Can Private Companies Contribute to Public Outreach Efforts?
Evidence from California

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Abstract

We study an innovative outreach effort in California, which trains and certifies community organizations to help complete Medicaid and SCHIP applications and, for several years, paid a $50 fee for each accepted application. We provide a detailed description of these organizations, the populations they serve, and the extent to which they turn submitted applications into enrollments. We find that insurance brokers and tax preparers, for-profit groups not typically associated with outreach efforts, make significant contributions to California's program. Brokers in particular help serve a notoriously hard to reach population, those on the higher end of the income eligibility thresholds.

Over the past two decades, expansions of income eligibility criteria have led to a steady and dramatic increase in the number of American children eligible for public health insurance. The most far-reaching of these expansions, the State Children's Health Insurance Program (SCHIP), apportioned more than $40 billion in federal matching funds over 10 years beginning in fiscal year 1998 to extend coverage to children from families with incomes too high to qualify for existing Medicaid but too low to afford private health insurance coverage. By 2000, the modal state had raised its eligibility cutoffs from the pre-SCHIP mandated minimum cutoff of 133 to 200 percent of the federal poverty line for children under 6 years old and brought cutoffs for children 6 to 17 years old up to similar standards. The number of children with public health insurance has also grown markedly. For example, SCHIP enrollment increased from about 900,000 in 1998 to almost 3.9 million in 2005, and many states maintain that traditional Medicaid programs also grew as a result of SCHIP outreach efforts.[1]

Despite this enrollment growth, the number of eligible uninsured children remains high. In 2002, about 2.8 million uninsured children ages 18 and under were eligible for SCHIP and an additional 3.7 million were eligible for Medicaid.[2] Together, these two groups represent over 60 percent of uninsured children.[3] Devising strategies to increase take-up is essential for reducing the number of uninsured children. Eligible uninsured children are difficult to reach because they are disproportionately children of the "working poor". Their parents often have little experience with means-tested benefits programs and many do not realize that their children are eligible for public health insurance.[4] With this in mind, SCHIP, more than past expansions, was developed with an emphasis on and financial commitment to outreach efforts. In almost all states, outreach

efforts aimed to increase public awareness through radio, television and newspaper advertisements, brochures and flyers, and toll-free hotlines. Many, states also used community-level, in-person eligibility workers or volunteers to offer in-depth program information and provide application assistance.[5]

Little is known about the impact of these strategies.[6] The bulk of the literature on outreach has taken a demand-side perspective, assessing the characteristics of the "eligible uninsured" population and recommending efforts that target specific populations.[7] While these studies have been crucial in the design and implementation of current outreach strategies, we remain ill-informed about which particular outreach efforts were most effective. The best information on the supply-side comes from federally mandated SCHIP evaluations that required states to rate the effectiveness of their outreach efforts on a five point scale. This evidence suggests that personalized efforts, such as hotlines and home visits, were more effective strategies than television or print advertisements and that health centers and schools were more effective settings than libraries or senior centers.[8] To date, however, independent assessments of the effectiveness of different outreach efforts remain rare.

To help fill this gap, we study an outreach strategy adopted by California as part of its implementation of SCHIP. Beginning in 1998, the state worked with a variety of private organizations to provide application assistance to families who were potentially eligible for Healthy Families (California SCHIP) or Medi-Cal (California Medicaid). These "enrollment entities" include organizations such as hospitals and clinics that make up the health care safety net as well as schools, faith-based charities and commercial entities such as insurance brokers and agents and tax preparers. Initially, these entities

received a payment of $50 for each child that they enrolled and $25 for each successful renewal.[9]

Application assistance is an important outreach strategy because it addresses several of the most significant barriers to enrollment – complexity of the enrollment process, confusion about eligibility, and language difficulties.[10] A recent study by Aizer suggests that California's use of community-based application assistants was effective at increasing public insurance take-up.[11] She finds that proximity to an additional bilingual application assistant increased new monthly Medi-Cal enrollments among Hispanic children by 16 to 46 percent and among Asians by 26 to 45 percent.[12] As shown in Exhibit 1, analysis of aggregate data indicates that by 2002, roughly 60 percent of Healthy Families applications forwarded to the state and almost 70 percent of those deemed eligible were completed with assistance

Despite this apparent success, the state's budget crisis forced payments to be suspended in 2003. This resulted in a steep decline in the percentage of applications filed with assistance (see Exhibit 1). Moreover, as suggested by program administrators and illustrated in Exhibit 2, this drop in assistance increased the number of applications that were incomplete or completed with error, delaying new enrollments and leading to denials of applications that, if properly completed, might have been accepted.

