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Evaluating Disaster Relief Medicaid and Family Health Plus
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Chairpersons Gottfried, Quinn, deBlasio, and Gioia; and distinguished members of the New York State Assembly Health Committee and New York City Council Committees on Health, General Welfare, and Oversight and Investigations; thank you for inviting Greater New York Hospital Association (GNYHA) to testify before you on Disaster Relief Medicaid and Family Health Plus. I am Rima Cohen, a Vice President at Greater New York Hospital Foundation, the Association's foundation arm, and Director of the Insurance Options for the Uninsured (IOU) project. GNYHA represents the interests of more than 200 hospitals and continuing care facilities in New York City and surrounding communities. All of GNYHA's members are either not-for-profit public or voluntary institutions that together serve a high number of Medicaid, Family Health Plus, and indigent patients. The sole aim of the IOU project is to develop and implement strategies for expanding health coverage in New York State.

Our members have a proud tradition of providing patients access to high-quality care, regardless of their ability to pay. However, unrelenting increases in the number of uninsured in New York coupled with factors like steep Medicare cuts and declining payments from managed care companies have put severe pressures on these institutions and threaten their ability to provide the health care access and quality that New Yorkers enjoy and deserve.

Tackling our uninsured problem and strengthening our State's publicly funded health care programs are among GNYHA's highest priorities, and we have engaged in a number of aggressive efforts to that end. For example, together with 1199/SEIU and the New York State Health Care Campaign, we developed the blueprint and advocated for the passage of the Family Health Plus (FHP) insurance program. With the strong leadership of the Assembly and the unanimous support of the Senate and Governor Pataki, FHP was signed into law in December 1999. I served on the State's FHP implementation advisory committee, and my colleagues and I at GNYHA continue to work closely with our members, the City, and the State to ensure the smooth implementation of this program. We have also put forward recommendations for the simplification of our State's public health insurance programs (Medicaid, Child Health Plus (CHP), and FHP) and applaud Assemblyman Gottfried and his colleagues in the Legislature for including a number of these measures in the Health Care Reform Act (HCRA) Amendments of 2002. GNYHA's current agenda includes protecting and further streamlining the administration of these programs.

NEW YORK AS A LEADER IN HEALTH INSURANCE PROGRAMS

Though New York, like the rest of the nation, struggles with a growing uninsured problem, our State also has a particularly strong tradition of taking care of the health needs of its most vulnerable residents. Vitaly important programs like Medicaid, CHP, and most recently FHP provide a lifeline to millions of New Yorkers who would otherwise be uninsured. Our programs have inspired other states to expand coverage and, in the case of Child Health Plus (CHP), have served as a model for Federal legislation. The enactment of FHP has made New York a leader in the nation in devising innovative solutions to expand coverage.

However, a close examination of CHP and Medicaid, especially compared with our recent experience with Disaster Relief Medicaid (DRM), reveals that neither program has yet realized its full potential. Recent studies have documented that too many uninsured individuals do not know about these programs, mistakenly believe they are ineligible, fail to apply because the application process is too complicated, or leave the program while they still qualify for coverage. According to an October 2000 report written by Dr. Kenneth Thorpe for the United Hospital Fund, approximately one-third of New York's 3 million uninsured-1.1 million people-are eligible for either Medicaid or CHP but are not enrolled. Equally troubling, roughly 50% of CHP and Medicaid managed care recipients disenroll each year, according to a report by the New York State Coalition of Prepaid Health Services Plans, even though the vast majority still qualify for coverage. While the passage of FHP was an enormous victory for New Yorkers and, thanks to the State's aggressive efforts, 140,000 low-income, working adults have enrolled in the program in its first year, FHP's potential effects will be diluted if enrollment and retention in FHP mirrors that of CHP and Medicaid.

One of the most straightforward ways to reduce the number of uninsured in our State and boost the health of our residents is to maximize the participation of eligible individuals in our public health insurance programs and enable participants to maintain continuous coverage once they enroll. New York has taken bold and positive steps in that direction by, for example, establishing a statewide system of "facilitated enrollers" who assist families in applying for children's health coverage. The HCRA Amendments of 2002 contained additional, positive reforms to the enrollment and recertification processes of these programs. And, of course, our City's experience with DRM is a striking example of New York streamlining a program to ensure maximum ease of enrollment. We can build on and learn from these successful efforts to guarantee that all eligible individuals have the opportunity to enroll in CHP, Medicaid, or FHP and retain their coverage while still eligible.

