An Examination of Enrollment of Children in Public Health Insurance in New York City Through Facilitated Enrollment

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ABSTRACT *A cohort of families was followed through the enrollment process for Medicaid and Child Health Plus in New York City to determine success in enrollment and the time it takes to enroll. Families were recruited into the study by enrollers in community-based organizations and managed-care organizations. In our sample, three of four families were successful in enrolling. On average, it took 60 days to attain insurance. Most applicants (76%) received some sort of assistance from enrollers, most frequently in determining which documents were needed (74%). In a multivariable analysis, some of the factors associated with success in enrollment included being assisted by a community-based facilitated enroller, knowledge of required documents, and having lost a child's other health insurance.*

KEYWORDS *Health insurance, Medicaid, State children's health insurance.*

INTRODUCTION

The State Child Health Insurance Program (S-CHIP), enacted in 1997 as Title XXI of the Social Security Act, was the largest expansion in expenditures for child health care since the enactment of Medicaid in 1965. Through S-CHIP, approximately 24 billion new federal dollars were made available to states for child health insurance over a 5-year period. States used this funding to expand access to health insurance to new groups of children. Currently, 4 states have expanded coverage up to 150% of poverty, 33 up to 200% of poverty, and 14 to over 200% of poverty.¹ States had the option to use S-CHIP funds to expand their current Medicaid programs or to institute new programs. Sixteen states used the federal funds to expand their Medicaid programs, 16 instituted separate S-CHIPs, and 19 expanded Medicaid eligibility thresholds as well as instituted a new S-CHIP.²

New York was one of the states that did both. At the time of the S-CHIP's passage, New York already had two health insurance programs for children: Medicaid and Child Health Plus (CHPlus). CHPlus was instituted in 1991 to complement the preexisting Medicaid program. The influx of federal dollars through S-CHIP enabled New York to expand eligibility thresholds for both programs. Currently, children age 18 years and younger are eligible for Medicaid up to 133% of the

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federal poverty level (FPL). The CHPlus program provides coverage to children up to 250% of the FPL.

In addition to raising eligibility thresholds, states took steps to increase enrollment for children in both Medicaid and S-CHIP. Many states addressed administrative barriers to successful enrollment, such as simplifying enrollment forms and removing asset tests and the face-to-face interview requirement.^{3,4} They launched outreach programs, often community based, to find and enroll eligible children.^{3,5,6} These efforts were in response to studies that identified barriers to enrollment such as a lack of accurate and adequate information about programs,⁶⁻¹⁰ problems associated with the enrollment process,^{6,7,9} and possibly stigma associated with the Medicaid program because of its historical association with welfare.¹¹

The State of New York has also taken steps both to simplify the enrollment process for children and to find and enroll eligible children. For example, New York uses a combined application for its Medicaid and CHPlus programs, whereas previously it had a separate application for each. New York eliminated the Medicaid asset test for children, but retained the requirement for a face-to-face interview.

New York also created a new outreach program called facilitated enrollment.¹² The program, which started in New York in June 2000, funded community-based groups to find and enroll families in high-need areas. As of 2002, there were 32 community-based groups in New York, 11 of these in New York City. Although any community-based group can participate, in practice they usually consist of such groups as perinatal consortia, immigrant service groups, health care organizations, faith-based groups, and other community-based organizations. A special effort was made to include groups with linguistic and cultural competency to be able to reach immigrant communities. Trained "facilitated enrollers" help families fill out the application for Medicaid and CHPlus and assemble the documents necessary for processing the application (proof of income, residence, age, and for some children, immigration status). They also track applications as they are processed by the local Social Service Agency (for Medicaid) or by health plans (for CHPlus). In addition to funding the community-based facilitated enrollment system, New York took steps to make the enrollment process through managed-care organizations (MCOs) easier by training MCO marketers to act as facilitated enrollers and giving them the authority to enroll children in Medicaid and CHPlus.

MCOs and community-based organizations have different recruitment strategies and reach different populations. Community-based organizations rely heavily on "inreach" recruitment into families already coming to the organization and engaging in its services, whereas MCOs engage in broader outreach and are responsible for a larger share of the enrollment.¹³ MCOs and community-based organizations also differ in options they are able to offer families: MCOs can enroll children who appear eligible immediately in a "presumptive" or "temporary" status while the application is processed. This allows families enrolling through MCOs to attend to their children's existing health care needs immediately, whereas families applying through community-based groups do not have this option.

