

**Effects of Social Environmental Factors
On Child Health Insurance**

by

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Effects of Social Environmental Factors on Child Health Insurance

I. Introduction

Statement of the Problem:

Over the past two decades, the health care system has undergone significant changes. The rise of health care costs and less personal health care coverage plans has produced problems for the overall well-being of low income children and children of minorities. These changes have created language, cultural and financial barriers. Though children are usually healthy, they require health care that emphasizes preventive services such as immunizations.¹ Child health insurance is necessary for families so they can provide the proper care for their children.²

This study looks into social environment factors and government funded programs in the state of Mississippi. In Mississippi, there are approximately 156,000 children lacking health insurance according to 1994-1996 Children's Defense Fund (CDF) data.³ Another CDF report states that out of 100 poor counties in the United States, 84 counties were found in the south. One-third of these counties were in Mississippi. Overall, southern children account for 50 percent of all poor children in the United States. One out of nine children live in what is now classified as "extreme poverty." Extreme poverty can be defined as a family of three who live below a median income of \$6,258 a year or \$522 a month. Poverty can be defined as family of three living below the median income of \$12,600 a year.⁴ Based on these statistics, the government has taken steps in alleviating the problem of low income children lacking health insurance.

The overall study question asks what are the different social environmental factors

affecting children in Mississippi and nationally from obtaining proper health care coverage and what steps have been done to improve the quality of health care.

Importance of Issue:

Nationally, not enough attention has been brought to child health care and its effects on children. As of 1998, there was an estimated 10 million American children with no health insurance.⁵ Of these 10 million children, four million are eligible for Medicaid but not enrolled because parents may not know they are qualified to receive Medicaid health coverage.⁶ Without proper health care when children are young, long term effects might arise.

The government expects an additional (to the number of present insured children) 2.5 million children will be insured by 2000. State/federal programs, such as the Child Health Insurance Program and Insure Kids Now, are all committed to helping the nation achieve this goal.

Background Information:

A recorded 27.6% of uninsured children, approximately 3.1 million, live in rural or frontier areas. Both areas provide different amounts of resources. A lack of these resources can lead to poorer health care coverage. For example, small businesses thrive in rural areas more so than in urban areas. Small businesses pay lower rates of employer sponsored health insurance coverage. From a 1998 survey, an estimated 51.7% of rural employees are covered by employer health plans compared to 60.4% coverage in urban areas.⁷ Also, rural areas do not have as many health providers as urbanized or metropolitan areas do. Fewer resources (smaller staffs, lesser revenue) contribute to the problem of health coverage.⁸

A region in the south is different from a region in the west according to

demographic features and resources available. For example, the south has the largest percentage of uninsured children because states along the Mexican border have a large Hispanic population. Hispanic families may not be aware that their children are eligible for health care coverage because language, culture and literacy barriers can inhibit communication between families and health care providers.⁹ Also, Hispanic families are afraid to become involved with government programs because of immigration problems for some family members.¹⁰ Financial barriers, low employment and high poverty rates are possible reasons behind why African Americans, another minority largely represented in the south, have a large uninsured population.¹¹

The Clinton Administration has started a program, Children's Health Insurance Program (CHIP). This has been recorded as the most significant improvement to health care for children since the creation of Medicaid, a federal/state program, in 1965.¹² Medicaid was designed to cover low income families, not families with incomes just above poverty levels.¹³ Also, families with children, pregnant women, and those who are aged, blind or disabled are eligible for Medicaid benefits. However, Medicaid has expanded in the late 1980's to cover more poor and near-poor children, but the program still has roots within the welfare program.¹⁴ On a cost-sharing basis, Medicaid provides federal funds to states based on each state's per capita income.¹⁵

The CHIP law, passed in 1997, allocated \$24 billion over five years to help states expand health insurance to children whose families earn too much to qualify for traditional Medicaid, yet not enough to afford private health insurance.¹⁶ CHIP offers three options to states: expand current Medicaid programs; design a new children's health insurance program; or a combination of the two. Currently, all the state approved programs anticipate providing health insurance coverage to 2.5 million children by

October 2000.¹⁷

Every state and territory had an approved CHIP program as of September 1999. The implementation of CHIP involved effort from several administrations and services. Those involved include: Department of Health and Human Services, Center for Medicaid and State Operations (CMSO) within the Health Care Financing Administration (HCFA), and the Health Resources and Services Administration (HRSA). HRSA along with HCFA has monitored the program as an addition to the Department's overall strategy to support coordination with other state and federal health programs in providing outreach to uninsured children.¹⁸