Many speakers at this hearing today will highlight specific lessons that flow from the unique experience of Disaster Relief Medicaid. My testimony will draw on research conducted by Greater New York Hospital Foundation into innovations implemented within health insurance programs in other states, many of which mirror aspects of DRM, to suggest specific approaches New York could consider to achieve these goals.

FAMILY HEALTH PLUS: LESSONS FROM OTHER STATES

With the support of The Commonwealth Fund, Greater New York Hospital Foundation researched and wrote a report, published in November 2001, documenting how 13 other states have addressed challenges that New York is now confronting as it implements FHP and attempts to coordinate that program with Medicaid and CHP. ¹ In this report, *Implementing New York's Family Health Plus Program: Lessons From Other States*, we explored how states have simplified their application procedures, maximized the retention of eligible enrollees, and coordinated the operations of two or more coexisting health insurance programs to ensure that transitions between programs are seamless and do not result in involuntary disenrollment. ²

The findings were clear: Many states have instituted policies and employed innovative mechanisms that could be relevant to New York's quest to coordinate FHP with CHP and Medicaid and provide continuous, quality coverage to the greatest number of eligible individuals in all three programs. Following are several examples gleaned from our initial research.

EXAMPLES OF STATE INNOVATIONS

The most effective overarching strategy states employ to simplify their health insurance programs and reduce administrative cost and paperwork is to coordinate funding streams from various health insurance programs under one umbrella program that is marketed and designed as a single plan with

simple, uniform application and enrollment requirements. The states we examined employ different levels of this strategy; some simply market their programs as a single plan while maintaining unique and varying program rules, while others actually align eligibility requirements and enrollment procedures. I will discuss these various levels of coordination and simplification and some additional mechanisms for streamlining public health insurance programs.

Outreach

Too often, uninsured individuals do not know about public health insurance programs or mistakenly assume they do not qualify for coverage. While New York has engaged in a statewide, multi-media campaign to publicize the availability of CHP and FHP, it has not yet extended this campaign to Medicaid. Indeed, Medicaid has historically focused more resources on preventing the enrollment of people who are ineligible for the program than it has on encouraging potentially eligible individuals to apply for coverage. Adults who qualify for Medicaid deserve to know about the program and how they can enroll. Outreach to entire families has an additional benefit—parents who enroll in Medicaid are more likely to enroll their children in CHP or Medicaid.

To encourage participation, health insurance programs must be aggressively marketed using messages that resonate with diverse target populations. States like New Jersey and Massachusetts coordinate funding streams from various health insurance programs under one umbrella program (FamilyCare and MassHealth, respectively) and market their program as a single plan. This encourages single adults, entire families, and, in general, a wider range of potentially eligible individuals to apply for coverage. NJ FamilyCare's promotional materials, for example, describe the program as "affordable health coverage for kids, grown-ups, and just about everyone in between." Tennessee hired a public relations firm to design billboards and radio and TV advertisements targeting a broad range of individuals beyond the State's former Medicaid population. The marketing campaign appealed to single adults by featuring race-car drivers in its ads, and it reached out to minority families through ads with ministers on radio stations popular with minorities. These states' marketing strategies are particularly effective because they are coupled with streamlined enrollment processes and a single point of entry for all health insurance programs.

Other states allow agencies beyond those administering health insurance programs to use information in their databases to target populations that are potentially eligible for coverage. For example, the Minnesota Department of Human Services partnered with its State Department of Revenue (DOR) to mail health insurance information packets to 150,000 families who were enrolled in a DOR tax credit program with eligibility guidelines similar to MinnesotaCare's. The packets included general information about the health insurance program, a toll-free number to request further information, and a stamped return card for application requests. This effort resulted in tens of thousands of requests for information and applications, and, ultimately, thousands of new enrollees in the program. Similarly, Tennessee's Health Department compared enrollment lists for several means-tested programs like Food Stamps with its Medicaid roster, and mailed a TennCare application to anyone who was not already enrolled in Medicaid.

Of course, confidentiality concerns must be addressed when agencies exchange sensitive information. However, data sharing among agencies is not a new practice. New York and other states routinely verify information provided on applications for public programs by cross-matching it with information from other agencies' databases. But while agencies cooperate to weed out potentially ineligible individuals, they rarely share information for the purpose of encouraging people to apply for benefits. Privacy concerns should be considered whenever agencies exchange information, regardless of their purpose, but it is worth keeping in mind that states are already engaging in data cross-matching. Allowing agencies to share information for the purpose of identifying individuals who are potentially eligible for public programs does not necessarily introduce a new set of concerns.