Payments to enrollment entities were reinstated in July 2005. But the long term future of this program remains in doubt as funding is subject to an annual budget and allocation process. Even if funding is continued, there are important questions as to how the program should be structured. Should the state continue to partner with so many different types of organizations? Or, as has been suggested, should outreach efforts be

more targeted, focusing on certain entities, such as schools?

In this study, we provide a detailed description of the organizations that provide application assistance and the relative success each type of organization had in increasing enrollment. In addition to documenting the relative importance of different entity types, we examine differences in their effectiveness—i.e., the percent of submitted applications deemed eligible—and the extent to which different types of entities serve different populations. Both questions are relevant to the broader issue of how to structure outreach efforts. The latter question is particularly important because the population of children eligible for public insurance is now quite heterogeneous in terms of socioeconomic status. As a result, organizations that are effective at reaching out to and enrolling very poor children may be less well-positioned to enroll children in families at the upper end of the SCHIP income eligibility range.

Data

Our analysis is based on detailed information on all "Enrollment Entities" (EEs) operating in the state from the start of Healthy Families through June of 2002. In addition to location, we know when the EE entered the program, the type of organization it is (clinic, community or faith-based organization, government-funded organization, hospital, insurance broker/agent, provider, school, or tax preparer), how many "Certified Application Assistants" were associated with the EE, what languages were spoken by EE staff, and, most importantly, how many applications were submitted and how many were deemed eligible for SCHIP or Medi-Cal Children. Since EEs differ in how long they were in the program as of June 2002, in some analyses we divide the total number of

submissions by that length of time and present the data in terms of the number of applications submitted per 100 days.

Application Assistance by Entity Type

Exhibit 3 describes the distribution of enrollment entities and application assistants by organizational type. There is considerable variation across types in both the number of entities and certified assistants participating in the program. For example, insurance brokers represent almost 40 percent of enrollment entities, but because these are small organizations—often just a single individual—they account for a much smaller share of all assistants. In contrast, hospitals account for less the 3 percent of EEs but they have many application assistants (on average 6.5) or about 8 percent of all CAAs. Government-funded organizations, typically outreach programs run by a county or municipal departments of health services, have an average of 17 CAAs per entity, far more than any other organization type. This may reflect the fact that government-funded organizations target the neediest cases. Many of their assistants may focus on adults or other groups for whom the state does not pay an application assistance fee.[13] And, finally, many employees at government-funded organizations may be certified to provide application assistance even if most of their time is spent on other responsibilities.

To gauge the participation and effectiveness of each of these types of organizations, the last three columns of Exhibit 3 provide statistics on the share of applications submitted and accepted statewide as well as acceptance rates by entity type. Clinics submitted about a third of all assisted applications over the study period. Only

community-based organizations come close in terms of the share of applications submitted; they submitted 18 percent of applications.

Exhibit 3 suggests only a small role for schools in the state's fee-based outreach efforts. Some schools, however, participate as grant based contractors instead of fee-based entities. Grants, administered through either the EE program or the Connecting Kids Program, a school-based outreach effort funded by the Packard Foundation, allow schools to hire dedicated outreach staff. The California Department of Health Services attributes 35 percent of all application requests made to its toll free hotline during the first 6 months of the HF program to school-based efforts.[14] Current school-based efforts involve distributing referral forms with joint HF/MC applications and linking families to local organizations offering application assistance. State administrators indicate that referral forms distributed by school-based staff are an effective and growing outreach tool. This is consistent with the experience in the 47 other states that use schools for SCHIP outreach; administrators consistently give them high effectiveness ratings.[15]

Hospitals may appear to play a small role in outreach, submitting only about 8 percent of applications. This contribution is considerable, however, given that hospitals account for less than 3 percent of entities and 5 percent of CAAs. Their relatively high share of submissions, like their relatively high share of CAAs, may reflect the fact that hospitals stand to gain not only an assistance fee but also reimbursement for services rendered.

