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ABSTRACT

Federal funding for children's health insurance may significantly reduce the problem of uninsured children in New York and subsequently improve child outcomes. This study evaluated the effectiveness of two program models in educating parents about available sources of health insurance and in increasing enrollment of uninsured children into Medicaid or Child Health Plus (CHP), New York's insurance program for children of low-income families. One model targeted low-income families applying for or receiving Women, Infants, and Children (WIC) nutritional services. The second model targeted owners/employees of small businesses selling WIC-approved foods and sought to educate them about the availability of Medicaid and CHP and to conduct enrollment at vendor sites. Pre- and post-implementation surveys were conducted to assess knowledge about health insurance, Medicaid, and CHP and to determine baseline enrollment rates. Findings indicated that WIC sites were ideal enrollment assistance sites. Awareness grew from 46 to 65 percent at enrollment-assistance sites, whereas comparison sites saw an increase from 52 to only 60 percent. Enrollment in CHP increased from 12 to 16 percent at intervention sites, compared to an increase from 8 to only 10 percent at comparison sites. Medicaid enrollment increased slightly at intervention sites and declined at the comparison sites. Small businesses participating in the WIC program were effective outreach vehicles but not efficient venues for enrollment. Facilitators could enroll approximately 1,000 children yearly at a cost of $35 per application. It was concluded that new efforts are needed to reach families within their own communities and to facilitate their enrollment in Medicaid and CHP. (KB)

THE COMMONWEALTH FUND

FIELD REPORT

THE ROLE OF WIC CENTERS AND SMALL BUSINESSES IN ENROLLING UNINSURED CHILDREN IN MEDICAID AND CHILD HEALTH PLUS

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MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY, INC.

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THE ROLE OF WIC CENTERS AND SMALL BUSINESSES IN ENROLLING UNINSURED CHILDREN IN MEDICAID AND CHILD HEALTH PLUS

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New York City, Inc.

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EXECUTIVE SUMMARY

New federal funding for children's health insurance may significantly reduce the problem of uninsured children in New York State and the nation. New York State will use its five-year federal allotment of $256 million annually to expand eligibility for Medicaid and Child Health Plus (CHP), the state's insurance program for children of low-income families. These expansions will require new strategies to identify and enroll all eligible children—about three-quarters of New York City's 420,000 uninsured children are eligible for but not enrolled in Medicaid or CHP. However, there are substantial barriers to program enrollment. Among those that have been identified are confusing eligibility criteria, onerous application processes and documentation requirements, the stigma of public assistance, concerns about privacy, and fears among immigrant families. To help overcome these barriers, New York State will spend approximately $10 million per year on outreach and facilitated enrollment.

With funding from The Commonwealth Fund, the Medical and Health Research Association of New York City, Inc. (MHRA) designed, conducted, and evaluated two innovative models for enrolling uninsured children into Medicaid or CHP. One model targeted low-income families applying for or receiving Supplemental Nutrition Program for Women, Infants, and Children (WIC) nutritional services at three neighborhood WIC sites in Brooklyn. Parents at these centers were given intensive one-on-one enrollment assistance and follow-up after applications had been filed. The second model was aimed at owners and employees of small supermarkets, grocery stores, and pharmacies that sell WIC-approved foods in five zip codes in the South Brooklyn area. This model sought to educate low-income workers in small businesses that do not provide health insurance coverage about the availability of Medicaid and CHP, and to conduct enrollment at the vendor sites.

During a seven-and-a-half month period, MHRA staff provided outreach and enrollment assistance to 835 people—58 adults and 777 uninsured children. Of that number, 737 completed the application process, resulting in the enrollment of 472 children in CHP and 262 children and adults in Medicaid.

Evaluation research sought to assess the models' effectiveness both in educating parents about available sources of health insurance coverage and in actually increasing enrollment of uninsured children. Before facilitated enrollment began, MHRA surveyed participants at the three WIC sites in southern Brooklyn and WIC vendors and their employees in the South Brooklyn area. In addition, participants at three WIC sites located in Queens where no outreach or enrollment assistance was to be provided were surveyed for comparison

purposes. The surveys were designed to assess knowledge about health insurance in general, and about Medicaid and CHP in particular. They also measured baseline enrollment rates in Medicaid and CHP.

WIC centers proved to be ideal sites at which to provide enrollment assistance because they receive heavy traffic from large numbers of parents with uninsured children. These parents welcome the opportunity to obtain health coverage for their children. Awareness of CHP grew 19 points—from 46 to 65 percent—at enrollment-assistance sites, compared with an eight-point increase—from 52 to 60 percent—in the comparison sites. Most important, CHP enrollment increased four points—from 12 to 16 percent—at the intervention sites, compared with an increase of two points—from 8 to 10 percent—at the comparison sites. In addition, Medicaid enrollment at the intervention sites increased slightly, while it declined at the comparison sites. This is consistent with a continuing decline in Medicaid enrollment that is occurring across the state and nation.

Small businesses that participate in the WIC program were effective vehicles for outreach but were not efficient venues in which to conduct actual enrollment. Initially, WIC vendors were receptive to on-site facilitated enrollment; in many cases the project succeeded in gaining access to the stores where MHRA staff could speak to employees, educate them about insurance coverage for their children, and distribute printed materials. Despite considerable efforts however, factors that included fears among immigrant storeowners and employees, administrative complications, and the very small workforces at many of the stores ultimately deterred the achievement of substantial enrollment. The project did succeed in increasing awareness of Medicaid and CHP among employees at these firms. This suggests that small businesses could play an educational role in the effort to increase coverage of children from low-income families. These firms tend to be very small. They pay low wages and generally do not provide insurance coverage to workers and their children, which makes their employees prime targets for Medicaid and CHP outreach.

Enrollment sites, hours of operation, and enrollment staff must be chosen carefully, with an eye to high traffic of eligible children and efficient use of enrollment staff. In New York City, an enrollment facilitator located in a high-traffic area of potentially eligible children can assist four to five families per day. Thus, a facilitator can enroll approximately 1,000 children per year, as long as a supervisor or alternate staff can provide follow-up with CHP plans and Medicaid. Assuming the facilitator's annual salary is $30,500 including fringe benefits, and adding the cost of supplies, telephone, travel, postage, and overhead, the cost per completed application is approximately $35. This does not include follow-up with the health plans or the Medicaid office before enrollment is finalized.