Enrollment

Effective outreach campaigns can generate interest in health coverage programs, but they will fail to boost enrollment if a complicated eligibility determination process discourages individuals from applying. New York has taken important steps in recent years to simplify enrollment into CHP A and CHP B, and the HCRA Amendments of 2002 provide for further important reforms to these programs and to Medicaid and FHP for adults. The establishment of community-based enrollment sites for all applicants, in particular, provides individuals and families with a single point of entry into all three programs and a convenient, family-friendly application process.

New York can build on these efforts and further simplify enrollment procedures by reducing documentation requirements and eliminating front-end fraud detection systems like Eligibility Verification Review and applicant finger imaging. These requirements, many of which reflect Medicaid's history as a by-product of welfare and are not explicitly required by New York Medicaid law, were designed to identify applicants who may not qualify for coverage rather than ensure that individuals receive the benefits to which they are entitled.

Indeed, Federal law gives states considerable flexibility to simplify Medicaid and CHP enrollment procedures, and the U.S. Centers for Medicare and Medicaid Services (CMS) has assured states that they can exercise this freedom without compromising program integrity. Some states have used this flexibility to reduce or nearly eliminate documentation requirements for applicants. Ohio, for example, allows self-affirmations of age, identity, Social Security number, citizenship, living arrangement, and residence; MassHealth applicants are not required to provide a birth certificate and need only two pay stubs to verify their income; and Vermont confirms applicant earnings through regular tape matches with the Internal Revenue Service.

A number of states have eliminated their assets tests for health insurance applicants, which reduces the burden on both eligibility workers and those applying for coverage. Massachusetts credits the elimination of MassHealth's asset test with a significant drop in the amount of time it takes the State to process applications. Ohio officials came to the same conclusion as did Oklahoma program administrators, who estimated that elimination of the asset test for Oklahoma saves the State over \$1 million annually. Other programs in the states studied for this report that have no asset test include Washington's Basic Health Plan, NJ FamilyCare, Rhode Island's RIte Care, Delaware's Diamond State Health Plan, and Wisconsin BadgerCare.

An increasing number of states are using computer software programs and the Internet to facilitate enrollment in public health insurance programs. For example, some states can process information that is transmitted electronically from eligibility workers in remote sites and determine immediately whether applicants qualify for health insurance or other public benefits programs. Wisconsin's statewide automated program, the Client Assistance for Reemployment and Economic Support (CARES) system, takes county workers and their clients through an interactive interview that prompts the client to provide family, financial, and employment information. This information is transmitted to CARES, which uses it to determine eligibility electronically for Medicaid, BadgerCare, Food Stamps, child care, and Temporary Assistance for Needy Families (TANF). CARES transfer this information to the Medicaid fiscal agent, which issues ID cards, enrolls families in HMOs, and establishes the premium. Delaware's system allows workers to collect information from their clients and, through use of an electronic cascading system, immediately determine eligibility for Medicaid, Food Stamps, and TANF.

MassHealth's automated eligibility system, MA21, is largely credited with decreasing the average time it takes to process applications from 24.0 days in June 1997 to 3.3 days in June 1998. MA21 checks data on applications for completeness and invokes a series of decision trees that assess the applicant's eligibility for the various MassHealth benefit plans and determines which of these plans offers the

applicant the most comprehensive coverage.

The California HealthCare Foundation and the Medi-Cal Policy Institute collaborated with the State on an effort to electronically enroll pregnant mothers and children into the Healthy Families (CHIP) and Medi-Cal (California Medicaid) programs. Health-e-App is a Web-based application used by enrollers to help families apply for coverage. Enrollers are equipped with wireless Internet connections, electronic signature pads, and portable printers, allowing them to conduct enrollment in schools, community centers, and even applicants' homes. The Web-based program prompts applicants on specific information that is needed to determine whether they qualify for coverage and delivers a real-time, preliminary eligibility determination for Medi-Cal or Healthy Families. The application captures applicants' signatures electronically and produces a fax cover sheet and documentation checklist for applicants, who must fax a complete set of documents to the State. A bar code on the fax coversheet allows the documentation to be matched electronically with the appropriate application, keeping the transmission process paperless. Families receive immediate, on-line feedback about their eligibility, and they are able to select physicians and health plans on-line. An independent analysis of the Health-e-App pilot test found that this system decreased the time between application submission and eligibility determination by 21%, and reduced application errors by 40%.