But, not all applications are deemed eligible. Overall, about 41 percent of applications submitted lead to successful enrollments.[16] The acceptance rate varies across different entity types. While insurance brokers contribute only about 13 percent of

submissions, they have by far the highest acceptance rate. About 44 percent of all applications submitted by brokers are deemed eligible. Consequently, they account for a larger share of accepted (13.4percent) than submitted (12.7 percent) applicatoins. Their success rate is particularly noteworthy since only three other states (Illinois, North Carolina, and Virginia) provide insurance agents incentives to participate in outreach efforts.[17]

A more detailed investigation reveals that the high acceptance rate of brokers is driven by a small number of high volume entities. The average broker submits very few applications and has an acceptance rate of only about 31 percent. This relationship between volume and accuracy, which holds for other entity types as well, suggests that there may be significant learning-by-doing. As entities submit more applications, they may gain a better understanding of the eligibility rules and requirements concerning documentation.

Hospitals, in contrast, have a relatively low acceptance rate (37.7 percent). As a result, they account for only about 7 percent of accepted applications. Government-funded organizations, community based organizations (CBOs), schools, and tax preparers all perform slightly below average.

The variation in acceptance rates across groups is consistent with differences in incentives as well as differences in the nature of the interaction with the client. Applications from hospitals are triggered when an uninsured patient presents for outpatient treatment or admission. Many of these patients arrive at the hospital without the necessary documentation or information for the hospital to make an accurate eligibility assessment. At the same time, submitting an application represents a minimal

cost to the hospital, as the application only marginally increases the necessary paperwork to be completed. And, the benefit to the hospital—the difference between what Medi-Cal or the Healthy Families plan will reimburse for the care and what they can recover from an uninsured patient—is potentially quite large. Thus, hospitals have an incentive to submit applications even when the probability of acceptance may be low. In contrast, because the only benefit that insurance brokers receive from submitting an application is the $50 fee and because they can easily request that a client return with more documentation, they may be reluctant to expend effort on cases where acceptance appears unlikely. Providers and clinics (other than hospitals) are the only other groups that come close to brokers in terms of acceptance rates. Like hospitals, these entities stand to gain reimbursement for services rendered on top of the application fee. Relative to hospitals, however, providers and clinics may have an added incentive to recruit and submit quality applications – obtaining insurance coverage for their clients may increase the likelihood of repeat business. Moreover, like insurance brokers and unlike emergency departments, providers and clinics may be able to request the documentation needed to determine eligibility before rendering services.

Application Assistance by Neighborhood SES and Entity Type

The heterogeneity of the population that is eligible for public health insurance provides one rationale for partnering with different types of organizations. Previous work suggests the importance of taking account of language differences among the population when designing outreach strategies.[18] Income is another important source of heterogeneity. Organizations that are effective at reaching very low income families may

not be as adept at enrolling families at the upper end of the SCHIP income eligibility

range, and vice versa. And the geographic distribution of organizations makes them

more accessible to different types of communities. For example, while the average clinic,

provider, school, or hospital-based EE is located in zip codes with per capita median

income of below $40,000, the typical tax preparer, government-funded and CBO-based

EE operates in zip codes with per capita income of just over $40,000. Insurance brokers

are located in zip codes with an average median per capita income of almost $50,000. In

addition, insurance brokers, in contrast to other EE types, operate in the widest range of

zip codes by income, with median per capita income under $15,000, at the lowest end,

and just over $119,000 at the highest end.

To shed light on the role of different EEs across the income distribution, in

Exhibit 4 we stratify the data by per capita zip code income and examine the distribution

of submissions and acceptances by income quartiles. Quartiles are defined by the 1999

median per capita income across zip codes where at least one enrollment entity was

operating during the study period. The first thing to note is that the distribution of

submissions and acceptances by entity type varies substantially by area income. Clinics

and CBOs account for about 60 percent of all applications submitted and accepted in the

lowest income zip codes, but less than 40 percent of submitted or accepted applications in

the top income quintile. The opposite pattern holds for brokers. While they submit only

6 percent of applications in the lowest income quartile, in the highest quartile brokers

account for a greater share of applications submitted and deemed eligible than any other

type of entity—24 percent and 26 percent, respectively. We see a similar pattern for tax

preparers, which account for a tiny share of applications in the lowest income zip codes,

but submit almost a tenth of all applications in the highest income category. Public

schools account for a small share of assisted applications across all income areas.

