MATHEMATICA Policy Research

IssueBRIEF

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Moving the Needle on Health Insurance Coverage: The Cities Expanding Health Access for Children and Families Project

Given the responsibilities cities have for protecting the health and well-being of their residents, and the platform city leaders have to engage residents on coverage issues, cities are well-suited to undertake health insurance outreach and enrollment work.

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 held great promise for expanding insurance coverage to millions of uninsured Americans. When the ACA was enacted, about 4.4 million children were uninsured even though they were eligible for public insurance coverage through Medicaid or the Children's Health Insurance Program (CHIP) (Kenney et al. 2012). Viewing the passage of the ACA as an opportunity to find and enroll these children into coverage, in December 2012, the Atlantic Philanthropies granted $3.25 million to the National League of Cities (NLC) to launch a three-year project to help cities find and enroll children and their families into coverage for which they were already eligible.

The CEHACF initiative. The Cities Expanding Health Access for Children and Families (CEHACF) project was designed to capitalize on both cities' responsibility for protecting the health and well-being of their residents and municipal leaders' platform for engaging residents. The project's overarching goal was to empower municipal leaders in competitively selected cities to partner with community stakeholders to find uninsured children already eligible for, but not enrolled in, public coverage available through Medicaid and CHIP—and, potentially, their adult parents who were newly eligible for Medicaid or marketplace coverage through ACA rules—and enroll them. Beginning in January 2013, CEHACF engaged selected cities on children's coverage issues through a three-stage, competitive grant-making process. In the first stage, NLC staff helped municipal leaders and their partners from 23 participating cities to learn more about the development and implementation of health insurance outreach and enrollment strategies. Of those 23 cities, 12 cities received phase two grants to develop business plans to implement outreach campaigns, and 8 cities were awarded phase three grants to implement those outreach campaigns (Figure 1).

Evaluating CEHACF. In June 2014, Atlantic commissioned Mathematica Policy Research to evaluate the CEHACF project. This issue brief summarizes evaluation findings about whether municipal governments can become effective agents for increasing coverage take-up, what factors contribute to success, what challenges were encountered, and whether the work is likely to be sustainable after the project ends. It is based primarily on interviews conducted in 2015 and 2016 with staff from participating cities and NLC, review of program documents, and analysis of monthly data collected between August 2014 and July 2016 from the eight cities that were selected to implement outreach and enrollment campaigns through the project.

The ATLANTIC Philanthropies

OCTOBER 2016

Cities have made strides in ensuring their residents are healthy and productive, supporting 19,829 enrollments and 5,232 renewals from August 2014 through July 2016. When children are insured, they have better health throughout childhood, greater academic performance, and are less likely to use emergency health care services.

Participating CEHACF cities

Figure 1

FINDINGS

Key findings from the final assessment include:

- **Cities can effectively conduct outreach and enrollment work: nearly 20,000 adults and children have enrolled in Medicaid or CHIP as a direct result of campaigns in four of the participating CEHACF cities.** As of July 2016, 12,730 adults and 7,099 children have enrolled in Medicaid or CHIP as a direct result of campaign efforts in four of the cities (the four other cities were unable to track enrollment data); presumably this is a lower bound, since the other cities also supported applications (even though they could not track resulting enrollments) (Figure 2). These four cities able to track enrollments also supported renewal efforts: together, these campaigns assisted 5,232 adults and children with renewal of their Medicaid or CHIP coverage. Although the cities focused primarily on enrolling children—only two of the eight cities set adult enrollment goals—adult enrollments were nearly double child enrollments. This appears to be the result of a combination of factors. First, there are so many more uninsured adults than uninsured children; as of 2014, there were nearly six uninsured adults for every one uninsured child. That makes uninsured adults much easier to find, compared to uninsured children. Second, ACA rules that permit expansion of Medicaid clearly helped drive adult enrollment, since the cities with the largest adult enrollments are all located in states that expanded Medicaid. Third, many cities conducted campaign outreach at locations that serve low-income adults and children, such as community centers and clinics, rather than focusing only on child-centric locations, such as schools or day care centers. Thus, many CEHACF campaigns benefited from the "welcome mat effect," which is when parents seeking to enroll their child in coverage find out that they, too, are eligible.

"We make sure that we are engaging people where they are in the community, because that's always been our biggest point—to reach them rather than having people try to find and reach us."