Along with CHIP there is a national hotline set up by health agencies. The hotline, Insure Kids Now, has been implemented by the National Governors Association to help families directly contact their state agencies with questions about health insurance for their children.¹⁹

Efforts to increase awareness of the availability of child health insurance to 6 million families in low-income housing programs have taken place. Peer outreach, multimedia campaigns, health fairs, coalitions of service providers, service provisions at convenient locations in the communities and incentives were used to inform the public of health care insurance. For example, brochures and pamphlets containing basic information about CHIP and its' eligibility requirements were sent out with children around the first weeks of the academic year or with report cards. In addition to informing the public, the government simplified the forms and applications for Medicaid and CHIP. For example, Mississippi's application is described as a "short application" (a 2-5 page application).²⁰

Mississippi Background:

According to a survey conducted for the W.K. Kellogg Foundation by Bonny & Company, an independent research firm, 25% of Mississippians (children and adults) do not have health insurance coverage.²¹ This information was from a 1998 national phone survey on 313 Mississippians between November 4 and November 27. Twenty-six questions ranging from welfare reform to health care reform were asked. This survey was part of a multi-year, multi-national dollar funding initiative known as the Devolution Initiative.²² This involved 19 strategic partners working in 40 states. Devolution is a term used to describe how responsibility for the development and management of various public policies and public services is shifting from the federal to the state and local levels of government.²³ The survey found that seven in 10 Mississippians believe that their state government should do more so that children could obtain adequate health care. The public also had strong faith that the government can do more to insure children of the state. Mississippi citizens advocate help for low-income families, so the uninsured can acquire health insurance. They also believe that people who cannot take care of themselves such as children, should receive social services paid by the government. Overall, the people of Mississippi have expressed concern about children receiving proper care.

Medicaid is the only public health insurance program in the state of Mississippi for children.²⁴ Before 1998, there was no public-private initiative for children in Mississippi. The only program that resembled a public-private partnership was the Blue Cross/Blue Shield Caring Program for Children. This program was closed due to a lack of private contributions and the program had not accepted any new enrollees for a year prior to the closing in December of 1997.²⁵ Another unreliable program was the State and Public School Employees' Health Insurance Program. It did not provide coverage for

CHIP targeted children because members had to pay premiums for dependent coverage.²⁶

Due to a lack of private insurance initiatives for children unable to afford any other kind of health care coverage, the 1998 Mississippi Legislature established the Mississippi Children's Health Insurance Program Commission. This commission explored the possibility of a public-private health care partnership for low income children who did not qualify for Medicaid.²⁷

Mississippi's CHIP program (Mississippi's Title XXI program) was the 45th plan to be approved in the first year of implementation of the CHIP program.²⁸ The State administrated program is a combination of Medicaid and CHIP. In 1998, the combination of programs was known as a "Medicaid look-alike." Children enrolled, receive no entitlement, but they have Medicaid benefits. Both programs have the same administrative agency, providers and plans, but the difference may be invisible to parents.²⁹ There was no Medicaid expansion, there was only another program that was exactly like the already existing Medicaid program.³⁰ This was noted as of May 1998 by the Children's Defense Fund (CDF). The CDF also reported that Mississippi's program to expand coverage was subject to change in the future.³¹ In October of 1998, the first phase of Mississippi's program (CHIP I) was approved by the Health Care Financing Administration (HCFA). The first phase, a Medicaid expansion, is expected to enroll 12,000 children by September 2000. Approximately 15,000 children are eligible for CHIP I, according to the Heritage Foundation and Urban Institute estimates.³² This expansion was targeted towards insuring children who are less than 19 years of age and living up to 100% of the federal poverty level (the 100% FPL of a four member family is \$16,450). The expansion involved a regular state Medicaid program with no costs to families. The Mississippi Department of Human Services started enrolling CHIP I children on July 1,

1998. The Mississippi Medicaid Agency mailed out letters to families with children (6-14 years of age) already enrolled in Medicaid, to inform them that their children between 15 and 18 years of age are eligible for CHIP I coverage.³³

