. For example, very different outcomes were reported for two projects that provided enrollment assistance in New York City. In one study of enrollment facilitators, researchers concluded that facilitators located in high-traffic areas could potentially assist four to five families per day. At that rate, the cost per completed application was estimated to be approximately $35.[110] But the cost per application was much higher for another effort that trained student volunteers to help families enroll in public coverage in New York because only a small number of applications per volunteer was submitted.[111]

Administrative savings associated with simplifying the enrollment and renewal processes are discussed in a few articles. For example, an effort in Oregon to reduce the number of application steps from 72 to 16 cut the average number of days to process an application and considerable savings were associated with the reduced need to pay eligibility workers for overtime.[112] Policy changes to simplify the renewal process for the Medicare Savings Programs in Louisiana also produced administrative savings.[113]

One other consideration related to cost is whether initiatives can be sustained and whether they can be implemented in a less costly manner. A review of five local access initiatives concludes that without outside support, local projects are difficult to sustain.[114] Activities such as translating applications into other languages can be expensive, especially for states where multiple languages are needed.[115]   The research suggests that in some instances the federal government may be able to provide assistance in a less costly manner because of economies of scale associated with sponsoring a single activity – such as the translation of program materials – that can be used by large numbers of people across the country.

Answers to research questions

Findings from the literature form the basis for responses to four key research questions pertaining to methods that have been or could be used to overcome enrollment barriers and increase participation rates in health insurance programs.

Effective strategies

What types of outreach, enrollment and retention strategies have proved most effective in ensuring that uninsured individuals have public or private coverage?

Based on the research to date, the strategy that has proved most effective is to provide assistance with every aspect of the enrollment and renewal process for those who need it. One-on-one assistors can help solve particular problems if they arise. Assistance geared to certain populations – such as assistance in languages other than English – is likely to be most effective. Also, applicants and enrollees are more likely to seek and use assistance from sources they trust. Examples in the literature of trusted sources include members of community-based organizations, health care providers, school officials, nurses, or coaches, and members of the religious community. Strategies to simplifying enrollment and renewal processes are also essential if efforts to help individuals obtain and retain coverage are to succeed. Findings from the literature indicate that using a combination of strategies – activities to publicize benefits, to simplify the enrollment and renewal processes, and to provide assistance can be very effective. Ideally, several types of complementary activities can be undertaken. The key point, however, is that without the availability of assistance for applicants and enrollees, other activities are less effective.

Cost-effectiveness of strategies to improve take up

Which outreach, enrollment and retention strategies are particularly cost-effective? Data on the cost-effectiveness of various strategies to increase take-up are not conclusive. In fact, very little definitive research is available on this topic. There is some evidence to suggest that well-targeted efforts are more likely to be successful and cost-effective. Some estimates of the cost of various activities do appear in the research literature, but because each effort is so different in terms of magnitude as well as how and where it was implemented, who it targeted, how long it lasted, and at what point in the program it occurred, it is not possible to compare or generalize from these data.

In discussions of findings, several researchers note that efforts to increase insurance coverage can be seen as good investments. This is particularly true for health care providers, who stand to benefit from additional compensation from insurers if their patients are insured. Also, the administrative savings associated with simplifying enrollment and renewal processes were documented in some articles. Discussions also highlight the issues that local initiatives to increase coverage may be difficult to sustain without a consistent source of support. Economies of scale can be achieved when certain activities, such as translating materials into other languages, can be accomplished on the federal or state level.

Strategies for special populations

Which outreach, enrollment and retention strategies are particularly effective for special populations (those living in urban and rural areas, those whose first language is not English, and those whose cultural background or practices are different from the majority of program participants)? **The literature does not provide definitive information about strategies for take-up that are particularly effective for populations living in rural or urban areas. Given the findings of this report, rural areas may face challenges related to finding economies of scale in their efforts to increase take up. One-on-one assistance may be more costly to provide in less populated areas.**

There are indications from the literature about the importance of making accommodations for individuals whose first language is not English or whose cultural background or practices are different from the majority of program participants. Specifically, applicants and enrollees should have the opportunity to receive assistance from trusted sources who speak the language they are most comfortable speaking and who are familiar with their culture. There is also some evidence that publicity about programs will be more effective if other languages as well as English are used. Findings from the literature indicate that one-on-one assistance is particularly effective in helping individuals whose first language is not English.