Although there has been great interest in the effect of New York and other state initiatives to find and enroll eligible children, there has been little research on the topic. In the present study, we followed a cohort of families over a 6-month period in New York City from the time they initiated the process of applying for Medicaid or CHPlus to determine how many were successful at attaining insurance, the time it took to receive insurance for those who were successful, determinants of a successful enrollment, and reasons for a lack of success among families that did not obtain insurance.

METHOD

Data

At the time of our study, there were 9 community-based organizations and 19 MCOs enrolling children in Medicaid and CHPlus. To be geographically representative and to work with MCOs that had fairly even distributions of Medicaid and CHPlus, we selected 3 of the MCOs covering different areas of New York City. Because the community-based groups were smaller than the MCOs and enrolled substantially fewer children, we selected 5 of the 9 community-based groups. These groups also gave us geographical representation in Brooklyn, the Bronx, Queens, and Manhattan. All parents (or a caretaker) who initiated the process of applying for Medicaid or CHPlus for a child in their household between September 2000 and February 2001 at one of these locations were asked if they would be willing to participate in the study and be contacted at a later date (within one month of the initial contact). A total of 708 potential participants were approached, and 622 or (88%) agreed to be contacted for the study. Of the 622 parents referred for the study, 598 were eligible to participate. Up to 10 attempts were made to contact each respondent. Baseline interviews were completed with 426 families using a computer-assisted telephone interview, for a response rate of 71.2% calculated according to customary standards.¹⁴ Respondents were asked questions using a structured questionnaire that was 20 minutes long. During the baseline interview, one child in the household was randomly selected (using the most recent birthday method) to be followed through the insurance process.

Respondents who had not received insurance for the randomly selected child at the time of the baseline interview were contacted up to four additional times: at months 1, 2, 4, and 6 or until the time the child received insurance. The follow-up survey was 10 minutes long. All interviews were completed by September 2001.

To verify the insurance status of the randomly selected child, survey information was complemented by data collected from facilitated enrollers. The data collected from facilitated enrollers were considered the “gold standard” because they receive notification of enrollment and keep this information on file. Because children in New York City children can be enrolled temporarily, some families may erroneously conclude that they successfully completed the enrollment process when in fact they are only enrolled temporarily. This study was interested in measuring completed enrollment. The survey data were supplemented with the complementary data in two instances: (1) the respondent was lost to follow-up, and the complementary database had a record of whether the child got insurance ($N = 76$); and (2) when the respondent reported obtaining insurance but the complementary data indicated otherwise ($N = 31$). There were 23 parents lost to the enrollment process, meaning neither the survey data nor the complementary information from facilitated enrollers could confirm if the respondent received insurance for the child. Approval to complete this study was obtained from the New York Academy of Medicine’s Institutional Review Board Committee.

Survey Instruments

During the baseline interview, respondents were asked about their progress in the application process, their motivation for applying for insurance, their experience obtaining eligibility documentation, how long it took to obtain each document required for the application, and the help they received from facilitated enrollers. During the follow-up interviews, respondents were asked about their progress in

the application process and about additional help they received from facilitated enrollers.

The independent variables for this study included the following sociodemographic characteristics of the respondent: gender, race/ethnicity, income, education, and age. The nature of the relationship between the respondent and the child (e.g., parent, grandparent, aunt) and the child's age were ascertained. Respondents were asked about their motivation for applying for insurance in particular, if the child had a health problem that needed care, or if the child lost his or her other insurance. Prior experience with public benefits was assessed, and respondents were asked about their own insurance status. We also created a variable of respondent knowledge of the documents required to complete the application process based on whether they could name a document to verify their age, income, and residence. Finally, we asked if the respondent was applying for Medicaid or CHPlus. The dependent variable was a binary outcome indicating whether the child obtained insurance (yes/no) and was determined from information obtained during the surveys complemented by data provided by the facilitated enrollers.