Coordination of Insurance Programs

States like New York that offer more than one public health insurance program face unique challenges. Variations among and within programs can add to the complexity of the application and eligibility determination processes and lead to patient confusion and involuntary disenrollment. New York has been moving CHP A and B toward an integrated health insurance system with uniform enrollment procedures and continuous care, but historical differences remain in the programs. Less effort has been focused on coordinating Medicaid with children's health insurance programs. FHP introduced into the system a new set of eligibility standards and program rules, a new population of enrollees, and unique documentation requirements that have added to the coordination challenges our State faces. In addition, FHP's and Medicaid's information database is separate from CHP's information system, and family members who qualify for different programs may not be able to enroll in the same health plans or maintain their existing providers if they transfer between programs.

The states examined for this report use a variety of strategies to coordinate their health insurance programs so that families and individuals can more easily navigate the system and experience fewer disruptions in care. Some, like Minnesota, require managed care organizations that wish to participate in any of the State-sponsored health care programs to accept enrollees from all three programs. Likewise, Wisconsin's BadgerCare, Healthy Start, and Medicaid programs use the same managed care plans, a common identification card, and a single point of entry into all three programs; and all of Vermont's health insurance programs use the same providers and service delivery networks.

Eligibility determinations are simpler and less error-prone when a state's health insurance programs use the same rules for calculating income, family size, and allowable deductions from income. Wisconsin's Medicaid, Healthy Start, and BadgerCare programs have nearly identical disregards, deductions, and benefits packages.

Some states have mechanisms that enable enrollees to transfer from one health insurance program into another without submitting a new application or experiencing a break in coverage. For example, MassHealth's automated eligibility system, MA21, stores applicant information so that enrollees who lose eligibility for one of MassHealth's component programs can be automatically screened and enrolled in another program without submitting a new application. Similarly, Wisconsin's automated eligibility determination system uses enrollee information stored in its database to move Medicaid enrollees automatically to BadgerCare without a new application.

Recertification

Simplifying the application process is crucial to maximizing enrollment in public programs, but it is only one piece of the puzzle. Far too often enrollees lose their health insurance while they are still eligible for coverage. In New York, many eligible families and individuals, perhaps half of those enrolled in CHP and Medicaid, drop out of these programs each year, though most still qualify for coverage. Simplifying the recertification process can minimize churning and the resulting disruptions of care and care management.

The HCRA Amendments of 2002 eliminate face-to-face interviews for Medicaid recertification and require the development of simplified recertification forms for all three health insurance programs. New York can look at a number of other states for guidance on how to implement these reforms.

New Jersey, for example, pre-prints information from the original application and asks only that the enrollee note changes and include one-month verification of income. The State also includes a self-addressed, stamped envelope with the forms. Wisconsin is considering the testing of "no response" recertification, which would allow program administrators to renew coverage automatically if an enrollee fails to return a pre-printed application. MassHealth is piloting "express renewal" that enables families enrolled in MassHealth longer than six months who have had no changes in income or health insurance status and do not receive cash assistance to recertify their eligibility at any time during the second six months of their enrollment in the program. Families can recertify their coverage through managed care organizations or at a clinical site when they arrive for an appointment. Enrollee information is verified through database matches, and those who are found eligible continue to receive health coverage for one year following the date of recertification.

CONCLUSION

The purpose of presenting examples of reforms that other states have implemented to improve their health insurance programs is not to suggest that New York should adopt wholesale another state's policies. Rather, it is to inspire New York to build upon its successful efforts while it continues to review its current practices and develop proposals that will break down the barriers to enrolling and remaining in our health insurance programs. Clearly, there are a wide range of options from which New York could choose to streamline and improve Medicaid, CHP, and FHP.

GNYHA thanks the New York State Assembly's Committee on Health and the City Council Committees on Health, General Welfare, and Oversight and Investigations for the opportunity to present our views on this important and timely issue. GNYHA will continue to devise solutions to address our State's uninsured problem, in particular by boosting enrollment in our existing health insurance programs, because we believe better coverage of both children and adults is important to ensure healthy, productive citizens and strong, healthy communities.