Lessons for the new coverage program initiatives

What lessons are particularly important to consider with regard to new programs to expand coverage, such as the Affordable Choices Initiative? **One important lesson for the Affordable Choices Initiative or any new initiative or program to increase health insurance coverage is that outreach activities are crucial early on to introduce people to the new benefit, but that publicity alone will not ensure that individuals seek and successfully enroll in coverage.**

The simpler the enrollment process, the more likely that uninsured individuals will complete the process successfully. Strategies to achieve a simple process include allowing individuals to make self-declarations about their circumstances and using data to which the government has access to verify that information or using the existing data to make determinations about eligibility. Allowing individuals to apply using a variety of methods including mail-in, telephone and on-line applications, which do not involve a face-to-face meeting, is another recommendation to increase enrollment. These recommendations also apply to the renewal process. Establishing a 12-month eligibility period is another recommendation to simplify renewal. A review of the literature suggests that the best approach is to implement all of these policies, rather than just selected policies for simplification. Additionally, if feasible, automatic enrollment is the simplest and likely most effective strategy for take-up.

There is a good deal of evidence that without the availability of assistance, efforts to publicize programs or simplify enrollment will not be as effective as they could be. One-on-one assistance appears to be most effective. Although face-to-face meetings should not be required, all applicants and enrollees should have the option of receiving assistance if the goal is to achieve maximum take-up. The assistance should be comprehensive, comprising not only assistance completing applications and obtaining documentation if it is required, but also providing follow-up to determine if enrollment occurred and to provide further assistance if needed.

If the nature of a new initiative differs in design from current insurance programs and options then it will be important to provide adequate training about the new initiative as well as about existing programs and their relationship to the new initiative for those who may be assisting applicants. For example, implementation of a the premium assistance program in Massachusetts posed challenges for community-based outreach workers because they were less familiar with private health insurance than with traditional Medicaid and initially experienced difficulty in explaining the premium subsidy to potentially eligible low-income workers.[116]

Another lesson is that both outreach and assistance should be tailored to the target population. This is especially important if individuals who are linguistically or culturally different from the majority are to be successfully enrolled. Much of the literature on increasing take-up rates pertains to the low-income population. If coverage expansions include individuals with higher incomes then it may be necessary to consider who the new target population would view as a trusted source for information and assistance.

Finally, with any new initiative there is a need to provide sufficient funding not only to help with the initial enrollment, but also to sustain activities to ensure that individuals who are eligible for coverage obtain and retain it successfully.

Recommendations for further research

Although this project was not originally designed to develop recommendations about evaluation techniques, findings from this as well as previous efforts to synthesize existing research on take-up strategies indicate that there is a need for more rigorous research to better inform policy in this area. The literature review revealed strengths and weaknesses of the research that has been done to date on this topic. Therefore, this report includes some recommendations regarding future research to improve the availability and quality of information on the topic of take-up.

Conduct more quantitative research

The first recommendation is for more quantitative research. Although a great deal has been written about outreach and enrollment efforts, the majority of the literature is descriptive in nature. As noted above, the existing literature provides a good deal of information and the basis for some strong conclusions about increasing take-up, but it is not possible to draw conclusions about cause and effect.

Use meaningful outcomes to measure success

If the goal of an intervention is to increase take-up, then the meaningful outcome is whether a change in enrollment occurs. Other measures such as the number of individuals reached, the number assisted, the number potentially eligible for benefits, the number of applications distributed or filed, or the approval rates for applications may provide useful information and lead to program improvements, but these are *process* measures. The *outcome* measure of real interest is the number of individuals that actually enroll in a health insurance program as a consequence of an intervention. As noted above, enrollment is a function both of the number of

people obtaining coverage and the number losing it. Thus, both measures should be examined to get the most complete understanding of the impact of particular interventions on enrollment.

If enrollment data are not available, health insurance coverage data may also be examined, but generally it is not possible to find coverage data specific to the population eligible for particular programs or benefits. These data are consequently not as reliable for the purpose of measuring outcomes.

Make meaningful comparisons

Simply measuring enrollment changes is not sufficient to show whether an intervention has been successful or not. To determine that, it is necessary to compare what happened because of the intervention with what would have happened otherwise. In a classic experiment, the comparison would be between one group exposed to the intervention and another comparable group that is not exposed. Even if it is not possible or practical to conduct such an experiment it should be possible to make meaningful comparisons. Baseline data that show usual enrollment patterns prior to an intervention can be compared to patterns later. Actual enrollment can be compared to the expected enrollment. Or, enrollment patterns for comparable counties or other regions or for comparable groups may be compared if an intervention is conducted for one group but not another.

Take other factors into account

The goal in assessing the effectiveness of an intervention is to determine whether changes in policy or practice have an effect on enrollment or coverage. Other factors such as economic conditions may have an effect on the number of individuals seeking health care coverage, however. Changes in unrelated program regulations or data systems also may affect enrollment. These factors sometimes may be beyond the control of those who implement or measure interventions to improve take-up. At the very least factors that may affect coverage should be acknowledged. If possible they should be taken into account in measuring impact.

Include measures of cost-effectiveness

As noted earlier, there is a dearth of information about the cost-effectiveness of various interventions to increase take-up. This is an area of research that deserves much more attention.