Several differences across income groups and entity types deserve additional

mention. Consider hospitals. Across all but the second income quartile, hospitals have a

lower than average success rate. The acceptance rate for hospitals is especially low in the

top half of the distribution. In the highest quartile, only a quarter of applications

submitted by hospitals are deemed eligible. This pattern provides support for the idea

that hospitals are less able to screen for eligibility and more likely to submit applications

irrespective of the probability of acceptance. According to this argument, hospitals

located in affluent areas have lower success rates than those in poor areas because they

interact with a population that has a lower probability of eligibility.

Insurance brokers perform comparatively well across zip codes in all income

quartiles. But, those brokers located in zip codes in the highest income quartiles perform

particularly well. In the two highest income quartiles, where the overall acceptance rates

are each just about 38 percent, insurance brokers still turn over 40 percent of their

submissions into successful applications. Thus, in areas where the probability of

encountering an eligible client may be lowest, insurance brokers have contributed the

most to the generation of Medicaid and SCHIP enrollments.

Within Neighborhood Comparisons of Application Assistance

Enrollment entities are not randomly distributed across the state. Indeed, Exhibit

4 suggests that some of the differences across entity types may be driven by where the

organizations are located. To gain a more complete understanding of how different types

of entities perform, we need to control for key features of the local environment in which

EEs operate. We do this by estimating multivariate regressions. We consider two

outcomes: total applications submitted (measured as a rate per 100 days) and the percent

of all submissions that were accepted (i.e., the success rate). For each outcome, we report

results from models with zip code fixed effects. This allows us to control completely for

fixed differences in local area conditions, generating estimates that compare entity types

within instead of across neighborhoods.

More specifically, we estimate models of the form:

$$(1) \qquad Y_{ze} = + X'\beta + \delta_z + \gamma_e + \varepsilon_{ze},$$

where Y_{ze} measures either the number of submissions per 100 days or the share of

applications deemed eligible by EE e in zip code z. The acceptance rate models are

weighted by submissions to account for differences in volume across EEs. All models

include zip code fixed effects, δ_z *to* control for unobserved time-invariant characteristics

of the zip codes where an EE operates; X captures basic EE characteristics — the number

of competitors in the zip code at entry into the program, the log of their number of CAAs,

and, for the share analysis, the number of days the entity has been operating in the

program and its square. Of main interest, however, are $_{e,}$ the coefficients on indicators

of an EE's organization type. They characterize submissions and acceptance rates taking

into account the neighborhoods where each organization is located and the resources it

contributes to the enrollment process. Clinics, the highest-volume submitters, are the

excluded group. Thus, the coefficients on the other EE types can be interpreted as

submissions or acceptance rates above the clinic mean.

The regression results, reported in Exhibit 5, confirm the patterns in Exhibits 3 and 4. Within a given zip code and relative to clinics, hospitals submit a large and insurance brokers a small number of applications per 100 days in the program. However, insurance brokers and tax preparers have higher success rates. The point estimates imply that, holding other factors such as neighborhood socioeconomic status constant, brokers have a roughly 8 percentage point higher share of applications accepted.[19] Similarly, all else equal, tax preparers have an almost 9 percentage point higher share of applications accepted. Off a mean acceptance rate of 41 percent, this suggests that brokers and tax preparers improve upon the success rate of clinics by about 19 and 21 percent respectively.

As would be expected, EEs with more application assistants on staff submit a higher number of applications, though interestingly they have a lower success rate. The success rate increases with how long an EE has been involved in the program, which suggests the importance of learning by doing.

Discussion

Prior research has shown that insurance brokers and agents play a critical, if underappreciated, role in the small group and non-group health insurance markets.[20] Small employers and individuals purchasing non-group coverage rely on them for information on insurance options and assistance with enrollment and insurers operating in these markets view brokers as a key component of their distribution channel. In the 1990s, some states that enacted small group reforms attempted to lower premiums by

"cutting out the middleman" and reducing consumers' reliance on brokers. These efforts have generally not been successful. Even where reforms made it easier for small employers to purchase insurance directly from insurers or through a cooperative, a large fraction continued to go through brokers.

Our results suggest that insurance brokers can also play an important role in assisting eligible families enroll in Medicaid and SCHIP. Relative to other types of enrollment entities, brokers have been quite successful at increasing the take-up of public health insurance in California. Our data suggest that they are located near and thus may have better access to a population that prior research indicates is less aware that their children qualify for free or subsidized health insurance. This is important because many of these families have little or no prior experience with the social service system and may not be in contact with the same types of organizations as lower income families.