The second phase in Mississippi's program (CHIP II) was approved of in February 1999. The expectancy of this amendment's health care coverage is to insure an additional 50,000 children for the year 2001.³⁴ This amendment created a separate state health insurance program to insure children up to age 19 in families with incomes between 100-133% of the federal poverty level (FPL). Compared to the first phase, this new phase of the CHIP plan insures children in families up to 133% of the FPL, a 33% increase. With this new amendment, the benefit package is equivalent to the state employee's plan, with the addition of hearing, dental, and vision services.³⁵

A third amendment was approved of in December of 1999. This phase increases income eligibility to 200% of the FPL (for a family of four this is an income up to \$33,000 per year).³⁶ Included in the amendment, is cost-sharing up to 5% of the families' income.³⁷ The benefit package will be equivalent to State and public employer's health insurance programs with the addition of immunizations and hearing, vision, and dental services. The Mississippi S-CHIP program also offers premium assistance to families who insure their children through employer sponsored insurance programs. However, the insurance plans must meet the benchmark equivalent standards set up by the S-CHIP health coverage. In addition, if the employer's health coverage plan does not offer vaccinations, then the local health department or physician will offer the shots.³⁸

As of March 2000, a bill that would eliminate the waiting period for enrollment in the S-CHIP program was proposed. The original bill proposed to shorten the six month waiting period to three months. However, another amendment to eliminate the waiting

period was proposed instead. There is an estimated 90,000 Mississippi children who meet the eligibility criteria to be enrolled, but they must be uninsured for six months to apply and enroll in the program.³⁹

The cost to implement and carry out the initial program, CHIP I, and CHIP II is relatively high. Along with federal matching funds for actual expenditures done to insure children, Mississippi can also use money from the state's tobacco lawsuit, decided by lawyers in March to be used for a health care trust fund. This lawsuit contributes \$10 million to the overall cost of \$66 million allocated to carry out this program. Eighty-three percent of this cost will be covered by federal matching funds.⁴⁰

According to federal statistics, there were 3,464 children enrolled in Mississippi CHIP I by December 1998.⁴¹ Data for how many children were enrolled for CHIP II was not available.

II. Methodology

Study Design:

The questions proposed for this research are based on “how” and “why” questions. I am asking “why” is health insurance hard to obtain for some children and “how” is the government handling this problem. In order to collect data for these questions, I used study propositions to help guide me as I found data and analyzed information. With main study questions based on “how” and “why”, the study design that best fits my research is the case study approach.⁴²

A case study design is preferred when “how” and “why” questions are being asked and when the investigator has little control over the events.⁴³ Some “events” in my research are bills and amendments passed by the legislature and national and state poverty levels. Also, a case study is defined as a design method where numerous amounts of

evidence - documents, artifacts, interviews and observations - were used because a clear boundary between phenomenon and context is not evident.⁴⁴ A case study approach also allows the investigator to expand and generalize theories. In my research, for example, I am expanding the general theory that low income rates influence the rate of children becoming insured. Overall, the basis of my research questions, the means of obtaining evidence and data, and the fact that child health insurance is a complex social phenomenon leads to the use of a case study design.

Study Areas:

The main area of study in my research is Mississippi state. I am focusing my questions on what social environmental factors are evident in Mississippi and how they are affecting children from obtaining health insurance. I also focused my research on the nation because government programs influence the entire country.

Mississippi was selected for my topic because the main project team, SEARCH (Office of Social Environment and Rural Community Health), chose labor market areas (LMA's) from Mississippi-Louisiana and New Mexico. In addition, more data was available for Mississippi than on New Mexico or Louisiana.

The project team is currently working on a case study on social environmental factors affecting rural community health, specifically cardiovascular diseases in two areas. The areas were selected on data analysis of mortality rates, from 1985 to 1995. Percent changes due to cardiovascular diseases throughout this time span were calculated and rates were age adjusted. A comparison of cardiovascular disease mortality to overall mortality was completed as well. As a result of the data analysis, New Mexico's labor market area (LMA) ranked 2nd in the first percentile (meaning that they had the one of the lowest mortality rates) and the Mississippi/Louisiana LMA ranked 138th (out of a

possible 139 areas) in the tenth percentile. The project team's investigation is based on what social environmental factors are evident in the study areas, "how" the factors have influenced the mortality rates and "why" were the mortality rates drastically different in the two areas.