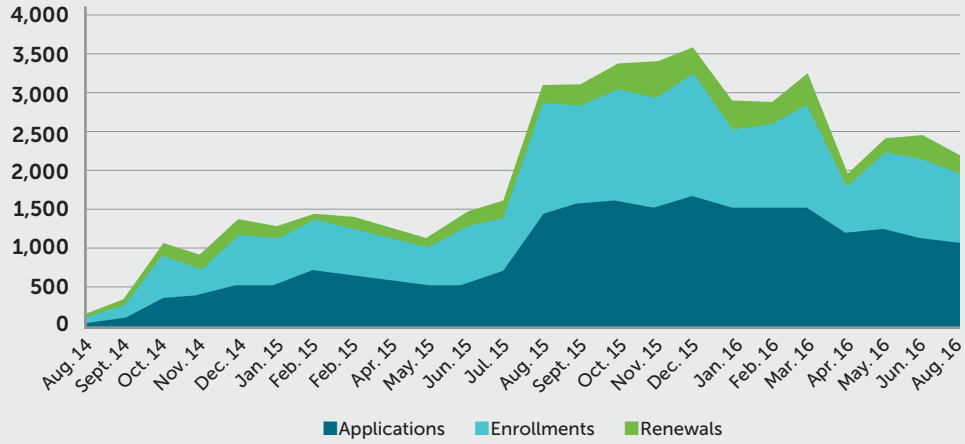
—Pittsburgh grantee

- **Developing partnerships with community organizations that were likely to serve uninsured children and families during the grant period was challenging; the most successful cities leveraged partnerships that predated their CEHACF campaigns.** Most of the participating cities used the first months of their campaigns to build relationships with local partners. As a result, it took them much longer to ramp up application and enrollment assistance, resulting in fewer campaign-supported applications and enrollments than expected as of July 2016. The two cities that were most successful in terms of total applications and enrollments designed their campaigns around longstanding partnerships with local schools, a community health center, and a local county

"WIC has a long history in the community. As far as finding the right place and the right partnership, that was key. But then to make it successful, we had to be an expected part of that agency culture. We have become known in those WIC centers, so our clients know that we're going to be in the same place at the same time every week, so if they have questions they can come back to us. They don't have to hunt for us, they can find us as part of their regular routine."

—Hattiesburg grantee

Total applications, enrollments, and renewals (children and adults), August 2014–July 2016



Source: Mathematica analysis of city-reported data, August 2014–July 2016.
Note: Applications include those applications submitted for Medicaid and/or CHIP initial enrollment or renewal. An application can include more than one individual, such as multiple members of the same family. Enrollments represent individuals, rather than households or families.

Figure 2

safety net agency, gaining buy-in from these groups before they won their CEHACF grants. This enabled these two cities to start providing assistance immediately when the grant began.

- **With partnerships, context is key: partnerships that are essential to one city's campaign may not be easily replicated in another city.** Partnerships critical to outreach and enrollment campaigns in one city did not always work well in another city. For example, although schools are a natural place to find children—all of the cities' initial business plans identified partnerships with schools as key to their campaigns, and the city with the most enrollment success based their campaign primarily around a school partnership—most participating cities were unable to develop relationships that enabled them to embed high-touch enrollment strategies and assistance in schools during the grant period. This meant they had to identify alternative partners that could help their campaigns. Through a trial and error process, many of the cities found that other government programs and municipal agencies could be important conduits for reaching uninsured families. For example, one participating city had its greatest campaign success when the local water agency included information about the campaign as an insert with the monthly water bill.

- **The cities that had the most success tracking enrollments attributable to their campaigns thought about data from the outset: they had detailed data plans and data-sharing agreements in place before their campaigns began.** Detailed data collection and reporting plans for partners, as well as access to Medicaid and CHIP enrollment data, were essential components of successful campaigns: cities needed to be able to track an application, determine if the application resulted in an enrollment, or if not, provide additional enrollment assistance to the family (such as obtaining additional income documentation or helping a family file an appeal). The CEHACF cities that tracked application and enrollment data successfully had thorough data collection plans in place before their campaigns began. This enabled them to assess campaign successes and failures, and to identify patterns to help them modify their campaigns, if needed. Several of the CEHACF campaigns were hampered by data problems

On one-on-one enrollment assistance: "We found that mobile enrollment assistors, helping people, holding their hand, doing this enrollment assistance is critical to kids and families getting on Medicaid."

—Savannah grantee

throughout their grants. For example, some cities could not get partners to report data back to the campaign, while others could not get agreements with their state Medicaid agencies to enable them to track enrollment outcomes.