The reason for the success of insurance brokers may be manifold. State officials have indicated that brokers are particularly experienced at filling out complex forms. Because of their profession, most brokers should have a pre-existing system for identifying people who are interested in obtaining health insurance. The financial reward for application assistance is such that brokers have little incentive to submit applications that are unlikely to be eligible. They may also use the programs as alternative options for commercial product line customers that have family members who do not qualify for or cannot afford the cost of those product lines.

Similarly, our results suggest that tax preparers may be an underutilized resource in outreach efforts. While not obvious from the raw data, once we account for the neighborhoods where they operate, tax preparers have higher success rates than clinics

and most other organizations working in the same zip codes. Their success may reflect their access to the most important application requirement, income documentation, allowing them to more readily and accurately assess eligibility than other EEs. As reflected by their low submission rates, however, tax preparers have not actively participated in the program and, when they do, their efforts are quite seasonal (January through April). Recognizing their potential to be an efficient source of applications and enrollments, state administrators are currently exploring ways, including partnering with a major tax preparer, to increase tax preparer participation rates.

California's application assistance program offers lessons for many other states and public benefit programs. Only three other states provide incentives to insurance brokers who assist SCHIP enrollments. To our knowledge, no other state recruits tax preparers to provide application assistance. Our results indicate, however, that means-tested benefit programs may be well served by recruiting a diverse set of organizations, including those that, like brokers and tax preparers, are not typically associated with outreach efforts.
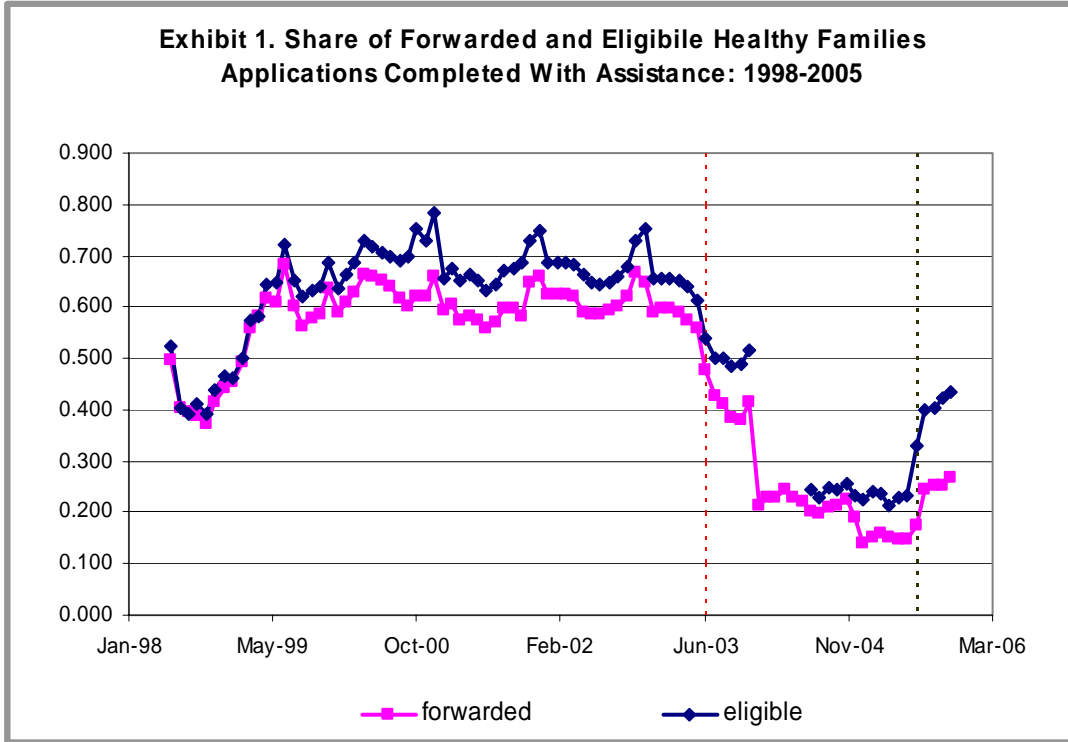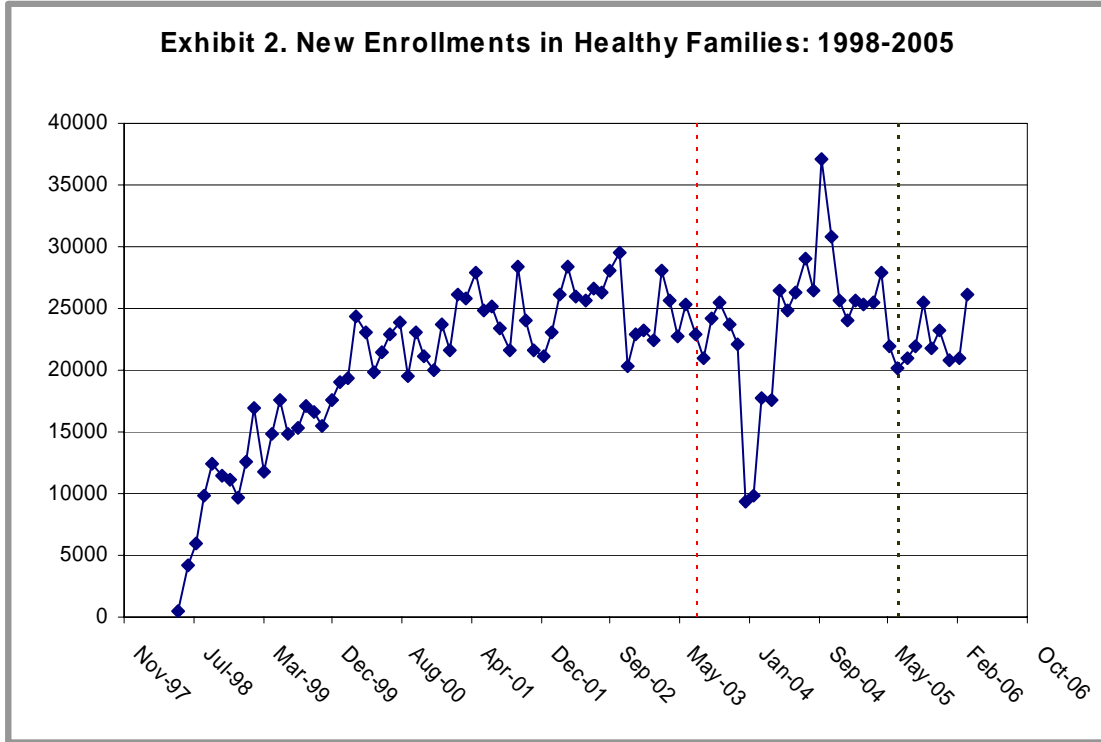
Exhibit 1. Share of Forwarded and Eligibile Healthy Families Applications Completed With Assistance: 1998-2005