Labor market areas (LMAs) are defined as a geographical unit of analysis. The project team used LMAs as study areas for their investigation because they are beneficial to the organization of collecting data and they provide reliable information about the area. Each LMA reflects a geographic space within which a population both lives and works. Labor market areas are determined by central labor activities and it takes into account how many people are being affected by the labor activity (eg. how many are employed). With this information the United States Census Bureau determines the boundaries of an LMA. Overall, LMAs provide a clearer analysis of rural/urban employment issues and labor market performance. In addition, LMAs can be adapted to do research on demographic processes and health services.⁴⁵

SEARCH investigators helped me with the research project by providing resources and guidance, specifically Dr. Beth Barnett. Dr. Barnett is the key investigator for the SEARCH project and is the faculty mentor for my research project.

SEARCH Team Members:

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Study Population:

The main focus of the research is on Mississippi children. The research also

focused on children throughout the entire nation. The age span was from 0 to 21 years of age. Within this population, statistics on how many Hispanic, black and white children are uninsured/insured were obtained on a state and national level. The study population also included families living under the federal poverty level or under poverty conditions throughout the state and the nation. I included the national population along with the state population because with both groups represented, a clearer understanding of Mississippi children's status is produced. I also looked at information pertaining to the overall Mississippi population (adults and children) to obtain data on how the public feels about health insurance.

Data Sources:

The majority of the information came from sources on the Internet. The Children's Defense Fund (CDF) website and the Health Care Financing Administration (HCFA) website contained state and national level data about CHIP and uninsured children in general. The CDF website contained articles about what possible barriers are evident in specific areas and populations. HCFA website provides numerous documents on state child health care insurance plans. The HCFA website also contained numerous links to other websites promoting and explaining what the Child Health Insurance Program was and how it was implemented within each state. The CHIP website explained each state's child health insurance program. It also contained various articles and documentations on the overall status of children and how successful the program has been in each state. The Robert Wood Johnson and Kaiser Commission on Medicaid and the Uninsured websites included national surveys and reports with information about how the public feels about Medicaid and what are some possible suggestions on how to improve health care for children.

Newspaper articles were found on the internet through the Mississippi Link, a website for information about Mississippi. Articles on the public's opinion, bills and amendments, and the latest information were available through this site. The Clarion Ledger site provided this type of information as well. The Clarion Ledger is a newspaper published and distributed in Mississippi. Also, the project team subscribed to various newspapers and kept copies in the office. Other articles came from medical journals and magazines.

Data Collection Procedures:

Documentary information was used for research purposes. Letters, administrative documents, and newspaper articles are all examples of documents used for the research topic. The majority of facts stated in the report came from documentary information, because various organizations, letters, and other reports stated the same facts. By having non-contrasting thoughts and figures, the facts were valid and I was able to use them for research purposes. An example of this type of information include the Mississippi S-CHIP facts.

Archival records were also used for the research. Survey data came from foundations or organizations dedicated to helping uninsured children. The HCFA and CHIP websites provide information about the budget and finances used by states to implement CHIP. Census records (provided by the United States Census Bureau website) supplied information on poverty rates among uninsured children in the state and nation.

All of the data used for the research was clearly noted and documented. The facts used in the report were taken off numerous organizational and foundation reports and articles. Website addresses were also documented for the report.

Restrictions on Obtaining Data:

Complete data on Mississippi child health insurance was not available. Current facts and figures were not compiled for years 1998-2000. Information on the latest report of how CHIP is doing in Mississippi is not available as of yet. Current data on how many children are insured or how many children were insured by the government/state programs was not available for Mississippi.

The amount of state data obtained was small in comparison to data obtained on a national level. Minimum facts about uninsured minority children in the state and nation were available. The majority of websites that were accessed noted that recent or current data about the progress of the state's condition was not yet available.

Overall there was more information and data available for Mississippi than the other two states used for the project team's study areas. Although, there were some restrictions on obtaining data, enough facts and figures were obtained to complete the research project.

III. Results

Who are the Uninsured Children?

The Kaiser Commission on Medicaid and the Uninsured issued a March 2000 report stating that the risk of being uninsured varies by income, age, race and ethnicity.⁴⁶ The Kaiser Commission was established by the Henry J. Kaiser Family Foundation to analyze health care coverage, financing, and access for the low income population. The Commission also assesses options for health care reform. According to their report, two-thirds of all children have private insurance. Medicaid covers one in five children in the U.S., while one in seven children remain uninsured. Low-income children are more likely to be covered by Medicaid or to be uninsured and less likely to have private coverage

than those with higher incomes.⁴⁷ Out of 11 million uninsured children, two-thirds live in families with household incomes below the 200% poverty level. Many of these children may be eligible for Medicaid, but are not enrolled. Younger children are more likely to be insured than adolescents because of lower Medicaid income eligibility levels for older children. The report also states that Hispanic children are most likely to be uninsured.⁴⁸