It is important to measure the cost of an intervention, but costs alone are not meaningful without information about the outcome associated with the intervention. For example, discussions in the literature often note that one-on-one counseling is expensive relative to other strategies to increase take-up. But more appropriate than comparing the relative cost of interventions is comparing the cost per *enrolled* individual associated with each intervention. As noted above, the appropriate enrollment outcome measure is the number enrolled above the number ordinarily expected to enroll.

In calculating costs, any savings that may be associated with an intervention, such as administrative savings associated with simplifying an application or renewal process should be considered along with new costs associated with the intervention. Another meaningful comparison for providers is the cost of an intervention relative to actual or anticipated increases in revenue from insurance payments. Finally, a more difficult, but potentially useful,

comparison is the cost of interventions relative to actual or anticipated changes in overall health care spending for newly covered individuals who may then have greater access to preventive, primary, and other types of care.

Invest in simple, routine measurement

Health insurance programs that routinely measure the number of individuals who enter and leave the program and the proportion of enrollees that successfully renew coverage each month have an advantage in that they have baseline measures to use in evaluating the impact of a new intervention. Thus, the number of new enrollments that occur during a particular promotional effort or following a policy change designed to promote enrollment can be compared with the number that usually occur to help gauge the impact of the new efforts. Similarly, policies that may have a negative effect on coverage can be more easily identified if baseline data are available.

Conclusion

Policy changes to expand health insurance coverage are more likely to succeed if they are accompanied by efforts to ensure that optimal take-up of benefits occurs. This concept is generally recognized and there are many examples of activity on the federal, state, and local levels geared to increasing enrollment in public programs for children, families and the elderly. Yet, program participation rates generally are lower than expected even as a substantial portion of the uninsured population is eligible for public insurance programs. Thus, there is a need to understand how to best promote uptake. A review of the literature on this topic indicates that individuals are more likely to enroll in insurance programs and maintain their coverage when extensive personal assistance is available. Also, simpler enrollment and renewal processes are advantageous for both applicants and those who assist them, and contribute to higher enrollment rates. More rigorous research is needed, however, to understand more about the efficacy and particularly the cost-effectiveness of different approaches.

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Appendix

Analysis of Best Practices for Take-Up Rates
NORC and Georgetown University
Preliminary Literature Review
January 31, 2008

OVERVIEW

The purpose of the project, "Analysis of Best Practices for Take-Up Rates" is to provide models of best practices that are relevant for States and private health insurance plans as they contemplate how to best tailor outreach, enrollment, and retention for the Administration's Affordable Choices Initiative as well as existing health insurance programs.

A literature review, the first major task associated with the project, catalogues resources on the basis of populations featured in the research, types of take-up strategies and activities studied, and the study methods used. The resources gathered were reviewed to determine which should be included in the next phase of the project and what form the next phase should take. The project is designed to feature a meta-analysis to answer the key research questions:

> • What types of outreach, enrollment and retention strategies have proved most effective in ensuring that uninsured individuals have public or private coverage?
> • Which outreach, enrollment and retention strategies are particularly cost-effective?
> • Which outreach, enrollment and retention strategies are particularly effective for special populations (those living in urban and rural areas, those whose first language is not English, and those whose cultural background or practices are different from the majority of program participants)?
> • What lessons are particularly important to consider with regard new coverage expansion initiatives, such as the Affordable Choices Initiative?

An examination of the database constructed during the literature review suggests that the number of methodologically rigorous studies is small and that it may therefore be prudent to consider modifications to the meta-analysis approach. There are few studies in the database that

definitively demonstrate causation between outreach strategies and reported outcomes. Strong correlations are reported, however, and these findings can help inform responses to the research questions. This report describes the methods used to construct the database and the contents of the database and discusses how the data can be used to answer the research questions posed for this project.

METHODS

We identified all studies that might be relevant for the meta-analysis. A thorough review of the articles followed and then we constructed a project database. These tasks are described in more detail below.

Gathering resources

Health and social science databases including Medline, Healthstar, Social Science Abstracts and CINAHL were searched to identify possible relevant studies or articles published or completed in the last ten years. Keywords used in searching each database include: take-up, enrollment, outreach, retention and churning. We also looked for literature on private health insurance (small group, individual market, and employer-sponsored) and public health insurance (Medicaid, SCHIP, Medicare, Part D low-income subsidy, prescription drug cards, and state health insurance programs.) Several specific peer-reviewed publications were searched for relevant articles as well. They include *Health Affairs, Health Services Research, the Journal of Health Care for the Poor and Uninsured, The Millbank Quarterly*, and the *Journal of the American Public Health Association.*

The same criteria and keywords were used to search the "gray literature," including technical reports, working papers, conference proceedings, and newsletters from foundations, government sources, and policy or advocacy organizations. Some of these resources are available in the files on this topic maintained at Georgetown's Health Policy Institute. Other studies were identified by searching websites for relevant organizations and projects. The technique of snowballing was also used to gather resources; bibliographies were checked for additional sources. We identified a total of 1,177 articles and created a master spreadsheet of articles.[116]

Reviewing resources

In gathering the literature we cast a wide net. In reviewing the resources we looked for very specific literature. Initially, some 864 articles were classified as "not relevant." Based on our knowledge of the literature as well as a review of abstracts and executive summaries, these articles where excluded for reasons such as:

1. They are opinion or editorial pieces or blueprints for change.
2. The focus is on barriers to health care services.
3. They examine "crowd out."
4. They concern the effect of health care coverage on providers.
5. They examine employer or consumer choice.
6. They are about health status or policies to reduce racial and ethnic disparities.