New York's historic commitment to health care for all its citizens, combined with new sources of financing for children's insurance, offer the promise of drastically reducing the number of uninsured children throughout the state. To fulfill this promise, we must make new efforts to reach families within their own communities and to facilitate their enrollment in Medicaid and CHP. By providing one-on-one assistance that is culturally and linguistically sensitive to the state's diverse population, we could increase health coverage for a large number of uninsured children and help assure that New York's children grow up to lead healthy and productive lives.

I. INTRODUCTION

The federal Children's Health Insurance Program provides states with block grants they can use to provide health coverage for uninsured children through Medicaid or a separate health insurance plan for children. New York State will receive $256 million each year for five years, up to 10 percent of which may be spent on outreach and enrollment assistance. In New York City, approximately 420,000 children currently have no health insurance, and about three-quarters of them are eligible for Medicaid or Child Health Plus (CHP), the state's insurance program for children from low-income families.

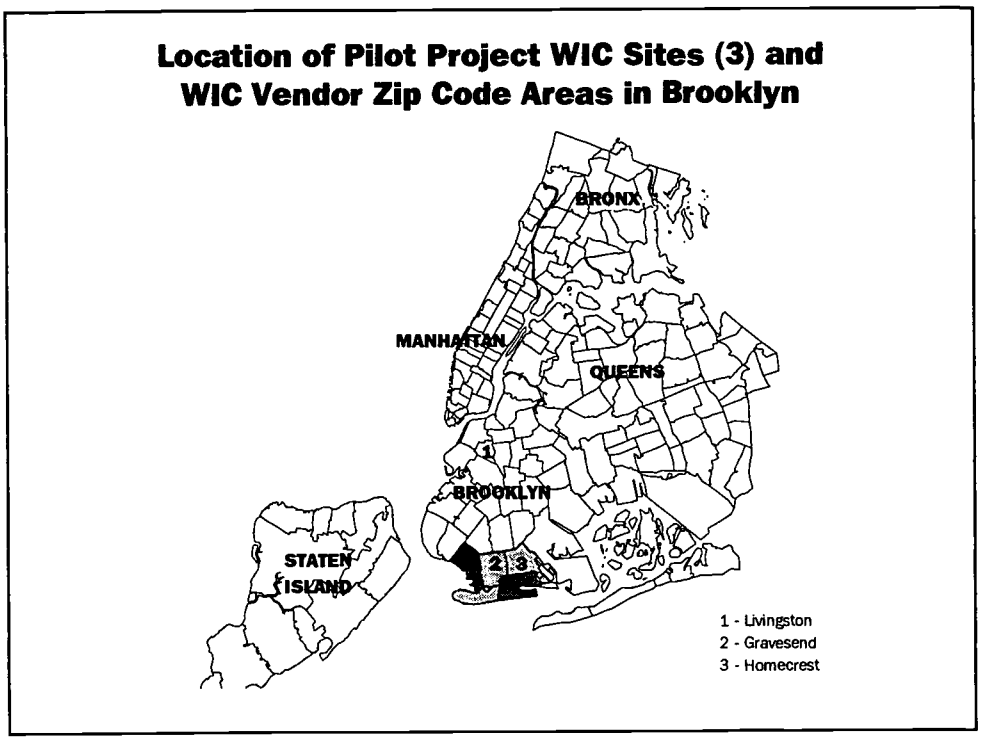
Reaching and enrolling these children requires effective, community-based approaches. Parents need intensive assistance to navigate complex enrollment processes. To test new outreach and enrollment strategies, Medical and Health Research Association of New York City, Inc. (MHRA) conducted two pilot demonstrations, both of which used the federal Supplemental Nutrition Program for Women, Infants and Children (WIC) as a vehicle to reach low-income parents of uninsured children. Each year, MHRA's WIC program serves approximately 56,000 children up to age 5 and pregnant and lactating women in 20 neighborhood centers throughout New York City. Here, participants receive nutrition counseling, education, and food checks. While the clients have low incomes, the program's income-eligibility cutoff is higher than Medicaid's, so these centers offer unique opportunities for reaching a large number of families with CHP-eligible children. The same holds true for establishments that sell WIC-approved foods and infant formulas. Most are small businesses that pay low wages and offer no health insurance for their employees or employees' dependents.

MHRA conducted two pilot model programs aimed at reaching and enrolling children from low-income families associated with the WIC program in Medicaid or CHP. One model targeted low-income families who were applying for or receiving WIC nutritional services at three neighborhood WIC sites in South Brooklyn. At these designated centers, parents received intensive, one-on-one enrollment assistance and follow-up after the Medicaid or CHP applications had been filed. The second approach worked with owners and employees of small supermarkets, grocery stores, and pharmacies that sell WIC-approved foods in five zip codes in the South Brooklyn area. This model sought to educate low-income workers in small businesses that do not provide health insurance coverage about the availability of Medicaid and CHP and to conduct enrollment at the job site.

II. THE FACILITATED ENROLLMENT PILOT PROJECTS

WIC Neighborhood Sites

MHRA chose three of its busiest WIC sites in South Brooklyn as venues for outreach, education, and enrollment assistance for Medicaid or Child Health Plus (see map). The Livingston site serves an average of 5,000 WIC participants per year; Gravesend serves 4,000 and Homecrest 3,000 per year.



Before enrollment assistance began, MHRA conducted baseline surveys of WIC clients at the three Brooklyn centers and, for comparison purposes, at three WIC sites in Queens where no intervention was planned. A total of 941 people participated in the survey. Its goal was to test WIC participants' knowledge about health insurance in general and Medicaid and CHP in particular, and to measure baseline enrollment in the two programs. The results were also intended for use in the development of an effective education component that would facilitate the enrollment of uninsured children.

After the baseline survey was complete, MHRA stationed staff at the three WIC intervention sites to conduct outreach and assist eligible participants with enrollment in Medicaid or CHP. Livingston and Gravesend, the two busiest sites, had staff in attendance three days per week; Homecrest had staff one day a week. In addition, appointments were available at other times with enrollment educators and facilitators at all three sites. Families were advised of the staff's presence and familiarized with Medicaid and CHP through on-

site posters and fliers, as well as in regular presentations in WIC waiting rooms and nutrition classes. In addition, a flier about the enrollment program accompanied all WIC checks, and WIC staff referred any client with an uninsured child to the enrollment staff.

WIC Vendors and Vendor Employees

WIC participants receive checks they can redeem for specific foods and infant formula at participating grocery stores and pharmacies. State-funded agencies, including MHRA, monitor and train these vendors to ensure they stock WIC-approved foods and dispense only WIC-approved items in exchange for WIC checks. Few of these merchants offer health insurance to their employees and fewer still make it available to employees' dependents.