The 1998 March Census Brief reports poor children were far more likely to lack health coverage than non-poor children who did not have health insurance in 1996.⁴⁹ Approximately one in four children lacked health insurance in 1996. According to their statistics for 1996, 13.9% percent of white children, 28.9% of Hispanic children, and 18.8% of African American children lacked health coverage. The Brief also noted that Hispanic children are the least likely to have health insurance coverage.⁵⁰

According to a Children's Defense Fund (CDF) 1998 mid-term report on the State Children's Health Insurance Program (S-CHIP), the majority of uninsured children (up to 18 years of age) lived in the southern region of the United States.⁵¹ Out of the national total of 74,899 million children, 25,749 million children live in the south. There are 13,772 million children in the northeast, 17,731 million children in the midwest and 17,647 million children in the west. Of these 74,899 million children, there was an approximately estimated 11,300 million children lacking health insurance. In the south, there was 4,794 million uninsured children, the west had the next highest with 3,093 million uninsured children, the midwest had 1,674 million children, and the northeast had 1,739 million uninsured children.⁵²

The mid-term report also included the number of uninsured children living under the 100%, 100-199%, and 200% federal poverty levels (FPL). For a family of four living under the 100% federal poverty level in 1998, the estimated income is \$16,450. For a

family of four living under the 200% level, the estimated income is \$33,000.⁵³ The 1998 CDF report states that the percent of all uninsured children in families with an income below the 100% FPL is 29.7% in the northeast, 30.0% in the midwest, 35.4% in the south, and 36.6% in the west. For uninsured children living under the 100-199% FPL there is 33.6% in the northeast, 31.2% in the midwest, 37.7% in the south and 35.6% in the west. For uninsured children living under the 200% FPL, there is 36.6% in the northeast, 38.8% in the midwest, 26.9% in the south and 27.8% in the west. Note, that for the South and the West population, the percentage of uninsured children living under the 200% FPL is significantly lower than for the other percentage levels.⁵⁴

The US Census Bureau March 1999, 1998 and 1997 surveys determined how many uninsured children live in each state under a 200% federal poverty level (approximately \$33,000 per year for a family of a four).⁵⁵ In Mississippi, including all income levels, there was an estimated 830,000 children under the age of 19. There was 450,000 children living under the 200% federal poverty level. There was a recorded number of 127,000 children living under the 200% FPL without health insurance.⁵⁶

Before CHIP was implemented in 1998, there were other public-private health insurance programs available for children in Mississippi. However, the only program that had numbers and estimates available was Medicaid. Medicaid was the most used government program to enroll children for health insurance in Mississippi. In 1994, there was a total of 289,870 children (up to 21 years of age) already enrolled with Medicaid and 369,286 children not enrolled, but eligible for Medicaid. The statistics of the number of children in each major race receiving Medicaid during 1994 was: 28.1% were white, 69.5% were black and 0.1% were Hispanic. The statistics of how many children by race are eligible for Medicaid, but uninsured was: 28.7% were white, 68.7% were black, and

0.2% were Hispanic.⁵⁷ For the year 1995 there was a total of 281,815 children receiving Medicaid, and 320,163 children eligible for Medicaid, but not enrolled. The number of children by race receiving Medicaid care was: 27.9% were white, 69.4% were black and 0.2% were Hispanic. The statistics for how many children by race are eligible, but not enrolled was: 27.1% were white, 70.2% were black, and 0.2% were Hispanic.⁵⁸ The 1995 Medicaid annual report notes that Mississippi has not yet adopted a program to provide insurance coverage to uninsured children.⁵⁹

For the year 1996, there was a total of 318,420 children eligible for Medicaid, but not enrolled for health insurance, while there were 277,017 children receiving Medicaid care. The statistics on how many children by race was eligible for Medicaid, but not covered was: 27.2% were white, 69.9% were black, and 0.3% were Hispanic. The statistics for how many children by race received Medicaid help in 1996 was: 27.8% were white, 69.2% were black, and 0.3% were Hispanic.⁶⁰ As of July 16, 1996 the federal welfare legislation required states to use the AFDC income eligibility levels to determine Medicaid eligibility. This established a state specific minimum eligibility level for poor children ages 15 through 18. Also, Mississippi expanded its Title XIX Medicaid program to 185% federal poverty level for pregnant women and infants. According to the 1996 Medicaid annual report, the cost of providing health care to children is a fraction of the cost for adults. In Mississippi, Medicaid can insure three children for less than what it would cost to insure one adult.⁶¹