The majority of articles chosen for an in-depth review were read by a research associate at HPI. Additional staff at HPI and NORC read the remainder. Of the 313 articles, 229 more were excluded upon further review because they do not provide information about effects of initiatives to increase take-up rates. These articles were reviewed by senior staff at HPI before being excluded from the database. Table 2 summarizes the following general subjects covered by the 229 excluded articles. These include:

1. Describe barriers to enrollment or retention
2. Present data on patterns of insurance coverage (particularly numbers eligible or enrolled) or describe the characteristics of individuals or groups that do or do not have health insurance
3. Describe the consequences of having or not having health insurance
4. Discuss program policies that affect take-up or retention, rather than initiatives to improve take-up (for example, studies about policies such as: parental expansions, continuous eligibility, the use of premiums, the availability of subsidies were excluded)
5. Concern strategies to increase the use of health care or other services rather than to increase enrollment in health insurance or other benefits
6. Describe a specific process to improve take-up, but do not describe outcomes

The remaining 84 articles comprise the database for this project (see Table 1).

Table 1: Articles reviewed and included in the database

	Number of articles selected
Articles identified (Master List)	1177
In-depth review	313
Total articles in database	*84*

Table 2: Topics of articles excluded from database

	Number of articles excluded
Describe barriers	30
Present data on insurance coverage patterns	48
Describe consequences of having insurance or not	10
Discuss program policies rather than initiatives	94
Concern strategies to increase the use of services	7
Describe process, but not outcomes	40
Total articles excluded	*229*

THE DATABASE

The project database contains detailed descriptive information about the population groups involved, the type of take-up strategies and activities studied, and the type of study featured in each article.[116] A large majority of the studies in the database focus on the enrollment and retention of children in public benefits programs. Four broad types of take-up strategies are featured in the database: strategies to publicize benefits, to provide special assistance for applicants and enrollees, to simplify the application process, and to simplify the renewal process. Each represents a number of different activities. A variety of evaluation approaches are used in the research, with case studies being the most popular method among the studies in the database. The following suumarizes the database in the following sections:

- Groups represented in the database
- Types of takeup strategies and activities studied
- Evaluation approaches
- Quality of the studies in the database

Groups represented in the database

To characterize the studies, we examined the type of coverage studied, the age group targeted, the geographic region represented, and the inclusion of certain groups of participants of interest such as those living in rural areas, those with limited English proficiency, and those representing certain cultural groups.

Type of coverage

Most studies examine public rather than private coverage, though these categories are not exclusive. Some studies, such as those about high-risk pools – which are generally state sponsored, but provide enrollees with private insurance coverage – would also fall into both categories. Some states and localities also sponsor their own insurance coverage and outsource their administration to private insurance companies. As Table 3 indicates, public benefits, primarily insurance programs, are the subject of 72 of the studies in the database. Six studies concern only private coverage and six others refer to both public and private coverage.

Within the public insurance category, the focus of the great majority of the studies is on the Medicaid or SCHIP programs, which serve children and some parents. Public benefit programs for older people or people with disabilities, including the Medicare program, the Medicare Savings Programs (SLMB, QMB, and QI), and Supplemental Security Income (SSI) are also represented but to a much lesser extent. Private coverage was featured in a large number of the articles collected originally, but most were excluded because they examine the effect of benefit design (subsidies, premiums, other costs) on take-up rather than the effect of specific initiatives to increase take-up.

Table 3: Articles in the database by type of coverage*

	Number of Articles
Just public benefits	72
Just private benefits	6
Public and private benefits	6
Total articles in database	84

*Includes a small number of articles referring to benefits other than insurance coverage

Age

The populations studied reflect the programs studied. Therefore, most of the studies in the database concern coverage for children. A few consider coverage for both children and their parents. There are relatively few studies focused on the enrollment of older persons or persons with disabilities or on couples or single adults. The remaining research considers coverage for several age groups or the general population, through a mix of public and private approaches (see Table 4).