In order to gather information and develop an outreach and enrollment model targeted at WIC vendors, MHRA administered a questionnaire at citywide vendor management-training sessions, conducted a group interview at these sessions, and conducted a survey with WIC vendors and their employees at the vendors' stores in South Brooklyn. While the training sessions attracted merchants from outside the South Brooklyn target area, the on-site interviews were limited to employees at the stores in the project area. MHRA used the information collected from the surveys and interviews to develop modified versions of an outreach and education model for WIC vendors and their employees.

The model's approaches varied depending on the size and receptivity of the targeted vendor. Store owners or managers who had indicated an interest in enrollment assistance received a letter describing the project and fliers about Medicaid and CHP. In follow-up phone calls, appointments were scheduled to assist owners and their employees with enrollment in the appropriate insurance program. Owners and managers of small and medium-sized stores who were less receptive to the program also received a letter and fliers. Follow-up calls addressed their concerns, answered any questions, and scheduled a visit if they were interested. In the case of larger chains and supermarkets, letters describing the facilitated enrollment program and fliers containing general information about Medicaid and CHP were sent to company headquarters, rather than to the local store manager. The letter explained when enrollment staff would be available at each of the participating WIC centers to assist the vendor's employees with enrollment. After follow-up calls to company representatives for recommendations, MHRA contacted individual stores and developed schedules for enrollment assistance.

The enrollment-assistance period for both models lasted seven-and-a-half months—from November 16, 1998, through June 30, 1999. Once an application had been completed, it

took about two weeks for applicants to assemble and submit all the Medicaid or CHP supporting documentation to the project staff. Therefore, MHRA suspended outreach efforts and did not recruit new families after May 31 so staff could follow up on all pending applications by the close of the project on June 30, 1999.

III. EVALUATION FINDINGS: PRE- AND POST-INTERVENTION SURVEYS

Survey data indicate that the MHRA pilot programs had a positive effect on increasing health insurance coverage of children in the targeted populations. This is particularly the case with data related to CHP knowledge and enrollment. The survey results also suggest that the project helped stabilize the rate of children's Medicaid enrollment, which is declining elsewhere in New York City and the state.

WIC Recipient Surveys

MHRA conducted surveys of WIC recipients in the three Brooklyn sites and in three WIC centers in Queens (the comparison sites) both before and after the outreach and enrollment assistance projects. The second set of surveys, administered at the same six sites, took place about five or six months after the pre-intervention surveys at any given site. To help avoid interviewer bias, interviewers went to the WIC centers on the centers' busiest days, and they rotated among the sites. A total of 1,811 questionnaires were completed in the pre- and post-intervention surveys of WIC participants. The surveys were fairly evenly distributed between the two times and across the three intervention and three control sites.

The pre- and post-survey questionnaires were similar, except that the post-intervention survey administered at the Brooklyn sites included additional items related to the enrollment assistance program itself. Both questionnaires covered participants' basic demographic characteristics, their knowledge about health insurance for their children, their participation in public benefit programs such as welfare, and the participation of their children in Medicaid and CHP. The post-intervention survey was designed to measure any changes that could be attributed to the intervention activities at the three project sites or between intervention-site and comparison-site participants. The questionnaires were written and the surveys conducted in English, Spanish, and Russian.

Tables 1–6 detail demographic characteristics of the WIC participants at the intervention and comparison sites. Respondents provided information about their birthplace, race/ethnicity, marital status, education, employment status, welfare status, and preferred language. Most respondents (52.8%) were married; 31.3 percent were single and 42 percent were living without a male partner (single, separated, divorced or widowed).

Table 1
WIC Recipients' Marital Status by Borough of WIC Center

Borough/ Survey	Single	Married	Living Together	Separated	Divorced	Widowed
Brooklyn/Pre	25.0	55.5	6.4	9.3	3.4	0.5
(440)	(110)	(244)	(28)	(41)	(15)	(2)
Brooklyn/Post	30.6	56.7	3.6	6.5	2.0	0.6
(496)	(152)	(281)	(18)	(32)	(10)	(3)
Queens/Pre	33.5	48.3	7.1	7.7	2.8	0.6
(493)	(165)	(238)	(35)	(38)	(14)	(3)
Queens/Post	36.6	50.5	3.2	6.7	2.4	0.5
(374)	(137)	(189)	(12)	(25)	(9)	(2)
Total	31.3	52.8	5.2	7.5	2.7	0.6
(1,803)	(564)	(952)	(93)	(136)	(48)	(10)

Missing cases = 8.

Note: The Chi-square comparison between Brooklyn and Queens for the pre-test is not significant. The Chi-square comparison for the post-test is not significant.

WIC clients in this enrollment demonstration were ethnically, racially, and linguistically diverse. This suggests a need to present outreach and enrollment materials in a variety of languages, and with sensitivity to individual cultural differences. Overall, approximately 30 percent of respondents were white non-Hispanic, 32 percent were Hispanic; 23 percent were black non-Hispanic; and 11 percent were Asian.

Table 2
WIC Recipients' Race/Ethnicity by Borough of WIC Center

Borough/ Survey	White Non-Hispanic	Black Non-Hispanic	Hispanic	Asian	Other
Brooklyn/Pre	36.5	25.2	19.0	13.2	6.1
(441)	(161)	(111)	(84)	(58)	(27)
Brooklyn/Post	47.5	22.8	19.8	9.4	0.6
(491)	(233)	(112)	(97)	(46)	(3)
Queens/Pre	17.9	19.1	49.0	8.8	5.1
(486)	(87)	(93)	(238)	(43)	(25)
Queens/Post	16.9	23.3	41.8	13.4	4.6
(373)	(63)	(87)	(156)	(50)	(17)
Total	30.4	22.5	32.1	11.0	4.0
(1,791)	(544)	(403)	(575)	(197)	(72)

Missing cases = 20.

Note: The Chi-square comparison between Brooklyn and Queens for the pre-test is significant at $p \leq .01$. The Chi-square comparison for the post-test is significant at $p \leq .01$.

There was a wide range of diverse birthplaces and languages in all six of the WIC centers that we surveyed. Only 32 percent of all respondents were born in the United States; foreign-born respondents represented more than 45 different nations. Russian-born

women constituted a relatively large percentage of respondents at the Brooklyn centers. There was a greater proportion of women born in Puerto Rico, the Dominican Republic, or Mexico at the Queens centers. Only 47 percent of all respondents reported they usually spoke English at home.