For the year 1997, there is an estimated total of 544,722 children in Mississippi and 307,460 of these children (approximately 56.4%) were enrollees of the Medicaid program. The number of children by race considered as enrollees was: 27.0% of white, 69.8% of blacks, and 0.3% of Hispanics.⁶² An estimated 29.6% of 151K uninsured

children under age 19 in the state of Mississippi were Medicaid eligible but not enrolled during the year 1997.⁶³

The CHIP program was implemented in 1998 in Mississippi. There is an estimated 809,755 children in Mississippi and 18% of these children do not have health insurance.⁶⁴ Approximately 51,000 uninsured children in Mississippi are Medicaid eligible but are not enrolled. According the 1998 Medicaid annual report, three fourths of the total number of uninsured children (142,818) could receive coverage from Medicaid or a separate state program under Title XXI.⁶⁵

In 1999, approximately one year after CHIP has been implemented, 148,000 of the 810,000 children in Mississippi do not have health insurance.⁶⁶ In 1999, Mississippi received approval to expand health insurance to children in families living up to the 133% federal poverty level (FPL). The expansion was approved of in March 1999. In December 1999, an amendment to expand coverage to children in families living up to the 200% FPL was approved of. By raising the FPL to 200%, 61,000 children are eligible for health insurance coverage. Approximately one third of 148,000 children are eligible for Medicaid, but are not enrolled.⁶⁷ According to the 1999 Medicaid annual report, the federal government pays 76.8% of Mississippi's Medicaid costs and federal funds cover 83.8% of CHIP expenditures (Title XXI).⁶⁸

For the year 2000, numbers and statistics were not yet available for how many children were enrolled or were eligible for health coverage, but not covered. However, the American Academy of Pediatrics analyzed the March 1999 Current population Survey and other data sources to report 2000 projections on Medicaid and State program eligibility of uninsured children through the age of 18 years. For Mississippi, the American Academy of Pediatrics estimated that 60.6% of the total population were

eligible for Medicaid and 27.2% were eligible for the state program. Approximately 12.2% of total children were ineligible for both health insurance programs.⁶⁹

Outreach and Enrollment:

The American Public Human Services Association published a report, “CHIP Outreach and Enrollment: A View from the States.”⁷⁰ This report was based on information from a 1999 survey of state Medicaid and CHIP agencies in 33 states, including Mississippi.* The survey asked states for information on their outreach materials including their cost and effectiveness as well as how they were developed.

Twenty-nine of the 33 states (88%) responding use posters, fact sheets or pamphlets to give an overview of the program to families. All materials conveyed the message to families that their children may be eligible for free or low-cost health insurance. Pamphlets (these were used in Mississippi) included basic information about the state’s CHIP program and eligibility guidelines. States reported distributing informational material everywhere from fast food restaurants to welfare/government agencies to child care centers.⁷¹

Other modes of spreading information about CHIP are notices in Newspapers and other publications (27 states relied on this method), flyers in other mailings (33 states relied on this approach), direct mailings (23 states used this approach) and radio and television spots (29 states relied on this method). Some states reported that radio messages were effective in rural, large areas. Also advertising on foreign language radios could convey the message to minorities. Also distributing flyers with school mailings generated a large response. This approach targets specific populations or communities.⁷²

* The following states responded to the survey: AL, AK, AZ, CA, CO, CT, DE, DC, FL, ID, IL, IA, LA, MD, MI, MN, MS, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, SC, TX, UT, and WV.

In addition to these methods and approaches, a toll free hotline, Insure Kids Now, has been implemented to provide callers with information and referrals. The hotline will also send out an application to interested individuals. Nine states take applications over the phone.⁷³

Mississippi Medicaid agencies relied on various methods to encourage families to enroll their children in CHIP. In Mississippi, letters were distributed to families who had children ages 6 through 14 enrolled in Medicaid to inform them that CHIP coverage was now available to their children ages 15 through 18 years. The Mississippi Medicaid agency has produced written, radio and television informational material. The agency has also participated in a number of meetings with advocacy groups throughout the State who are willing and interested in helping deliver the message about CHIP to families throughout the state, assist them in filling out the CHIP application and turning in the application to the local Human Services Office. The Medicaid agency has also established a program within the school system to identify children who are Medicaid eligible, CHIP I eligible, and who could access Medicaid's Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).⁷⁴