- **Cities worked to balance best practices in outreach and enrollment against the desire to develop innovative campaigns.** In the end, the cities that built their campaigns on evidence-based practices and adapted them to their local circumstances were more likely to find and enroll the uninsured. The CEHACF application for the implementation grants encouraged cities to propose innovative outreach and enrollment approaches. However, this frequently resulted in the use of outreach approaches that were not effective in enrolling individuals into coverage. For example, although one-on-one enrollment assistance is associated with increased enrollment rates, the emphasis on—and proportion of the total grant budgeted for—such assistance varied among cities. Cities with the most enrollment success budgeted much more than their counterpart cities to support direct enrollment assistance. Cities that planned to incorporate more enrollment assistance through partner donations of "in-kind" staff time found it was difficult to supervise, and nearly impossible to monitor, such work.
- **Participating cities are developing strategies to sustain this work, including institutionalizing campaigns within existing city efforts and seeking additional funding sources.** NLC required that all campaign business plans include plans for sustainability following the end of CEHACF funding. Incorporating sustainability discussions from the outset ensured that campaign strategies and activities were planned and implemented with an eye toward continuing beyond the grant period. As a result, campaign staff reported that they either will continue their work under the city department or agency in which they began, or will transition the work to a key campaign partner willing to support staff involved in day-to-day operations of the campaign. As of July 2016, seven of eight CEHACF cities reported that they have already, or are currently integrating campaign efforts within city operations, while three cities have obtained additional funding to support continuation of their campaigns.

DISCUSSION AND IMPLICATIONS

Over the past two years, our evaluation has found that cities can move the needle on health insurance coverage. The cities participating in this project found they were well positioned to navigate complex federal and state Medicaid and CHIP policies in developing and implementing outreach and enrollment campaigns in areas with concentrations of eligible but not enrolled children and adults. At the same time, while progress in health benefits outreach and enrollment work at the city level is promising, several challenges persisted throughout the grant. For example, neither NLC nor the cities fully anticipated the level of trust and numerous "touches" the campaigns would need to develop with families before these families would share sensitive income and health status information. In some cities, campaign staff noted that they assumed at the start that people in need of health insurance would show up for assistance once they learned help was available. In fact, in order to reach the target population, campaign staff learned they had to establish or leverage partnerships with entities that already provide services to this population, which helped to provide legitimacy to the outreach campaigns.

Cities interested in pursuing similar work should consider the following lessons before initiating their own outreach campaigns:

- **Network with local organizations and city agencies to help determine which types of partners are most conducive to outreach and enrollment work to the target population, and to foster buy-in for the campaign.** Among the CEHACF cities, those with partnerships established before campaign implementation had more successful campaigns. If not already in place, cities should begin cultivating partnerships with groups likely to have access to the target population before beginning outreach and enrollment activities, and if possible, provide incentives for partners to participate.
- **Develop comprehensive data collection plans to monitor and assess progress, and execute data-sharing agreements.** Cities that were most successful in collecting application and enrollment data established data collection processes and agreements with outreach and enrollment partners.

ACKNOWLEDGEMENTS

The authors wish to thank Atlantic Philanthropies for their support of this issue brief. This brief is based on a longer report, "Moving the Needle on Health Insurance Coverage: Evaluation of the Cities Expanding Health Access for Children and Families," available at https://www.mathematica-mpr.com/our-publications-and-findings/publications/moving-the-needle-on-health-insurance-coverage-evaluation-of-the-cities-expanding-health-access.

They also had agreements in place with their state Medicaid agencies to enable them to track campaign-assisted Medicaid or CHIP enrollments. It is important for cities to collect this data, since without it they cannot assess what aspects of their campaign are or are not working well, nor examine data patterns that might show where activities could be modified.

- **Use evidence-based outreach and enrollment strategies.** Although innovation is important—and might be required to identify and develop successful partnerships in a particular city—one-on-one direct enrollment assistance was the most successful strategy for enrolling children and their parents in the CEHACF cities. If possible, cities should incorporate a 'warm hand-off' approach, which promotes a seamless referral between identification as eligible and enrollment assistance. Many seemingly innovative strategies, such as referrals from 2-1-1, 3-1-1, or robo-calls, did not yield the same response as boots-on-the-ground, direct enrollment assistance. Such referral strategies put the burden on the uninsured, requiring them to reach out for assistance, rather than targeting members of the potential eligible population where they already accessed programs and services.

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The Atlantic Philanthropies also provided support for children's coverage through the development of the KidsWell campaign, a $29 million investment in state and national advocates to advance a coordinated agenda to accelerate progress in covering children in the short term, while building an infrastructure to maintain gains in coverage in the long term (see Hoag et al. [2015] and Peebles et al. [2016] for more information on KidsWell). Atlantic Philanthropies further supported ACA implementation by joining with seven other national foundations to create the ACA Implementation Fund, which provided strategic support to state-based health advocates.