Source: Managed Risk Medical Insurance Board's Healthy Families Program Enrollment Reports (various issues). See http://www.mrmib.ca.gov/MRMIB/HFP/HFPReportsHis.shtml

Notes: The first dotted line corresponds to the suspension of the $50 application assistance fee in July 2003. The second dotted line corresponds to the reinstatement of the $50 fee in July 2005.

Changes to data reporting between December 2003 and July 2004 make it impossible to calculate the share of eligible applications that were submitted with assistance during that period.

Exhibit 2. New Enrollments in Healthy Families: 1998-2005

Source: Managed Risk Medical Insurance Board's Healthy Families Program Enrollment Reports (various issues). See http://www.mrmib.ca.gov/MRMIB/HFP/HFPReportsHis.shtml

Notes: The first dotted line corresponds to the suspension of the $50 application assistance fee in July 2003. The second dotted line corresponds to the reinstatement of the $50 fee in July 2005.

The state switched administrative vendors in late 2003, which may have also impacted the efficiency of application processing, enrollments, and eligibility appeals.

Exhibit 3. Healthy Families or Medi-Cal Children Submissions by Type of Enrollment Entity (Data through June 2002)

	Entities	Assistants	Applications Submitted	Applications Accepted	Acceptance Rate
Total	2722	10116	189145	77942	42.1%
Share or rate by Type of Entity					
Clinic	13.2%	15.0%	30.2%	31.5%	42.8%
Community-based Org.	17.5	25.4	18.0	17.3	39.6
Government Funded	2.5	11.4	8.9	8.7	40.6
Hospital	2.8	4.9	7.9	7.2	37.7
Insurance Broker	39.2	17.6	12.7	13.4	43.6
Provider	13.8	9.2	13.3	13.8	42.6
School	7.5	13.2	6.1	5.3	35.7
Tax Preparer	3.5	3.3	2.9	2.8	39.8