Table 4: Age groups represented in the database

	Number of Articles
Children	57
Parents and children	3
Elderly or adults with disabilities	9
Couples and single adults	1
General population	14
Total articles in database	*84*

Geography

Since the majority of articles concern the Medicaid and SCHIP programs, which are jointly administered and financed by states and the federal government, it is logical that the majority of articles in the database have a state focus. There is some overlap among geographic category. For example, some research examines local or regional initiatives to enroll the uninsured into state or national programs. Likewise, a study detailing Medicaid and SCHIP enrollment in several states could be classified as both state and national. Studies are classified in Table 5 by the largest geographic area they represent.

Table 5: Articles by largest geographic region represented

	Number of Articles
National	15
State	48
Regional	1
Local	20
Total articles in database	*84*

Some states are featured more frequently in the identified articles than others. States represented in ten or more of the articles include some of the most populous states: California, Florida, Georgia, Massachusetts, New York, Ohio, Texas, and Washington. Activities in California and New York featured in 19 and 22 articles, respectively.

Populations of particular interest

Certain populations are of particular interest for policymakers considering how to increase insurance coverage among populations that may differ in certain ways from the general population. Among the articles in the database, 10 provide information about reaching people living in rural areas. Strategies aimed at reaching individuals who have limited English proficiency are featured in 23 articles. An additional 18 articles discuss the use of strategies geared to certain cultural groups such as Latinos and Asians. We also identified one study dealing with outreach to undocumented immigrants, and one that referenced outreach to uninsured adolescents.

Types of take-up strategies and activities studied

Several types of strategies can be used to reach people, inform them about the availability of benefits, and help them enroll in benefit programs. Studies are broadly categorized in the database according to whether they examine four types of strategies. A number of studies examine more than one strategy. Thus, strategies are discussed 155 separate time in the 84 articles. Table 6 shows the number of studies that discuss each strategy, though not all strategies were evaluated in all studies. The most popular strategy examined in the articles is the provision of special assistance for applicants or enrollees, which was cited in 57 of the 84 studies. Efforts to publicize benefits were also the subject of almost half (41 of the 84) studies on take-up.

Table 6: Types of take-up strategies represented in the database

	Number of studies that discuss strategy
Publicize benefits	41
Provide special assistance for applicants/ enrollees	57
Simplify the enrollment process	48
Simplify the renewal process	9
Total studies that discuss the strategy	*155*

Publicize benefits

Prior research suggests that many eligible families simply do not know about health insurance programs or are not aware that they may qualify for benefits. Efforts to raise awareness of programs might include media campaigns, television, radio, or print media, and advertisements

on public transit or billboards. Another outlet is the use of products – objects printed with a program's information that can be easily distributed, like fans in churches, emery boards at nail salons, and tray liners at fast food restaurants. Health fairs allow program representatives to speak to potential enrollees in person. Another tactic, "in-reach," uses existing organizations such as schools and employers to inform people about the availability of benefits. As Table 7 shows, media campaigns are the most frequently mentioned activity. Publicity campaigns may be conducted in languages other than English. Some 18 of the database articles highlight efforts conducted in other languages other than English to target specific populations.

Table 7: Types of publicity activities represented in the database

	Activities discussed in articles
Media campaigns	21
Use of products	9
Health fairs	15
In-reach	12
Languages other than English	18
Total activities discussed in the articles	*75*

Special assistance for applicants and enrollees

Enrollment facilitators guide individuals who need assistance through the process of enrolling in public or private benefit programs or help them maintain their benefits. Facilitators may be associated with community organizations or other groups. Community groups provide other types of enrollment assistance as well, such as sponsoring outreach events or making translation services available. Outreach and enrollment efforts also involve health care providers. Some providers have an incentive to help uninsured patients sign up for health insurance to reduce the amount of uncompensated care that they provide. Emergency rooms and community health centers are among the most common sites where individuals receive assistance with benefit applications. As Table 8 shows, activities involving community workers have been evaluated most frequently.

Table 8: Types of assistance activities represented in the database

	Activities discussed in articles

Enrollment facilitators (community and other groups)	36
Other enrollment assistance from community groups	19
Health care providers	24
Total activities discussed in the articles	*79*

Simplify enrollment

Activities and practices to simplify enrollment may include offering applications and assistance in several languages; eliminating requirements for face-to-face interviews, which spares enrollees the need to take time off from work or travel to an office; creating shorter, simpler applications; allowing applicants to submit paperwork through the mail or online; and allowing individuals to apply for benefits "in the field," rather than in a Medicaid office. Programs can further simplify their enrollment by using data already on file from other programs or sources to verify an applicant's residence, age, or income (see Table 9).