Statistical Analyses

Frequency analyses based on the respondent survey were used to describe the study population and the prevalence of successfully obtaining insurance. We assessed the concordance between what the respondent said about whether the child obtained insurance and what the data from the community-based and MCO facilitated enrollers indicated. For the remaining analyses, we eliminated seven respondents from the data set who indicated they had stopped applying for insurance because they obtained other insurance for the child, leaving a total sample of 419. Frequency analyses were used to describe help respondents received from community-based and MCO facilitated enrollers. Unadjusted associations between the dependent variable and the independent were assessed with odds ratios, and chi-square statistics were used to test the significance of these associations. Finally, adjusted associations were estimated using logistic regression. In both the unadjusted and adjusted analyses, 95% confidence intervals were estimated and reported.

RESULTS

Table 1 shows the demographics of the study population obtained from the baseline interview. The majority (53%) of respondents were African American, and 34% were Hispanic. As expected, the income levels of those applying for insurance were quite low: 44% earned less than \$1,000 per month, and 42% earned between \$1,000 and \$2,000/per month. However, respondents reported having relatively high levels of education considering their income: More than 66% had at least a high school education. The majority of respondents (52%) who were applying for insurance for their child were between the ages of 21 and 35 years; 44% were older than 35 years. Of the respondents, 88% were the child's parent, and 90% were female. One third of the children were adolescents (between the ages of 12 and 18 years). Many respondents had no prior experience using public benefits; 44% reported they had never received public assistance, WIC (Women, Infants, and Children program), or food stamps. The majority of respondents (53%) reported being employed themselves and 82% reported living in a household where at least one person was employed full or part time (data not shown), although less than one third (31%) had health insurance for themselves.

TABLE 1. Demographics of study population (N = 426)

Characteristic	N	%	NYC %
Gender of applicant			
Male	43	10	
Female	383	90	
Race/ethnicity			
Hispanic	145	34	41*
Black, non-Hispanic	228	53	32*
Other	49	12	27*
DK	1		
Refused	3	1	
Household income			
<\$1,000/month	187	44	
\$1,000–\$1,500/month	123	29	
\$1,500–\$2,000/month	57	13	
>\$2,000/mo	24	6	
Don't know	29	7	
Refused	6	1	
Last grade applicant completed			
<High school	125	29	
High school/GED	147	35	
Technical school/some college or more	134	31	
Don't know	17	4	
Refused	3	1	
Motivation for applying for insurance			
Child has health problem and needs care	138	32	
Child lost other health insurance	189	45	
Age of applicant, years			
<20	16	4	
21–35	220	52	
36–65	188	44	
Refused	2	1	
Relationship of applicant to child			
Parent	377	88	
Nonparent	49	12	
Age of index child			
1–5	151	35	
6–11	134	32	
12–18	141	33	
Mean age of index child	9		
Home language			
English	294	69	
Spanish	50	12	
Bilingual	75	18	
Other	7	2	
Employment status of applicant			
Yes	224	53	
No	201	47	
Refused	1		

TABLE 1. Continued

Characteristic	N	%	NYC %
Child had insurance in past year			
Yes	232	55	
No	188	44	
Don't know	6	1	
Applicant has insurance			
Yes	131	31	
No	292	68	
Don't know	2	1	
Refused	1		
Has anyone in household applied for public benefits in past			
Yes	234	55	
No	189	44	
Don't Know	2	1	
Refused	1		

Source: From Current Population Survey March 1990–1996, US Department of Commerce, Bureau of the Census.

Note. Total does not always add to 426 because of missing data.

* These figures are for families below 150% of poverty level.

Overall, 76% of parents successfully enrolled their child in health insurance (Table 2). Fifteen percent of our sample did not get insurance: 9% were denied; 2% obtained other insurance; 4% stopped applying because of barriers. Of the applicants, 4% had not heard back by month 6; 5% were lost to the enrollment process, meaning that they were lost both to the survey and to the enrollment site.

Respondents who initiated the application process using community-based facilitated enrollers ($n = 339$) were more likely to enroll their child in Medicaid or CHPlus successfully as compared to those who initiated the process using MCOs ($n = 87$). Among those who applied through community-based groups, 80% successfully enrolled their children in insurance. Of those who applied through

TABLE 2. Percentage of respondents who successfully obtained insurance

	N	%	CBOs ($n = 339$)	MCOs ($n = 87$)
Yes, successfully enrolled*	324	76%	80%	60%
No, denied	38	9%	8%	14%
No, stopped applying because of barriers	15	4%	3%	6%
No, stopped applying, got other insurance	7	2%	1%	4%
Had not heard by month 6	19	4%	4%	6%
Lost to enrollment process†	23	5%	4%	10%

CBO, community-based organization. $N = 426$.