Exhibit 4. Application and Acceptance Rate by Entity Type and Area Income

	Below 25th Percentile		25th to 50th Percentile		50th to 75th Percentile		Above 75th Percentile	
	Submitted Applications	Acceptance Rate	Submitted Applications	Acceptance Rate	Submitted Applications	Acceptance Rate	Submitted Applications	Acceptance Rate
All Enrollment Entities	64887	42.5%	51046	42.4%	48058	38.3%	22173	38.3%
By Entity Type	Share of Applications		Share of Applications		Share of Applications		Share of Applications	
Clinic	39.3%	42.7%	30.6%	44.6%	22.1%	38.2%	18.0%	46.4%
CBO	20.9	45.9	17.8	34.4	13.2	33.6	19.9	39.2
Government Funded	4.9	41.4	4.7	41.5	20.7	41.4	4.3	25.2
Hospital	4.0	39.9	6.4	50.8	11.7	36.4	15.8	25.8
Insurance Broker	5.9	44.7	12.8	42.6	16.5	45.3	24.2	40.9
Provider	19.5	40.3	17.2	47.1	5.6	37.8	4.6	45.8
School	4.6	35.5	7.8	37.2	7.3	32.1	3.8	29.9
Tax Preparer	1.0	36.7	2.7	38.3	2.9	41.4	9.3	40.8

Exhibit 5. Predictors of Healthy Families or Medi-Cal Children Application Submissions and Share of Submissions Accepted by Enrollment Entities

Type of Entity	Submissions Per 100 Days mean = 5.28	Share Accepted weighted mean = .412
Log(# of CAAs)	7.95	-.016
	(.976)	(.007)
# of Competitors upon entry	-.424	-.002
	(.176)	(.004)
Days in Program	--	.0002
		(.00006)
(Days in Program)^2	--	-2.52e-08
		(2.74e-08)
Community or Faith Based Organization	-6.16	.0053
	(1.53)	(.025)
Government Funded	.229	-.079
	(.427)	(.042)
Hospital	1.22	-.010
	(3.43)	(.046)
Insurance Broker/Agent	-2.44	.077
	(1.17)	(.027)
Provider	-1.71	.019
	(1.29)	(.024)
School	-7.69	.043
	(1.97)	(.028)
Tax Preparer	-1.08	.087
	(2.29)	(.033)
Zip Code Fixed Effects	Yes	Yes
Observations	2722	2722
Adjusted R-squared	.405	.731

Notes: Data are at the enrollment entity level. Clinic is the omitted group. All regressions include zip code fixed effects. Regressions of the share of applications that were accepted are weighted by the number of submissions. Standard errors are "clustered" at the zip code level.

[1] M. Rosenbach et al., Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations (Baltimore: Centers for Medicare and Medicaid Services, 2003).

[2] T.M. Selden, J.L. Hudson, and J.S. Banthin, "Tracking Changes In Eligibility And Coverage Among Children, 1996-2002." *Health Affairs*, 23, no.5 (2004): 39-49.

[3] Estimates from the March 1999 CPS suggest that over 70 percent of uninsured children in California were eligible for Medicaid or SCHIP (California Department of Health Services, 2000).

[4] M. Perry et al., *Medicaid and Children: Overcoming Barriers to Medicaid Enrollment: Findings from a National Survey. Washington DC: Kaiser Commission on Medicaid and the Uninsured*. 2000; D. Card and L. Shore-Sheppard, "Using Discontinuous Eligibility Rules to Identify the Effects of the Federal Medicaid Expansions on Low Income Children," *Review of Economics and Statistics*, 86, no. 3 (2004):752-766.; G. Kenney, and J. Haley, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?*, The Urban Institute, Series B, No. B-35. 2001; G. Kenney, J. Haley and L. Dubay, *How Familiar Are Low-Income Parents With Medicaid and SCHIP*, The Urban Institute, Series B, No. B-34, 2001; J.S. McAlearney, "Opportunities for Outreach: Medicaid Participation Among Children in Ohio," *Journal of Health Care for the Poor and Underserved*, 15 (2004): 357-74.