Table 9: Types of enrollment activities represented in the database

	Activities discussed in articles
Materials, assistance in multiple languages	19
Eliminate interviews	9
Shorter, simpler, mail-in or online applications	12
Enrollment "in the field"	10
Existing data for verification	18
Total activities discussed in the articles	*68*

Simplify renewal

Attempts to increase take-up rates cannot succeed if individuals who have coverage lose it. Most Medicaid and SCHIP programs require enrollees to confirm their eligibility after 6 or 12 months of coverage; for a variety of reasons, many eligible beneficiaries lose coverage. Efforts to simplify the eligibility re-determination process for public programs are consequently needed to help keep people insured. Some programs or organizations, including managed care

organizations, remind enrollees by mail, phone, or an in-person visit that they will need to confirm their eligibility. They may also follow up with individuals or families that have not responded to notices regarding re-determination. Another approach is "passive" renewal, in which programs use the data provided in an initial application to fill out a renewal form, which is then sent to enrolled families. Families are only required to return the form if their circumstances have changed; otherwise, the enrollee is deemed eligible. Families have even fewer obligations in an "ex parte" renewal process, where their continued eligibility is confirmed based on data from other sources – food stamps, TANF, or wage records. As Table 10 indicates, the renewal activities most commonly cited in the database are reminders or follow-up with beneficiaries.

Table 10: Types of renewal activities represented in the database

	Activities discussed in articles
Reminders or follow-up	8
Passive renewal	1
Ex parte renewal	3
Total activities discussed in the articles	*12*

Evaluation approaches

Six broad classifications are used to distinguish the approaches or techniques represented in the studies included in the database. Table 11 shows the primary method employed.

Table 11: Types of studies in the database

	Number of studies
Case study	29
Focus groups	2
Survey/structured interview	15
Data set	18
Descriptive overview	18
Research synthesis	2

Total articles in the database	*84*

Case studies

The case study method is the most common. The category includes research about singular efforts (for example assistance for patients in a hospital emergency department) or about a variety of strategies implemented at several sites. Some of the case studies use data from a site visit or visits. The number of enrollees involved in the efforts studied ranges from fewer than 100 to several thousand. Almost all of the case studies are cross-sectional studies. All provide descriptive data. In addition, many include quantitative measures, generally reports of changes in the numbers of program enrollees. Only a few case studies control for various factors that may affect enrollment.

Focus groups

Only two of the studies represented in the database primarily use focus groups. One set involved 55 and the other 94 participants. A number of the articles we collected originally use the focus group technique, but generally they describe barriers to program participation rather than outcomes of an intervention to increase participation.

Surveys or structured interviews

Responses gathered through surveys or structured interviews of substantial numbers of participants – generally 500 to 1,000 respondents – comprise this category. Most are cross-sectional though a few follow panels of participants. The studies differ considerably with regard to how carefully the samples were chosen, how representative they are of the population studied, and whether they are applicable for other populations. Most are conducted following an initiative, but do make comparisons to circumstances prior to the initiative.

Analysis of existing data sets

Major national or state surveys with data for many thousands of individuals have been examined to glean information about the efficacy of efforts to improve take-up rates. Similarly, enrollment or other program data have been used to try to make determinations about whether particular interventions have an impact on enrollment. For the most part, these are longitudinal time-series analyses that attempt to correlate activities with changes in enrollment. About one-third of these studies try to control for factors other than the intervention that may affect enrollment, while the others typically only look at the change over time without regard to other potential factors.

Descriptive overviews

In an effort to include as much information as possible about the outcomes of all types of efforts to increase enrollment, these studies also are included in the database. Generally the articles describe and summarize activities, often from a variety of sites, and attempt to draw conclusions or make recommendations based on observations about current practices. They have less analytical content than the other articles and therefore do not qualify for categories described

above, but some quantitative data regarding particular activities is presented and therefore they are included in the database.

Research synthesis

Two articles included in the database are of particular significance for this project because they attempt to synthesize research on take-up strategies. They are discussed in more detail below.

Quality of the studies in the database

One purpose of gathering and reviewing articles for the database is to determine what types of research have been done to examine the efficacy of initiatives to increase take-up rates for public and private insurance coverage. Each of the 84 articles included in the database presents some good information on this topic. The studies are very different, however, in terms of how rigorously they are designed and carried out and how methodologically sound they are. The parameters discussed below are useful in making determinations about the quality of the research represented in the database.

Quantitative data in the studies

A substantial proportion of the articles in the database – 79 percent, or 66 articles – contain some quantitative data. As noted above, the types of data and the way they are analyzed and reported differ considerably, however. In the majority of studies the reported data are not subject to statistical tests. In a small number of studies, the data are used to demonstrate the relationship between an initiative and the take-up rate. More often, the percent change in program enrollment is the reported outcome but there are no indications of the extent to which the change might or might not have occurred in the absence of the initiative – an increase in enrollment in the months following a media campaign or efforts to streamline an application process. Nor do the studies explain whether the change is related to the number of individuals entering or leaving the program. It is also important to note that some quantitative measures are more meaningful than others. For example, a number of studies report the number of people reached by a given outreach strategy – the number of people who visit a health fair, for example, or the estimated listening audience for a radio announcement. These data are of interest, but not sufficient to show whether initiatives are successful at increasing coverage.