* The following people were included in the “yes, successfully enrolled” category: those who got insurance according to the survey ($n = 279$). Included in the enrolled category: the people who were lost according to the survey, but the confirmatory database said they received insurance ($n = 76$). Excluded from the enrolled category: the people the survey said were insured, but the confirmatory data said they were not ($n = 31$).

† Subjects categorized as lost to enrollment process were those for whom follow-up information was not available from the survey or from the enrollment sites.

community-based groups, 12% did not get insurance: 8% were denied; 3% stopped applying because of barriers, and 1% obtained other insurance. There were 4% who had not heard by month 6, and 4% were lost to the enrollment process, meaning that they were lost to both the survey and the enrollment site.

Among those who applied through the MCOs, 60% of parents successfully enrolled their children in insurance. Of those who applied through MCOs, 24% did not get insurance: 14% were denied; 6% stopped applying because of barriers, and 4% obtained other insurance. There were 6% who had not heard by month 6, and 10% were lost to the enrollment process. Children enrolled presumptively who completed the process are in the “yes, successfully enrolled” category. Children enrolled presumptively who did not subsequently complete the process could be in any of the categories other than “yes, successfully enrolled.”

The Figure represents the time it took to obtain insurance. On average, from the time the respondent first spoke to an enroller, it took 67 days to obtain insurance. From the time the respondent reported handing in a completed application form (and not necessarily all of the required documents), it took 60 days to obtain insurance. It took slightly longer from the time the completed application form was handed in to obtain CHPlus (mean 61 days) than it did to obtain Medicaid (mean 57 days), although this difference was not statistically significant. There were also no significant differences by community-based facilitated enroller (61 days) and MCO (59 days) from the time the family handed in the completed application form until insurance was obtained.

Table 3 shows the respondents’ experiences with the enrollment process. There were 23% who indicated that they took less than 15 minutes to fill out the application; 32% took between 15 and 30 minutes, and 37% took more than half an hour.

FIGURE. Time to obtain insurance.

TABLE 3. Steps in process (n = 419)

	N	%
Time to complete application		
Less than 15 minutes	97	23
15–30 minutes	135	32
30–60 minutes	105	25
1–2 hours	37	9
More than 2 hours	11	3
Unknown	34	8
Help from enroller		
Received any type of help	319	76
Type of help		
Advised which documents were needed	310	74
Made a reminder call regarding documents	93	22
Advised about where to get a document	73	17
Wrote letter needed for a document	59	14
Helped contact a place to obtain a document	25	6

Of the sample, 76% reported having received some form of help from a facilitated enroller: 74% percent were advised which documents were needed, 22% reported that the enroller made a reminder phone call regarding the documents, 17% were advised about where to obtain a document, 14% reported that the enroller wrote a letter needed for a document, and 6% received help in contacting a place to get a document.

In bivariate analyses (Table 4), several factors were associated with successfully obtaining insurance. First, respondents who indicated that their child had lost health insurance were 1.7 times more likely to obtain insurance successfully (unadjusted odds ratio [OR] 1.7; 95% confidence interval [CI] 1.1–2.8). Second, respondents who initiated the process at a community-based facilitated enrollment site were 2.5 times as likely to obtain insurance compared to those who initiated the process at a health plan (unadjusted OR 2.5; 95% CI 1.5–4.3). Finally, respondents who were able to name the documents they needed to verify the child's age, income, and residence during the baseline interview were 1.9 times more likely to obtain insurance compared to those who could not name all three document types (unadjusted OR 1.9; 95% CI 1.2–3.1).

In a multivariate analysis, five factors were predictive of successful enrollment. Female respondents were more than twice as likely (adjusted OR 2.3; 95% CI 1.0–5.0) as male respondents to obtain insurance. Respondents who were parents were more likely to obtain insurance successfully compared to respondents who were of some other relationship to the child (adjusted OR 2.0; 95% CI 1.0–4.3). Respondents who applied with community-based groups were more than three times as likely to obtain insurance compared to families who applied with health insurance plans (adjusted OR 3.2; 95% CI 1.7–6.2). Respondents whose child had lost other health insurance were 1.8 times more likely to attain insurance successfully compared to children who had not lost their insurance (95% CI 1.1–3.1). Those applicants who could identify appropriate documentation at baseline were 1.7 times more likely to obtain insurance than those who could not identify required documents (95% CI 1.0–2.9).