Table 3
WIC Recipients' Birthplace by Borough of WIC Center

Borough/ Survey	United States	Puerto Rico	Dominican Republic	Mexico	Russia	India	Other*
Brooklyn/Pre (443)	27.1 (120)	2.5 (11)	1.8 (8)	7.0 (31)	19.4 (86)	.7 (3)	41.5 (184)
Brooklyn/ Post (496)	24.6 (122)	.6 (3)	1.6 (8)	9.5 (47)	24.8 (123)	.6 (3)	38.3 (190)
Queens/Pre (493)	40.0 (197)	3.7 (18)	7.3 (36)	7.1 (35)	1.2 (6)	1.8 (9)	38.9 (192)
Queens/Post (374)	34.8 (130)	4.5 (17)	4.8 (18)	6.4 (24)	1.1 (4)	3.2 (12)	45.2 (169)
Total (1,806)	31.5 (569)	2.7 (49)	3.9 (70)	7.6 (137)	12.1 (219)	1.5 (27)	40.7 (735)

Missing cases = 5.

* "Other" includes more than forty additional named countries.

Note: The Chi-square comparison between Brooklyn and Queens for the pre-test is significant at $p \leq .01$.
The Chi-square comparison for the post-test is significant at $p \leq .01$.

Table 4
WIC Recipients' Usual Language in the Home by Borough of WIC Center

Borough/ Survey	English	Spanish	Russian	Mandarin, etc.	Arabic	Hindi	Other*
Brooklyn/Pre (443)	40.9 (181)	12.6 (56)	18.3 (81)	4.1 (18)	6.5 (29)	0.5 (2)	17.2 (76)
Brooklyn/Post (495)	45.9 (227)	14.5 (72)	24.0 (119)	1.0 (5)	4.6 (23)	0.6 (3)	9.3 (46)
Queens/Pre (494)	52.8 (261)	31.4 (155)	1.6 (8)	0.8 (4)	3.8 (19)	1.6 (8)	7.9 (39)
Queens/Post (374)	47.6 (178)	32.9 (123)	0.5 (2)	0.3 (1)	2.7 (10)	2.4 (9)	13.6 (51)
Total (1,806)	46.9 (847)	22.5 (406)	11.6 (210)	1.6 (28)	4.5 (81)	1.2 (22)	11.7 (212)

Missing cases = 5.

* "Other" includes more than 15 additional named languages.

Note: The Chi-square comparison between Brooklyn and Queens for the pre-test is significant at $p \leq .01$.
The Chi-square comparison for the post-test is significant at $p \leq .01$.

Fewer than 16 percent of respondents across all sites and surveys were employed full time, making it unlikely that employer-sponsored health insurance could be counted on to

cover many of the respondents' children. Twenty-one percent of the respondents were receiving welfare. Consistent with statewide trends, the percentage of women who were receiving welfare declined in the period between the pre-intervention survey and the post-intervention survey, both at the Brooklyn and Queens WIC centers.

Table 5
WIC Recipients' Employment Status/Welfare Status by Borough of WIC Center

Borough/Survey	Respondent Is Employed Full Time (Missing Cases = 11)	Respondent Is Receiving Welfare (Missing Cases = 33)
Brooklyn/Pre (443) (432)	13.8 (61)	24.3 (105)
Brooklyn/Post (495) (491)	13.7 (68)	21.2 (104)
Queens/Pre (492) (488)	18.7 (92)	22.7 (111)
Queens/Post (370) (367)	15.7 (58)	15.5 (57)
Total (1,800) (1,778)	15.5 (279)	21.2 (377)

Note on employment: The Chi-square comparison between Brooklyn and Queens for the pre-test is significant at $p \leq .05$. The Chi-square for the post-test is not significant.
Note on welfare: The Chi-square comparison between Brooklyn and Queens for the pre-test is not significant. The Chi-square for the post-test is significant at $p \leq .05$.

More than 40 percent of all respondents had completed high school. An additional 21 percent said they had had some college, and fully 20 percent reported they were college graduates. These data suggest that WIC recipients in the project's targeted neighborhoods should have been able to understand relatively complex ideas about insurance coverage if those ideas were presented in a context appropriate to their cultural backgrounds and in a language they understood.

Table 6
WIC Recipients' Level of Education by Borough of WIC Center

Borough/ Survey	Less Than High School	High School Graduate	Some College	College Graduate
Brooklyn/Pre (442)	22.2 (98)	38.5 (170)	22.6 (100)	16.7 (74)
Brooklyn/Post (492)	15.0 (74)	40.4 (199)	17.7 (87)	26.8 (132)
Queens/Pre (486)	22.0 (107)	42.6 (207)	19.8 (96)	15.6 (76)
Queens/Post (369)	12.5 (46)	41.7 (154)	25.2 (93)	20.6 (76)
Total (1,789)	18.2 (325)	40.8 (730)	21.0 (376)	20.0 (358)

Missing cases = 22.
Note: The Chi-square comparison between Brooklyn and Queens for the pre-test is not significant. The Chi-square comparison for the post-test is significant at $p \leq .05$.

WIC Vendor/Employee Surveys

On-site WIC vendor and vendor employee surveys were carried out at participating WIC stores in five Brooklyn zip codes—the intervention sites—and at WIC stores in five Queens zip codes—the comparison sites. There were three subsets of surveys: a pre-intervention survey in Brooklyn conducted from November 1998 through January 1999, and two post-intervention surveys conducted in the spring of 1999, one in Brooklyn and one in Queens.

Before each survey, we sent letters to store owners or managers to inform them of the study. Subsequently, an interviewer visited the store to meet with all employees who were available to be interviewed at that time. The interviews were conducted in English, Spanish, or Russian.

Interviewers completed a total of 415 interviews at stores in all of the zip codes designated for study over the course of the pre- and post-intervention survey periods. Seventy-seven percent of the interviews were with owners or employees of small grocery stores or bodegas; 19 percent of the respondents worked in larger grocery stores that were part of citywide chains; the remaining 4 percent were employed in pharmacies. Vendors that participate in the WIC program tend to be extremely small businesses. While the number of employees working at each survey site ranged from one to 200, the median number of employees was four. Sixty-two percent of respondents reported there were five or fewer employees at their workplace.