Peer-reviewed studies

Generally, peer-reviewed studies are considered to be more methodologically rigorous than other studies. As noted above, the database contains articles from peer-reviewed publications and others identified in the "gray literature," studies sponsored and published by foundations, government agencies, and policy or advocacy organizations. About one-third of the studies in the database are from peer-reviewed publications. Table 12 shows the number of peer-reviewed articles by type of study. Studies involving focus groups and descriptive overviews are least likely to be peer-reviewed. About half of each of the other types of studies are peer reviewed.

Table 12: Peer-reviewed studies in the database, by type of study

	Number of studies	Number of peer-reviewed studies	Percent of studies peer-reviewed
Case study	29	13	45%
Focus groups	2	0	--
Survey/structured interview	15	8	53%
Data sets	18	8	44%
Descriptive overview	18	0	--
Research synthesis	2	1	50%
Total articles in the database	*84*	*30*	*36%*

Table 13 indicates whether the studies that discuss each take-up strategy are peer-reviewed.

Studies about providing special assistance for applicants and enrollees are most likely, relative to other strategies studied, to appear in peer-reviewed publications. Studies about simplifying the renewal process are least likely to be peer-reviewed.

Table 13: Peer-reviewed studies among articles in the database that discuss each strategy

	Number of studies	Number of peer-reviewed studies	Percent of studies peer-reviewed
Publicize benefits	41	14	34%
Provide special assistance for applicants/ enrollees	57	23	40%
Simplify the enrollment process	48	15	31%
Simplify the renewal process	9	1	11%
Total studies that discuss the strategy	*155*	*3*	*34%*

Study design: examining cause and correlation

Only four of the studies in the database are sufficiently rigorous in design to allow the authors to draw conclusions about the cause of outcomes. They control for exogenous influences with randomized samples, quantitative models or the use of control and comparison groups. Three studies in the database are randomized controlled studies:

- *A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children* (Flores et al.) randomly assigned uninsured children to an intervention group with trained case managers or a control group that received traditional outreach. Interviews with parents provide data for the evaluation.
- *The State Children's Health Insurance Program: A Multicenter Trial of Outreach Through the Emergency Department* (Gordon et al.) experimented by giving an intervention group of uninsured children SCHIP applications when they presented at one of five emergency rooms, and not giving applications to a control group.
- *Effectiveness of a Targeted Mailing Outreach Program on SSI Applications and Trends* (Goulet et al.), examines an initiative by the SSA to send letters to persons who were receiving Retirement, Survivors and Disability Insurance (RSDI) benefits but were not receiving Supplemental Security Income (SSI). Letters encouraging SSI applications were sent to a random sample of individuals deemed likely to be eligible; those who did not receive a letter served as controls.

The fourth highly-rigorous study, *The Effects of County "Outreach Environments" on Family Participation in Medi-Cal and Healthy Families* (Kiloche et al.), involves a multivariate analysis of data from two large data sets to examine the impact of outreach funding and activities in different counties.

Some seven other studies specifically mention that in conducting the study, attempts have been made to control for factors other than the intervention. Six others note that the study population was randomly selected. Most of the other studies demonstrate correlations between activities and changes in enrollment.

Measures of cost-effectiveness

Measures of cost-effectiveness are of particular interest for this project. Thus, we examined articles for any data related to the cost of outreach, enrollment, or retention activities. Some 27 studies in the database mention cost. Of these, five provide data on the cost per enrollee or potential enrollee of particular initiatives. Two calculate the magnitude of expected enrollment increase based on spending for outreach. The remainder report on other financial aspects of the interventions (see Table 14). In addition, a few studies that do not mention cost provide enough description to indicate that the initiative is very resource-intensive.

Table 14: Types of information about cost in the studies

	Number of studies
Cost per enrollee	5
Spending and expected enrollment increase	2
Cost of particular activities	6
Observations about the cost of activities	3
Comments about administrative savings	7
Reports of increased funds for providers with increased coverage	4
Total articles with any information on cost	*27*

DATABASE FINDINGS: IMPLICATIONS FOR THE TAKE-UP PROJECT

The purpose of constructing the database was to collect and review studies that could be used as the basis for a meta-analysis that ideally, would allow us to answer the following questions:

> • What types of outreach, enrollment and retention strategies have proved most effective in ensuring that uninsured individuals have public or private coverage?
> • Which outreach, enrollment and retention strategies are particularly cost-effective?
> • Which outreach, enrollment and retention strategies are particularly effective for special populations (those living in urban and rural areas, those whose first language is not English, and those whose cultural background or practices are different from the majority of program participants)?
> • What lessons are particularly important to consider with regard to the Affordable Choices Initiative?