TABLE 4. Factors associated with successful enrollment

	Bivariate			Multivariate		
	Unadjusted OR	95% CI	P	Adjusted OR	95% CI	P
Gender						
Male	—	—		—	—	
Female	1.6	(0.8–3.1)	.21	2.3	(1.0–5.0)	.05
Race/ethnicity						
Black	—	—		—	—	
Hispanic	0.8	(0.5–1.3)	.46	1.7	(0.9–3.3)	.10
Other	1.3	(0.6–2.8)	.49	1.4	(0.6–3.6)	.43
Income						
<\$1,000	—	—		—	—	
\$1,000–\$1,500	1.0	(0.7–1.7)	.87	1.1	(0.7–2.0)	.65
\$1,500–\$2,000	1.1	(0.6–2.2)	.75	1.2	(0.5–2.7)	.67
>\$2,000	1.3	(0.4–4.1)	.61	1.0	(0.3–3.5)	.98
Education						
<High school education	—	—		—	—	
High school graduate	1.2	(0.7–1.8)	.57	1.5	(0.8–2.8)	.17
More than a high school education	1.3	(0.8–2.1)	.38	1.6	(0.8–3.0)	.19
Motivation for applying for insurance						
Child has a health problem and needs care	0.9	(0.6–1.5)	.67	0.8	(0.5–1.4)	.51
Lost child's other health insurance	1.7	(1.1–2.8)	.02	1.8	(1.1–3.1)	.03
Relationship						
Applicant not parent	—	—		—	—	
Parent applicant	1.7	(0.9–3.2)	.14	2.0	(1.0–4.3)	.06
Applicant age, years						
20 or younger	—	—		—	—	
21–35	0.8	(0.5–1.3)	.44	0.7	(0.2–2.7)	.57
36 and older	1.2	(0.7–1.9)	.52	0.8	(0.2–3.4)	.81

TABLE 4. Continued

	Bivariate			Multivariate		
	Unadjusted OR	95% CI	P	Adjusted OR	95% CI	P
Age of child, years						
0–5	—	—		—	—	
6–11	0.8	(0.5–1.3)	.44	0.8	(0.4–1.5)	.49
12–18	1.4	(0.8–2.3)	.21	1.6	(0.8–3.1)	.20
Type of insurance						
CHPlus	—	—		—	—	
Medicaid	1.0	(0.6–1.7)	.97	1.1	(0.6–1.9)	.83
Experience with public benefits						
Someone in household applied for public benefits	1.0	(0.6–1.5)	.82	0.8	(0.5–1.4)	.39
Child has been insured in recent past						
No	—	—		—	—	
Yes	0.9	(0.6–1.5)	.70	0.7	(0.4–1.2)	.16
Insurance status of adult applicant						
Does not have insurance	—	—		—	—	
Has insurance	1.0	(0.6–1.6)	.91	0.7	(0.4–1.1)	.12
Employment status of adult applicant						
No	—	—		—	—	
Yes	0.7	(0.7–1.8)	.66	1.0	(0.6–1.6)	.93
Enroller type						
Plan	—	—		—	—	
Facilitated enroller	2.5	(1.5–4.3)	.00	3.2	(1.7–6.2)	.00
Experience with required documentation						
Applicant knew documents needed from age, income, and residence categories at baseline	1.9	(1.2–3.1)	.01	1.7	(1.0–2.9)	.05

DISCUSSION

This study shows that most families who received assistance from either the MCO or community-based groups succeeded in gaining insurance for their children. Specifically, in our sample 76% of the children received health insurance within the 6-month time frame during which they were followed. More children whose families were assisted by community-based enrollers were successfully enrolled (80%) compared to those assisted by MCOs (60%). On average, it took 60 days to enroll from the time the family handed in the application to the time the applicant was enrolled in insurance.