[5] M. Mickey, CHIP Outreach and Enrollment: A View from the States, American Public Health Services Association Report, 1999; Perry et al. "Medicaid and Children"; Rosenbach et al. "Implementation"; D. Ringold, T. Olson, and L. Leete, CHIP and Medicaid Outreach: Strategies, Efforts, and Evaluation, Federalism Research Group. 2003.

[6] More is know about the impact of SCHIP design features on take-up. This work suggests that program characteristics such as eliminating asset tests and face to face interviews, offering continuous coverage without monthly income verification, and instituting a joint SCHIP/Medi-Cal application form increases take-up. Mandatory waiting periods have the opposite effect. C. Bansak and S. Raphael, "The Effects of State Policy Design Features on Take Up and Crowd Out Rates for the State Children's Health Insurance Program," San Diego State University, Department of Economics Working Paper Series, 05-02, 2006; B. Wolfe and S. Scrivner, "The Devil May be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up*," Journal of Policy Analysis and Management*, 24, no. 3 (2005): 499-522; K. Kronebush and B. Elbel, "Enrolling Children in Public Insurance: SCHIP, Medicaid and State Implementation," *Journal of Health Politics, Policy, and Law,* 29, no. 3 2004): 451-489.

[7] US General Accounting Office, 1998. *Medicaid: Demographics of non-enrolled children suggest state outreach strategies*. Washington DC:US Government Printing Office, (GAO Pub no. GAO/HEHS-98-93); M. Perry et al., *Medicaid and Children;* Kenney and Haley, *Why Aren't More Uninsured Children Enrolled;* McAlearney, "Opportunities for Outreach"; J. Stuber and E. Bradley, "Barriers to Medicaid Enrollment: Who Is at Risk?" *American Journal of Public Health*, 95, no. 2 (2005): 292-298.

[8] Rosenbach et al. "Implementation"; Wolfe and Scrivner, 2005, while focusing primarily on SCHIP design features, provide further evidence that dedicated phone help lines and websites improve take-up.

[9] Through a competitive process, some entities instead entered into contract-based agreements to provide assistance. These entities, which were primarily schools and community-based organizations, were minor players in the application assistance program; over 80 percent of applications assisted between 1998 and 2002 came through fee-based enrollment entities. See page 8 of The Major Risk Medical Insurance Board's *2002 Application Assistance Factbook*. http://www.mrmib.ca.gov/MRMIB/HFP/CAAFactBk.pdf

[10] M. Perry et al., Medicaid and Children; J. Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid, Center for Health Services Research and Policy*, The George Washington University, Issue Brief, 2000.

[11] A. Aizer. "Public Health Insurance, Program Take-up and Child Health," *Review of Economics and Statistics,* forthcoming.

[12] Aizer also analyzed the effect of a statewide television advertising campaign. Her results indicate that this also had a large impact on enrollment.

[13] Prior to July 2003, fees were paid for assistance provided to pregnant women enrolled in the state's subsidized program for pregnant women and infants (AIM) and adults enrolled in the state's high risk insurance pool (MRMIP). Application assistance fees for these programs have not been reinstated.

[14] California Department of Health Services, *Healthy Families and Medi-Cal for Children Outreach and Education Campaign, 2000 Report to the Legislature*, 2000.

[15] Rosenbach et al. "Implementation."

[16] Note that this success rate is far below that described in official documents such as the *2002 Application Assistance Factbook*. Official figures put success rates for assisted application at about 79 percent (compared to 63 percent for unassisted applications). Some of the discrepancy may result from double counting resubmitted applications that were initially deemed incomplete. Some may also stem from double counting applications that are forwarded to both the Healthy Families and Medi-Cal programs for eligibility determination.

[17] Rosenbach et al. "Implementation."

[18] Aizer. "Public Health Insurance"; Perry et al. "Medicaid and Children"; Stuber et al. *Beyond Stigma*.

[19] State administrators indicate that this should not be surprising since brokers core business function is selling insurance and completing the necessary application forms for that coverage.

[20] D.W. Garnick, K. Swartz and K.C. Swarka, "Insurance Agents: Ignored Players in Health Insurnce Reform," *Health Affairs* (March/April 1998): 137-143; J.M. Yegian et al., "The Health Insurance Plan of California: The First Five Years," *Health Affairs*, (September/October 2000); M.A. Hall, "The Role of Independent Agents in the Success of Health Insurance Market Reforms," T*he Milbank Quarterly*, (2000): 23-45.