Demographic data on the WIC vendors and employees suggest that they are a group whose members are likely to need and benefit from outreach and enrollment assistance for Medicaid and CHP (Tables 7–12). Forty-one percent reported that children under the age of 19 lived with them. Of those, the number of children living at home ranged from one to seven. The reported average was two children; the median number was also two. Thirty-two percent of respondents' children were uninsured. Although 68 percent of all respondents with one or more children reported that their children had some type of health insurance coverage, in households with more than one child, all children were not necessarily covered.

Table 7
WIC Vendors/Employees' Age Groups

Age Group	Percent (Number)
Under 20	4.8 (20)
20–24	19.0 (79)
25–29	19.5 (81)
30–34	22.9 (95)
35–39	13.0 (54)
40–44	10.6 (44)
45–49	6.0 (25)
50 and Over	4.1 (17)
Total	100.0 (415)

Table 8
WIC Vendors/Employees' Race/Ethnicity

Race/Ethnicity	Percent (Number)
White Non-Hispanic	13.5 (55)
Black Non-Hispanic	4.7 (19)
Hispanic	42.2 (172)
Asian	14.7 (60)
Arabic	18.9 (77)
Other	6.1 (25)
Total	100.0 (408)

Missing cases = 7.

Table 9
Does the WIC Vendor/Employee Have Children Under 19 at Home?

Any Children Under 19	Percent (Number)
Yes	41.4 (172)
No	58.6 (243)
Total	100.0 (415)

Table 10
How Many Children Under 19 Does the WIC Vendor/Employee Have?

Statistic	Value
Mean	2.05
Median	2.00
Minimum	1.00
Maximum	7.00

Table 11
What Type of Health Insurance
Does the Respondent Have for His or Her Children?

Type of Insurance	Percent (Number)
No Insurance	32.0 (54)
Some Insurance	68.0 (115)
Private	51.3 (59)
Medicaid	36.5 (42)
Child Health Plus	11.3 (13)
Total	100.0 (169)

Employer-sponsored health insurance coverage for workers and their dependents is rare in these businesses. Only 16 percent of vendors provided health insurance for workers; fewer still—5 percent—provided health insurance coverage for the children of those workers. In stores with 51 to 200 employees, 53 percent of the respondents had individual coverage; only 12 percent of the respondents in stores with 50 or fewer employees were covered. In stores where individual insurance was available to employees, respondents reported that 75 percent of the employers paid in full for the coverage. None of the survey questions addressed income. However, based on the type and size of the stores, and considering the respondents' positions in their stores, it is probably safe to speculate that wages are relatively low and likely to meet CHP eligibility criteria.

Table 12
WIC Vendor Provides Health Insurance for Workers, Spouses, and Children by Number of Employees

Store Provides Insurance for:	1–50 Employees	51–200 Employees	Total
Workers* (Missing=32)	12.3 (43)	53.1 (17)	15.7 (60)
Spouses* (Missing=45)	4.7 (16)	17.9 (5)	5.7 (21)
Children** (Missing=46)	4.7 (16)	14.8 (4)	5.4 (20)

* Chi-square between store sizes is significant at $p \leq .01$.

** Chi-square between store sizes is significant at $p \leq .05$.

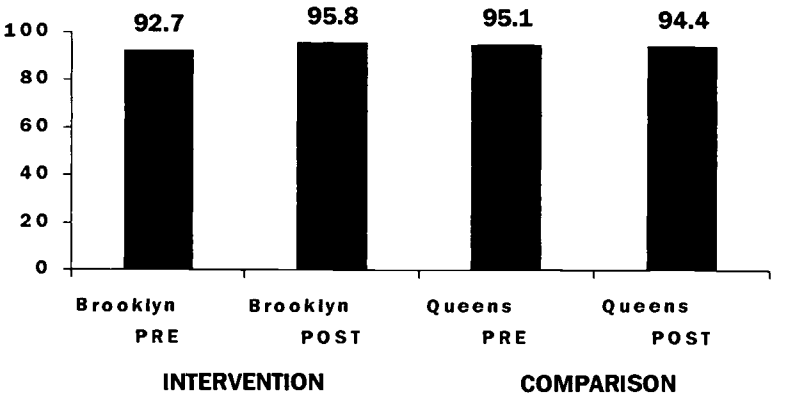
Knowledge of Medicaid and Child Health Plus

WIC Recipients

Virtually all WIC recipients were aware of Medicaid before the intervention, and there was almost no change during the demonstration period (Chart 1). At both the Brooklyn

and Queens sites, most respondents reported that they had first learned about Medicaid from friends, relatives, doctors, or nurses. For example, 40 percent of Brooklyn respondents had first learned about Medicaid from friends or relatives; in Queens, the figure was 42 percent.

Chart 1. WIC Recipient Surveys: Percent of Respondents Who Have Heard of Medicaid



Note: A logistic regression was completed with having heard of Medicaid as the dependent variable, and borough, time, and their interaction—the intervention term—as the independent variables. None of the independent variables has a significant coefficient.

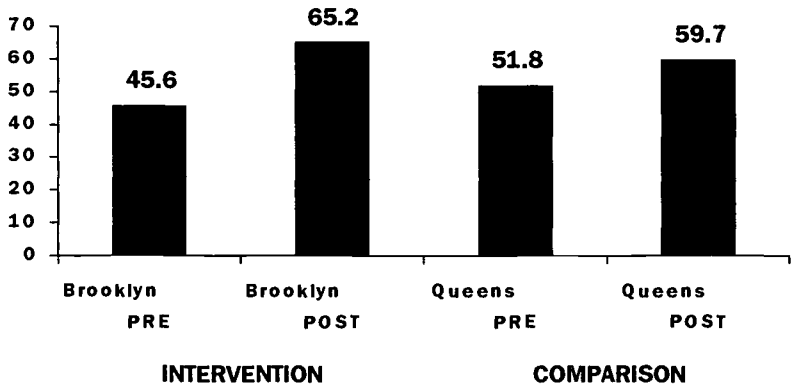
Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

However, awareness of CHP was far lower and there were significant differences across the WIC locations/pre- and post-intervention subgroups (Chart 2). The percentage of Brooklyn women who indicated they had some knowledge of CHP before the intervention was 46; afterwards, 65 percent of respondents knew of CHP. At the Queens WIC centers, where no MHRA-facilitated enrollment took place, the percentage of respondents who knew about CHP increased from 52 percent to 60 percent between the pre- and post-tests. While the 20 percent increase in Brooklyn could in part be the result of public advertising, analysis of the data suggests that the change is more likely to be a result of the MHRA intervention. The smaller awareness increase in the control sites may indeed be an effect of intensified public advertising about CHP between the pre- and post-intervention surveys.