Based on our assessment of the research included in the database, a meta-analysis is not recommended as a means to answer these questions. The methods used to construct the database ensure that it provides a rich source of reliable information that can be used effectively in other ways to provide answers to the research questions, however.

Considerations regarding the meta-analysis

Although meta-analysis is more commonly used with clinical research studies, it can also be used to examine research related to interventions that occur in non-clinical settings. Typically, a

meta-analysis combines the results of several isolated studies with small sample sizes to create one synthesized result with increased statistical power resulting from the combined sample sizes.

To be combined in this way, studies included in a meta-analysis are usually all focused on the same research hypothesis. The literature review indicates that although there is a substantial body of literature, there is not enough uniformity to support a meta-analysis. Comparison among the studies is complicated by the fact that they do not evaluate a single strategy, but a group of strategies and for each strategy a set of activities. In addition, it is rare that only one intervention is initiated. Most often, when there is a policy decision to make an effort to increase take-up, many activities occur. This reality makes it difficult to conduct definitive outcome-based research and to make comparisons among studies.

Furthermore, the results of a meta-analysis are only as reliable as the studies that feed into the analysis. The meta-analysis technique takes the relative reliability of the findings from a number of studies into account, and considers the size of the effect reported in synthesizing results. As the description of the database presented above indicates, however, there are not enough studies of sufficient rigor or quality on which to base a meta-analysis, even on a narrower topic. For example, of the three controlled experiments described above, one pertains to the strategy of providing assistance and two pertain to the strategy of publicizing the availability of benefits. And, the two involve different populations – families and the elderly.

One potential difficulty is that in studies of a non-clinical nature it is more difficult to control for exogenous factors that may affect outcomes. Many studies did not sufficiently address this concern, making it impossible to determine whether the observed effects were caused by the intervention or by other factors. We would be reluctant to combine results from such studies with the results of others which did carefully control for exogenous variables.

Lessons from similar research

Past efforts to synthesize research on take-up strategies support the conclusions presented here. In the course of conducting the literature review, we found a publication prepared for the Agency for Healthcare Research and Quality in March 2000, *Review of the Literature on Evaluations of Outreach for Public Health Insurance and Selected Other Programs* (Laschober et al.). It describes a literature review and synthesis of the empirically-based evidence on the effectiveness of interventions to increase enrollment of low-income children and families in public health insurance programs. Methods similar to those developed for this project were used to find and catalogue the literature: nine completed evaluations and 17 in progress at the time. The study authors concluded,

> "that rigorous evaluations…are largely absent from the published literature…no rigorous empirically-based evaluations exist. Of the few interventions for which there are completed evaluations, we did not identify a body of literature regarding any specific intervention or set of interventions that would help us to conclude with a high degree of confidence that the results are valid."

The authors also note, "We did not locate any completed cost-effectiveness evaluations." While a great deal more research has been conducted since 2000, the topic still has not invited widespread rigorous evaluation.

A 2003 study, *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs* (Remler and Glied), examines the take-up literature across a variety of programs. The study authors note, "our approach is akin to that of a meta-analysis, although we cannot do a formal meta-analysis because of insufficient structure and commonality across both programs and estimation strategies."

Both reviews reach similar conclusions about the feasibility of conducting a meta-analysis, but it is important to note that both also are able to draw some meaningful conclusions based on a careful systematic review of the available literature. The Laschober study conducted and reported on a detailed review of nine studies. Remler and Glied identified 37 studies that contain data on the magnitude of effects (quantitative and non-quantitative) and examined the effects to draw conclusions about methods to increase take-up.

Options for the take-up project

We continue to think that an evaluative rather than a descriptive exercise should be undertaken – one that might serve as the next best alternative to a meta-analysis. The database can be used to conduct a focused literature review that presents reasonable defensible conclusions based on the best available evidence to help answer the research questions.

As indicated above, we have constructed a useful database with a very well defined collection of articles that provide a wealth of evidence to examine. Strong consideration was given in the initial review of the literature to the quality of the research. The articles included in the database present evidence rather than opinions. The collection of articles is focused, pertaining just to strategies to promote take-up, rather than to program participation barriers. It is also limited to interventions, rather than program design or policies that may affect take-up. Although there is a dearth of causal evidence among the studies, there are some strong correlations reported. An even more careful, focused review of the data in the database can provide answers to some of the research questions.

The key in using the database will be to review the data in a careful structured manner. This can be accomplished with a strategy-specific review that examines the literature pertaining to each of the four strategies, presents findings based on available evidence from the database, explains which findings are strongest and why. In addition, although this project was not designed originally to develop recommendations about evaluation techniques, we have become quite familiar, in the course of reviewing resources for inclusion in the database, with the strengths and weaknesses of the research that has been done to date on this topic. Therefore, as part of a "strategy-specific" review, it would also be possible to include a discussion or make recommendations – based on examples from the literature – regarding the type of studies that could be done to improve the availability and quality of future research on the topic of take-up.