The study also shows that considerable assistance was needed for respondents to successfully attain insurance. Most applicants (76%) reported that they needed assistance gathering the documents needed to prove income, age, residence, or citizenship, most often in knowing which type of documentation was needed (74%). Furthermore, although the application form has been simplified, 37% of respondents reported it took over 30 minutes to complete the application form, even with assistance. These findings, taken together, suggest the assistance families received was important for overcoming administrative hassles and in gathering required documentation, barriers that in other studies have been found to deter enrollment.^{7,10}

The study also shows factors associated with successful enrollment. They include understanding the process (knowing at the outset which documents were needed), being motivated by having lost current insurance, having the applicant be female or a parent, and initiating the process with a community-based facilitated enroller rather than an MCO-based one.

We know of no other study that follows applicants through the process of applying for public health insurance for children; as such, this study sheds new light on the enrollment process. Our findings, however, are consistent with other studies, which ask respondents about perceived barriers^{8,9} or compare insured and uninsured for knowledge and other factors.^{7,10} Notably, the insured have been shown to have more knowledge of the application process than the uninsured.^{7,8} They also have been shown to understand the basic rules of the process.^{7,15} The association the present study found between having recently lost insurance and subsequent success in completing a new enrollment process may be an indication that families who know the rules and have the required documents (as indicated by prior insurance) traverse the enrollment process more easily than those without prior familiarity. These findings may indicate that more effort is needed to educate and assist families who are new to the process. Also noteworthy is that respondents who reported their child had a health problem had no better success in enrolling than those with children with no health problems. Success in acquiring insurance once the enrollment has been initiated appears to be more related to knowledge and availability of necessary documents than it is to need.

This study shows that families who do not have knowledge of required documentation are less likely to enroll successfully in Medicaid and CHPlus. There is substantial policy interest in the effect of documentation requirements. Federal law requires only that those applying for children's health insurance who are not citizens of the United States provide written proof of their qualified alien status.¹⁶ States have flexibility in what they accept as proof in meeting other eligibility requirements (e.g., age, income, residence). Many states have implemented policies that make it easier for families to prove their eligibility.^{1,17} Our findings suggest that if New York were to adopt some of these simplification requirements, it could lead to higher success in enrollment.

Of major importance in this study are some of the factors *not* associated with success in enrollment, findings that differ sharply from other studies comparing the insured to the uninsured. Prior studies found a strong association between demographic factors and Medicaid insurance coverage.^{8,9,18} By contrast, race, income and education level were not significantly associated with successful enrollment in the present study. Although our methodology was different from these other studies, and thus the results are not directly comparable, this is a striking and noteworthy difference. One interpretation of these findings is that the assistance provided by facilitated enrollers reduced these disparities. Many facilitated enrollers are embedded in their communities and speak the language of the applicants; thus, they may help those who disproportionately face barriers to succeed in completing the enrollment process.

The positive association between success in enrollment and receiving assistance from a community-based organization rather than an MCO merits explanation. There are similarities between the two types of organizations. Both employ enrollers who give considerable assistance to families. Both help applicants fill out the application as well as determine which documents are needed to prove income, residence, age, and immigration status and remind families to bring in these documents. Both types of organizations seek to employ culturally sensitive facilitated enrollers.

Despite the similar strategies employed by MCO and community-based organizations, there are also some fundamental differences, three of which may give rise to the observed differences in enrollment rates. First, it may be that the community-based groups have an advantage in that they have a greater depth of relationship with residents in the community than do the MCOs. Many of the community-based groups participating in the program provide multiple services, increasing their visibility in the community. For example, one community-based facilitated enroller in Queens provides infant and child development services, comprehensive mental health services, family support, homeless youth services, job training, and employment services to over 30,000 families annually.

Second, people applying for public health insurance coverage through community-based enrollers may be more motivated to complete the enrollment process compared to people who complete the process through MCOs. MCO facilitated enrollers generate a large number of contacts with families by marketing the programs at community events (such as health fairs) and by visiting places where they are likely to find eligible families (such as community health centers and schools). However, in the process, they are interacting with families who are not necessarily motivated to complete the application process. By contrast, community-based facilitated enrollers enroll families who come to them on site, which is an indication that they are highly motivated to obtain insurance. In addition, the families probably return to the site for continued use of other services, which facilitates the lengthy process of assembling the required documents.