Among those who were aware of CHP, 62 percent cited friends/relatives, health care, and social service providers as being primary initial sources of information about the program. "TV/radio" was a first source of information for an additional 15 percent. Significantly, however, 29 percent (the largest percentage) of Brooklyn WIC participants who answered questions about sources of CHP information during the post-intervention survey reported

they first heard about CHP from an MHRA representative. In both the pre- and post-intervention surveys, Brooklyn WIC recipients were more likely to have learned about CHP from friends or relatives than their Queens counterparts, and less likely to have received information via TV or the radio.

Chart 2. WIC Recipient Surveys: Percent of Respondents Who Have Heard of CHP



Note: A logistic regression was completed with having heard of CHP as the dependent variable, and borough, time, and their interaction—the intervention term—as the independent variables. The coefficient for borough is not significant; the coefficients for time and for the intervention term are significant at $p \leq .05$.

Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

WIC Vendors/Employees

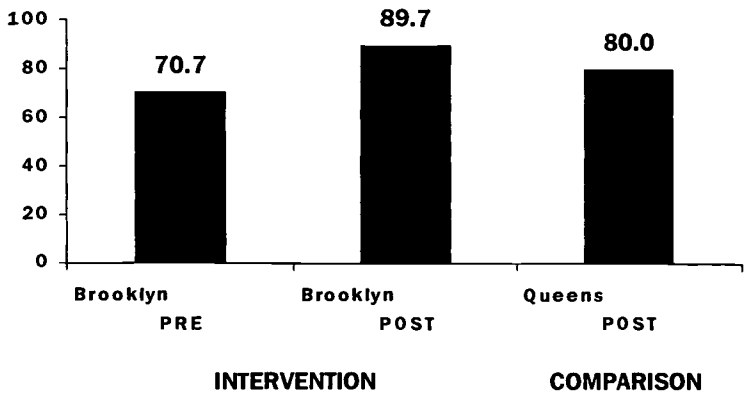
Awareness of Medicaid among WIC vendors and their employees was much more common than of CHP both before and after the intervention. Prior to the MHRA project, 71 percent of vendors and their employees had heard of Medicaid, compared with 16 percent for CHP. Awareness of both Medicaid and CHP increased significantly following the intervention and exceeded awareness of the programs in the comparison sites. The percentage of respondents at the Brooklyn intervention sites who were familiar with Medicaid increased significantly—from 71 percent to 90 percent—over the course of the intervention. The percentage of those who had heard of CHP increased from 16 percent to fully 59 percent (Charts 3 and 4).

Enrollment Outcomes

MHRA's outreach and enrollment staff assisted a total of 835 people, completed 737 applications, and enrolled 734 previously uninsured children and adults into Medicaid and CHP during the project period. Completed CHP applications numbered 475; 204 children's applications were for Medicaid. In addition, Medicaid applications were completed for 58 adults. Virtually all children and adults who gained coverage—97 percent—were enrolled

through the WIC neighborhood center demonstration. The WIC vendor model, an effective outreach and educational tool, accounted for only 3 percent of the total enrollment.

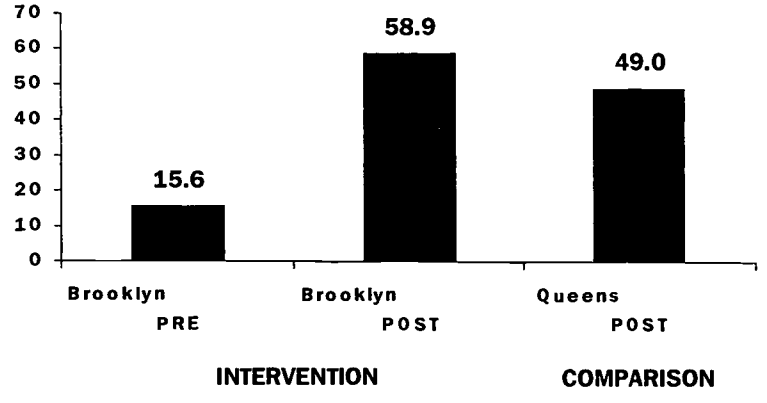
Chart 3. On-Site WIC Vendor/Employee Surveys: Percent of Respondents Who Have Heard of Medicaid



Note: The Chi-square between the Brooklyn pre- and post-tests is significant at $p \leq .01$.
The Chi-square between the Brooklyn post-test and the Queens post-test is significant at $p \leq .05$.

Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

Chart 4. On-Site WIC Vendor/Employee Surveys: Percent of Respondents Who Have Heard of CHP



Note: The Chi-square between the Brooklyn pre- and post-tests is significant at $p \leq .01$.
The Chi-square comparison between the Brooklyn post-test and the Queens post-test is not significant.

Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

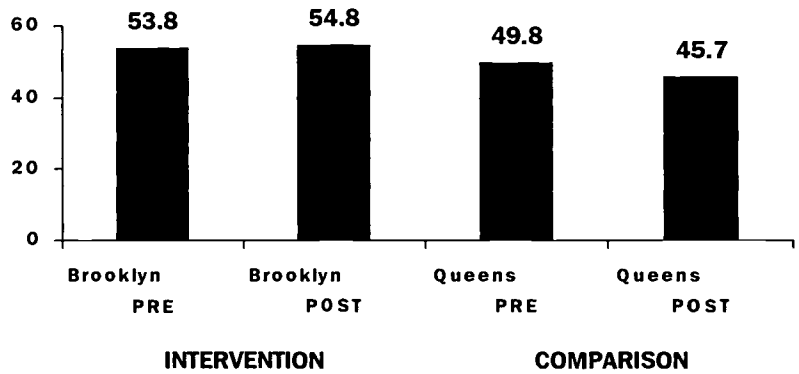
Eighteen CHP and 32 Medicaid applications were begun but never completed. These applications were from families who either could not be reached during follow-up, failed to provide necessary backup documents despite repeated follow-up attempts, or simply changed their minds about applying. An additional 50 people chose not to apply after they received information about both insurance programs.

Seven CHP plans were available in the project area and all were presented to clients equally. However, more than 85 percent of the families who enrolled their children in CHP elected either HIP (174 children) or Health Plus (232 children), the plans with the greatest name recognition in the South Brooklyn area.

There was an average of two uninsured children per assisted family. Seventeen percent of the children enrolled were from non-WIC-participating families who either heard of the project via word of mouth, or had occasion to notice the posters or enrollment staff.

