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Health-care reforms: Adopt proven tactics for boosting enrollment

JOHN BOUMAN • MARCH 25, 2008

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I had a chance to visit last week with the Iowa leaders trying to establish affordable, comprehensive health-coverage choices for all children, a step Illinois took in 2006.

I talked about how proud Illinois policymakers are of Illinois' All Kids program, how popular and affordable it is, and how it allows children to get well-child preventive and diagnostic care.

Most Iowa children are already covered, so Iowa does not have far to go to cover all kids. Leaders of this initiative are very impressive, and there is tremendous consensus to finish the job. Disagreements over details, such as whether to require parents to acquire coverage for their children, seem unlikely to derail the main job of establishing the coverage and rolling it out. Yet this requires specific actions, like those taken in Illinois, that Iowa has yet to do.

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Based on experience in other states, Iowa might find it useful to take some steps now, even though full coverage would be phased in later. It does little good to offer coverage if children do not enroll, and it does no good to enroll children only to kick them off the program for bureaucratic reasons and thus interrupt their health care.

Illinois conducted a vigorous, on-the-ground outreach effort and made the enrollment process as simple as possible. Great results flowed from enlisting trusted, community-based school personnel, health-care and social workers and others to sell the program and enroll kids. These trusted workers can also educate parents that they need the insurance because they need a relationship with a regular doctor where they can take their children for regular checkups even when they are not sick, to ensure healthy development.

Illinois also eliminated as much red tape as possible. Children unnecessarily lose coverage, especially at re-enrollment time, when there is too much red tape. For example, Illinois redetermines eligibility once a year (just like employer-based insurance) instead of every month. Iowa does this already for Hawk-I; it could easily do it with Medicaid, too.

We also tried to make the different programs as seamless and invisible as possible, so they feel like one program to consumers. Iowa could harmonize the Medicaid and Hawk-I programs so kids do not fall through the cracks if changing family income causes eligibility to fluctuate between different programs.

Illinois also established the family's financial participation on a sliding scale that phases out subsidies as income rises to about 400 percent of the federal poverty level (the subsidies are very small as income approaches that level). This avoids eligibility "cliffs," where an increase in income causes a family's overall finances to take a deep hit because of abrupt loss of health coverage.

Iowa is not alone in this admirable effort. Hopefully, some lessons learned around the country can be helpful.

JOHN BOUMAN is the president and advocacy director of Sargent Shriver National Center on Poverty Law in Chicago.

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