All thirty three states reported to have multiple partnerships. Most of the partnerships involve literature distribution and an effective way in reaching targeted populations. In addition, all states responded to having partnerships with their Title V or Women's Infant and Children (WIC) programs. These partnerships involve distribution of informational material and applications. A reason why this partnership was so successful was that WIC employees came in daily contact with families with children eligible for CHIP or Medicaid coverage. Some states have partnerships with other government agencies or with schools to promote and identify eligible children.⁷⁵

The majority of states have coordinated application and enrollment procedures because of the close relationship between CHIP and Medicaid. Twenty-eight states (including Mississippi) have a single combined application for Medicaid and CHIP eligibility. Title XXI requires every individual applying for CHIP, must first be screened for Medicaid. If that individual qualifies for Medicaid, then he or she cannot be enrolled in CHIP. Thirty states accept applications over mail and 16 states accept application information over the phone. Mississippi uses the combined application approach, accepts applications by mail and accepts information over the phone. However, Mississippi was one of the few states who did not accept applications face to face.⁷⁶

Barriers to Enrollment:

There are approximately 11 million children uninsured today despite efforts made to insure them. A national survey, “Medicaid and Children: Overcoming Barriers to Enrollment” was done for the Kaiser Commission on Medicaid and the Uninsured. The nationwide telephone survey focused on what families think of the Medicaid enrollment process. In winter 1998 and spring 1999, the Kaiser Commission on Medicaid and the Uninsured interviewed 1,335 low income parents of children age 15 and under. Two groups of parents participated in the survey. The first group consisted of parents with children enrolled in Medicaid and the second group consisted of parents with children who are uninsured, but eligible for Medicaid.⁷⁷

A complicated and burdensome enrollment process is the greatest barrier to enrollment. Some of the important reasons to why parents don’t complete the enrollment process include acquiring all the necessary documentation, the overall burden of completing the process, and the complexity of the enrollment process. In addition, parents who have never tried to enroll their children think that the enrollment process would take

too long and that the office where they need to go to was closed or far away.

Since it's inception, Medicaid has been linked to the welfare program causing Medicaid requirements to be the same as welfare requirements. Many working parents of eligible uninsured children are not attached to the welfare system causing them to assume that their children are not eligible for Medicaid. However, the link between the two programs have been severed, but the Medicaid enrollment process continues to impose requirements for cash assistance. Many barriers to enrollment have resulted from these requirements. Another problem due to the link between Medicaid and welfare is the negative public image associated with welfare. Approximately one third of the parents surveyed said that they did not want to go to the welfare offices to apply or they were afraid they would be treated badly by the people working at the enrollment office.⁷⁸

A lack of knowledge about Medicaid eligibility is also a barrier for families. Over half of the families interviewed for the report said that they did not know if their children would qualify. Other parents did not know where or how to apply or they were too confused about the rules and regulations. In addition the forms were too complicated.

For Spanish speaking families, a language barrier was a problem for enrolling their children. Nearly half of Spanish speaking parents said the belief that application material was not available in Spanish led them to not even try to enroll their children. Approximately 46% of Spanish speaking families did not complete the application process because the forms and the information were translated into their language.⁷⁹

Parents want a less complicated and user friendly enrollment process. The following strategies were what parents with Medicaid eligible, but not enrolled children want so they would enroll their children: 60% of parents wanted mail in or phone-in enrollment; 56% of parents wanted immediate enrollment with completion of forms later;

55% of parents wanted extended enrollment office hours. Parents with Medicaid enrolled children wanted the following so they would be more likely to stay enrolled: 54% of parents want better doctors; 53% of parents want automatic enrollment through a school lunch program; and 52% of parents want extended enrollment office hours.⁸⁰

The negative public image about Medicaid associated with welfare cannot easily be fixed, but there are some suggestions on how to improve the situation. Forty two percent of parents said that they would be more likely to enroll their children if they did not have to go to a welfare office to enroll them. Fourteen percent of parents of Medicaid enrolled children and 17% of parents of eligible uninsured children said that changing the name to something other than Medicaid would make them more likely to enroll their children. Reinforcing the fact that Medicaid is a health insurance program for the low-income families and not so closely related to welfare would help resolve this problem as well.⁸¹

Bilingual services would help resolve the problems to enroll children of Spanish speaking families. Parents interviewed for the report said that if more translated forms were available they would probably enroll their children. They would also be more likely to enroll their children if they could receive assistance from someone who was fluent in their language.