Third, MCOs have different enrollment requirements than the community-based groups. MCOs can enroll children presumptively or temporarily in CHPlus for 60 days. This means that MCOs can enroll children in CHPlus even if all the required documents have not been turned in if the child appears to be eligible at the time of the initial application. This allows a family to attend to the children's health care needs right away, while the application is being processed. As such, it is an important feature of MCO enrollment. (In this study, approximately one third of the children were reported to have an immediate health problem or need.) However, although families receive an insurance card for the child and can use health

care during this time, they are not fully enrolled. If by the end of the 60-day grace period the required documents have not been turned in, then the child loses this insurance. MCOs report that between 40% and 50% of the children enrolled presumptively or temporarily fail to complete the applications,¹⁹ possibly because the child has an insurance card and parents mistakenly believe that the child is insured, or possibly because parents lost track of the process in the 60-day grace period. In contrast, at the time of this study, community-based facilitated enrollers could not enroll children presumptively or temporarily, but instead had to ensure that the application and documentation were complete from the beginning. This gives the community-based organizations an advantage in terms of urgency in completing the enrollment, but a disadvantage in ability to meet health care needs immediately.

If this explanation accounts for some of the difference in completed enrollments, we would expect that the level of discordance between the survey data and the complementary data would be higher among respondents who initiated the application process with a MCO rather than a community-based organization. The level of discordance (the percentage of respondents who said they received insurance when the complementary data said they did not) was higher among respondents who had initiated the application process with an MCO (16%) compared to those who initiated the process with a community-based group (4%). Thus, it appears this explanation may account for some, but not all, of the difference in successful enrollment between MCOs and community-based facilitated enrollers. Another explanation for the discordance may be that the children enrolled through MCOs received immediate temporary coverage for their medical concerns. These families may address their immediate concerns and not be motivated to complete the process.

Respondents in this study reported that it took approximately 60 days to obtain notification of receipt of insurance from the time they submitted a completed application. This is substantially longer than requirements outlined by the relevant Medicaid statute and in the guidance for CHPlus.^{20,21} It is also likely to be a long time from the family's perspective and could lead to discouragement.

This study has limitations. Our sample consisted of individuals who began the enrollment process of applying for insurance for a child. They may systematically differ from individuals who have never initiated the process of applying for insurance in terms of success in enrolling and barriers encountered. For example, it may be that some people do not begin the process because they do not think they have the necessary documentation or have insufficient information about the program.¹⁰ Thus, the results do not generalize to the uninsured population as a whole, but rather to the portion of that population that seeks insurance.

A second limitation is that more of the families in the sample were recruited from community-based organizations than from MCOs. Because we intended the study to follow families through the enrollment process, it was necessary to recruit respondents at the point of initial contact between the facilitated enroller and applicant. Community-based and MCO facilitated enrollers had to explain the purpose of the study and secure consent to be contacted, which was difficult after they had already gone through a lengthy and complex application process. It was more onerous for MCOs because their enrollers were under greater pressure to meet enrollment goals. Hence, the sample from MCOs is smaller than from community groups. Although this difference does not affect bivariate or multivariate analyses, it does affect the prevalence of enrollment. For this reason, we give separate prevalence figures for successful enrollment in MCOs and community-based groups.

A third limitation is that we cannot compare the success rates for attaining insurance between individuals who initiated the process with a facilitated enroller and those who initiated process in the standard way at a Medicaid office. Although this comparison would have allowed us to demonstrate the value added through facilitated enrollment, lack of access to applicants from the Medicaid offices prevented us from designing the study in this manner.

Despite these limitations, this study has important implications for policy. Most of the respondents in this study who applied for insurance ultimately received it. However, even though the application was streamlined and the enrollment process simplified, most needed a considerable amount of assistance to fulfill all the enrollment requirements. Understanding which documents are necessary and assembling them is a major stumbling block for families, and explaining these requirements requires a major effort from enrollers. It appears that the effort and funds spent on assisting families through the enrollment process is necessary for many New York families. The full potential of enrollment assistance may not yet be realized. Over 60% of the 410,000 uninsured children in New York are eligible for either CHPlus or Medicaid.²² Enrollment assistance may help bring these children who are eligible but uninsured the health care to which they are entitled.

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