Among WIC recipients, 54 percent of those in Brooklyn and 50 percent of those in Queens reported they had a child who received Medicaid benefits prior to the initiation of outreach and enrollment assistance. At the time of the post-intervention survey, 55 percent of the Brooklyn respondents and 46 percent of those in Queens said they had a child insured through Medicaid. This suggests that the program stemmed the decline in Medicaid enrollment seen in the rest of the state and in Queens (Chart 5).

Chart 5. WIC Recipient Surveys: Percent of Respondents with Child on Medicaid

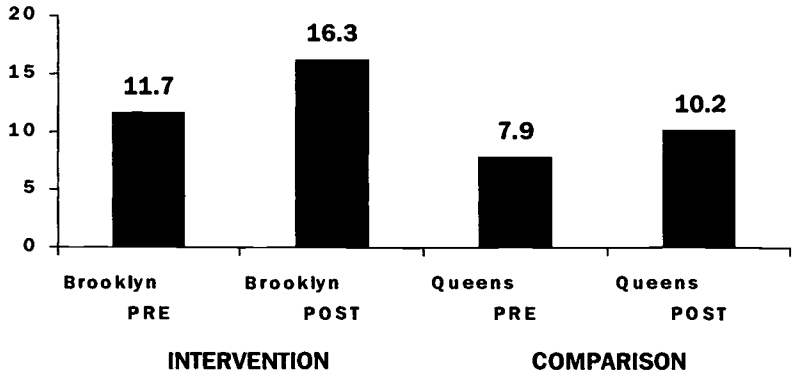


NOTE: A logistic regression was completed with a child receiving Medicaid as the dependent variable, and borough, time, and their interaction—the intervention term—as the independent variables. The coefficient for borough is significant at $p \leq .01$. The coefficients for time and for the intervention term are not significant.

Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

In both Brooklyn and Queens, the percentage of respondents with children enrolled in CHP increased between the pre- and the post-intervention survey. Increases for both intervention and control sites may have resulted from CHP plans' intensified enrollment efforts. There was a more substantial increase at the Brooklyn sites (from 12% to 16%), however, which strongly suggests that the MHRA initiative had a positive effect (Chart 6).

Chart 6. WIC Recipient Surveys: Percent of Respondents with Child on CHP



Note: A logistic regression was completed with child receiving CHP as the dependent variable, and borough, test, and their interaction—the intervention term—as the independent variables. The coefficient for borough is significant at $p \leq .01$. The coefficients for test and for the intervention term are not significant.

Source: Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc., *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus*, The Commonwealth Fund, March 2000.

Follow-up Phone Survey with CHP Enrollees

At the time of the post-intervention survey, 28 percent of WIC recipients at the Brooklyn sites who had children enrolled in Medicaid and 51 percent of those with children enrolled in CHP reported that an MHRA representative had helped with enrollment. From July 22 through September 3, 1999, we conducted a follow-up phone survey of families who received CHP enrollment assistance. Of the 217 families we contacted, 161 completed interviews (74%). Interviews with 56 families were not completed, either because their telephone was no longer in service, there was no English-speaking adult at the residence, the client had returned to his/her native country, or it was not possible to locate the client. It required considerable effort to reach the clients who did complete interviews—a clear indication of how difficult it is to do follow-up with this population of new insurance enrollees.

Respondents were assisted with enrollment between November 1998 and June 1999, and children were actually enrolled in a plan between December 1998 and August 1999. Interestingly, 23 percent of the respondents who knew they were enrolled in CHP did not know the name of the specific plan in which they were enrolled.

Changes in Enrollment

The number of children per family originally enrolled with CHP varied from one to seven. By the time of the follow-up phone survey, seventeen respondents (11%) no longer had any children enrolled in CHP, and two other families had fewer children enrolled at the time of the phone survey than had originally been enrolled. A variety of reasons were cited for the children's disenrollment. In most instances, respondents reported that the child(ren) had obtained other insurance, either private (30%) or Medicaid (15%). In other cases, there had been problems with communication from the plans themselves; 20 percent of the families had children no longer enrolled; 10 percent had never heard from the plan; and 10 percent had never received an ID card.

Satisfaction with MHRA's Outreach and Enrollment Program

All of the respondents who answered the question said that the WIC site was a convenient place for enrollment. A little more than a third (36%) had heard of CHP before speaking with the MHRA representative, and only 29 percent had ever tried to enroll in CHP before meeting with the MHRA staff. In response to specific questions, almost all of the clients rated the services of the MHRA representatives as "excellent" or "good." Staff members received the highest ratings for their overall help and for their explanation of the CHP program. They also received favorable ratings for their availability to answer questions and for their help with documents. Virtually all of the respondents said they had received enough information from the MHRA representative to be able to choose the plan that was right for them.

Only five respondents had any suggestions for improving MHRA's program. They suggested that the enrollment staff should be available on more days for more hours.

Experience with the Health Plans

Approximately one of five respondents (19%) stated that he or she had had a problem with a CHP insurance plan. In two-thirds of the cases, the problem related to receipt of an ID card: cards were never received, were incorrect, or were insufficient in number to cover all the children enrolled. A few respondents (one or two per problem) mentioned other issues, e.g., limited doctor's hours, inadequate drug coverage, or that the plan was not responsive to questions.

Similarly, about one of five respondents (17%) had a question about his or her coverage. Most of these questions involved the need for dental care; a few respondents were uncertain about recertification and the possible need to pay after recertifying. Other issues included concem about emergency care and the need for optical coverage.

Recertification and Recommendations for Plans

Nearly 90 percent of respondents with children still enrolled in a plan expressed the intention to recertify with the same plan, and 98.6 percent of respondents in a plan said they would recommend their plan to others. Those who were not planning to recertify with the same plan were either going to get private insurance or had been told by their doctors to switch plans (6 respondents). Very few respondents (5%) had suggestions for improving their plan. The most frequently cited need was for "better communication." A couple of respondents thought the client should be contacted before any payments were made to doctors.

IV. LESSONS

Community-based enrollment in sites such as WIC centers is effective in increasing health insurance coverage for low-income children.
WIC sites provide ideal settings in which to station enrollment facilitators: they serve a large population of uninsured families and children and they offer an opportunity to educate and reach out to clients with information and assistance with health coverage. In general, WIC participants visit WIC centers once every two months to pick up their checks and receive nutrition counseling. They prefer not to make additional interim visits. Therefore, many participants preferred to complete the CHP or Medicaid enrollment process during a regular visit to the WIC site, if at all possible, although back-up documents needed to be provided in some cases. Enrollment staff tried to assist clients by arranging for document pick-up at a location convenient to both parties, e.g., their place of work or their child's school. Clients highly appreciated the staff's flexibility in this regard, since it expedited enrollment considerably. Otherwise, clients brought the missing documents to the WIC center at the time of their next WIC appointment, usually two months later.