Some parents complete the enrollment process but are later denied health insurance coverage for their children. The survey lists eight reasons to why some parents are denied coverage and they are: income was too high, don't know why coverage was denied, incomplete forms, had a job, too many assets, agency's fault, and the family's living situation. The number one reason, with 48% of parents, was the income was too high.⁸²

Barriers to enrollment in Mississippi were noticed and the Mississippi Medicaid agency and the Mississippi Department of Human Services have established some steps to improve the situation. Three specific barriers to enrollment were evident and noted in the 1998 Annual report for the State of Mississippi. Families were not likely to enroll their children if the application process was too long or complicated. So, the agency shortened the application to one page and the same application is used for Medicaid and CHIP I eligibility assessment. An “application workbook” was suggested to guide an applicant through the application by explaining in simple terms what information a particular question is looking for.⁸³

Another problem was that parents were not as willing to go to a Human Services office to apply because of the “welfare” stigma and it is physically difficult for a family to reach the office during regular business hours. In order to alleviate this problem, the advocacy network is working on taking applications into the communities where families go - schools, churches, health clinics, hospitals, malls, and grocery stores - and help them fill out the application and mail it in to the Human Services office. Telephone applications were also available to help resolve this problem.⁸⁴

The third enrollment problem involved a language barrier. Mississippi has a growing Hispanic population in one area of the state. The agency is working on obtaining a language service through AT&T to help insure Spanish speaking children.⁸⁵

Children enrolled through CHIP I are able to choose a health care provider immediately. The problem with this is that there are not enough providers in some areas of the state to participate in the managed care program.⁸⁶

Progress:

Overall Mississippi has improved and expanded their children’s health insurance

program. As of February 2000, Mississippi has the following income eligibility guidelines for children:

	Medicaid:	State Program:
age 0-1	185%	200%
age 1-5	133%	200%
age 6-18	100%	200%

The expansion of income eligibility guidelines causes more children to become eligible for health insurance coverage.⁸⁷

In the beginning of the 1990's Mississippi's health data was scattered throughout different state agencies and organizations. Even within specific agencies data systems were not necessarily integrated.⁸⁸ However in 1992, the Information for State Health Policy program (InfoSHP) was initiated to help states build better health information systems. Mississippi was one of seven states to be awarded a one million grant to improve their health data systems.⁸⁹ With the data system more organized, Mississippi agencies could assess the information better.

The Children's Defense Fund (CDF) issued a report on how states have done so far with the CHIP implementation in 1998. The four categories the CDF took note of were: coverage, affordability, benefits and family friendliness. Mississippi had the lowest rating for coverage and affordability. For benefits and family friendliness, Mississippi had the highest rating.⁹⁰

IV. Commentary:

Health care coverage is important for all children to have. On the Mississippi Link, an article on a college student lacking health insurance was published. The article explains how a 19 year old Alcorn State University student has a painful golf-sized tumor growing in a gland in her cheek. The student is working and going to school full time and

still does not have health insurance. She cannot afford the necessary procedure to remove the benign tumor because of high medical bills.⁹¹ However, this student is no different than any other college student. The Independent Insurance Agents of America (IIAA) found that one in seven college students lack health insurance coverage. The majority of students have to depend on their employers for assistance or to receive the limited health coverage provided by their parents' health insurance. Most schools offer student insurance at reasonable prices, but according to this study, less than one percent took advantage of them.⁹² The article provides some insight on how important health coverage is for people of all ages, including children.

Despite many efforts made by the government, state agencies and community leaders, there is still an estimated 11 million uninsured children today. However some of the changes made were necessary and they did enroll more children. Expansion of income eligibility from 100% federal poverty level (FPL) to 200% FPL in Mississippi has greatly impacted how many children were eligible for health coverage. Public knowledge of who is eligible, where to go to enroll, and how to apply have all improved the chances of enrolling uninsured children.

The number of uninsured children in Mississippi has decreased each year, maybe not drastically, but it has decreased somewhat. The decreasing numbers represent that S-CHIP and the expanded eligibility requirements have caused an increase in enrollment of children. Overall CHIP, implemented in 1998, has been beneficial to increasing awareness of health insurance to families and enrolling uninsured children.

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