Small businesses can be effective venues for outreach and education about Medicaid and CHP, but are less effective as sites for actual enrollment.
Small businesses that participate in the WIC program were effective vehicles for outreach but were not efficient venues in which to conduct actual enrollment. Initially, WIC vendors were receptive to on-site facilitated enrollment and in many cases, the project staff was successful in gaining access to the stores where they could speak to employees, educate them about insurance coverage for their children, and distribute printed materials. The project did succeed in increasing awareness of Medicaid and CHP among these firms' employees, which suggests that small businesses could play an educational role in efforts to increase coverage of low-income children. In addition, these firms tend to be very small, pay low wages, and generally do not provide insurance coverage to workers and their children. Thus, their employees are prime targets for Medicaid and CHP outreach.

Ultimately, however, WIC vendors and their employees initiated very few applications. A number of vendors and employees were reluctant to speak to enrollment staff or to complete an application because of their immigration status: either they feared being identified by the federal Immigration and Naturalization Service (INS) or were concerned that applying for health insurance might jeopardize their ability to become citizens in the future. Administrative complications and the very small workforces at many of these stores also deterred any substantial enrollment despite considerable effort.

Large chain stores were less receptive to the program than small and medium-sized stores, and yielded only a limited number of applicants. Generally, the best approach to reach employees of large stores and chains proved to be the sending of an introductory letter and program fliers to the main office, which then facilitated an introduction to the branch stores as appropriate.

Small stores were more accessible, although misinformation about CHP, fear of the INS, and warnings from friends and relatives interfered with enrollment. Small stores, by definition, do not have a high volume of eligible applicants, and do not make efficient use of an on-site facilitator.

Facilitated enrollment programs are difficult to implement and are labor-intensive: the CHP application process is easier than Medicaid's.
The first step in assisting a client is to confirm that the potential applicant is in fact uninsured and eligible for enrollment in CHP or Medicaid. Some clients may have a Medicaid card, or have had one in the past. Others may have other insurance coverage, perhaps through a spouse. Second, it is vital to make every effort to send to CHP plans or the Medicaid office all supporting documentation with the completed applications; otherwise, delays can result. In many cases, clients need the help of the enrollment staff to gather all the required documents and to remind them of the application deadline and of scheduled appointments.

The CHP application and enrollment process is fairly straightforward and the required supporting documentation is relatively easy for families to assemble—proof of income, age, and address are the only items required. The entire CHP enrollment process, including a face-to-face interview with the family and subsequent follow-up, required between one-half hour to one hour per child enrolled. An average of three follow-up calls and/or visits was necessary to complete the application.

Since a number of CHP plans were available to potential clients, the formation of a relationship with the individual plans was critical to the project's success. The plans trained MHRA enrollment staff in their respective application policies and procedures, as well as on the specifics of their benefit packages. The plans also provided continuing training and updated provider directories and plan packages on an as-needed basis.

Occasionally, the notion of "presumptive eligibility" caused confusion among families who began receiving services before all missing documents were delivered to the CHP plan. Although the CHP plans are supposed to explain the enrollment process, it often

takes some time after enrollment before they provide new members with complete information. Therefore, families who receive CHP enrollment assistance may not fully understand the process that ensues after the enrollment documents are submitted. Enrollees may also need help with the first stages of plan participation—receiving an ID card and selecting a primary care physician, for example. This may require considerable staff time, however, because families can be very difficult to reach via phone after enrollment, even if only a short time has elapsed.

On the whole, most participants were favorable toward CHP, and a follow-up telephone survey of clients who had been assisted with CHP enrollment at WIC sites indicated a very high level of approval of the MHRA pilot program.

The completion and processing of Medicaid applications is more time-consuming, since documentation requirements are more complex and generally take families longer to assemble. In addition to proof of income, age and address, Medicaid requires rent receipts, child support (if applicable), a social security number, and utility bills. Medicaid also requires "parent absentee" forms from families with single heads of household. Many Medicaid-eligible applicants require more time from staff to help them overcome their anxieties, misconceptions, and concerns about the program. Some eligible families refuse to apply for Medicaid even when told they will not need to be interviewed face-to-face by a Medical Assistance Program (MAP) worker, claiming the process is too complicated and takes too long—as many as 45 days can elapse before an eligibility decision is made. Some Medicaid applicants change their minds at the last minute because a spouse becomes eligible for private insurance or because they decide they would prefer to enroll in CHP. On occasion, an applicant goes through the entire enrollment process unaware that Medicaid coverage already exists and just needs to be updated.

Establishing contact with the supervisor of a local Medicaid office expedited the processing of applications. The supervisor designated a Medical Assistance Program (MAP) eligibility specialist to work with the project's staff, thus eliminating Medicaid's requirement for a face-to-face encounter with the applicant family. Project staff took applications to the Medicaid office in batches of five, and they reviewed them with the MAP worker. It took staff between 90 minutes and two hours to enroll an applicant in Medicaid.

Cultural and linguistic diversity among enrollment staff is necessary to gain the trust of low-income families.

A manager and two enrollment facilitators staffed this pilot project. The staff was ethnically diverse, multilingual, and from different countries of origin, which proved

essential in communicating culturally sensitive information and providing services to the mostly immigrant client population.

MHRA was the sole manager and provider of staff for this project. An expanded program could well subcontract with umbrella organizations to coordinate outreach and education efforts within their member agencies, and either refer clients to the central program facilitators or hire their own facilitators and be reimbursed for each application completed and submitted that results in enrollment.

It is important to choose enrollment sites and hours of operation carefully to ensure that there will be consistently high traffic of eligible applicant families, and thus efficient use of enrollment staff. Ideally, enrollment assistance staff should be stationed at convenient enrollment sites (e.g., WIC centers) for more days and more hours than the MHRA pilot program was able to schedule. We also recommend the use of a toll-free telephone number. This enables enrollment program staff to answer clients' questions and schedule enrollment appointments outside normal hours. A toll-free number also makes staff accessible after enrollment is completed, so they can answer questions that might arise.

RELATED PUBLICATIONS

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