

Improving Health Insurance Coverage for American Indian Children and Families under Healthy Families (SCHIP)

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ABSTRACT

Background: More American Indians and Alaska Natives (AIAN) reside in California than any other single state in the United States; Los Angeles is home to the largest number of AIAN in the country. In 1997 the federal government initiated the State Children's Health Insurance Program (SCHIP – called Healthy Families in CA). In 2000 federal regulations were amended to exempt AIAN children from *any* SCHIP cost sharing. Since the California waiver implementation date there has been no significant change in the rate of AIAN enrollment.

Methods: This study examined the policy and implementation barriers for AIAN children to obtain Healthy Families coverage. The principal research methods focused on: (a) a review of administrative data; (b) the development of eligibility estimates of the AIAN population; and (c) key informant interviews with AIAN-health serving institutions, health care providers (including urban, rural, and non-Indian clinics), the Healthy Families administrative unit (MRMIB), Department of Health Services (DHS), and health insurance plans.

Results: About 2,200 Healthy Family recipients are currently identified as AIAN, and we estimate that over 7,000 additional uninsured AIAN children in California are Healthy Families eligible. AIAN applicants using certified assistors are more likely to be approved for enrollment than those not using assistors, but one third of those using assistors are denied coverage. This research identified many barriers to AIAN enrollment including: diverse and inconsistent understandings of the waiver and eligibility requirements; insufficient training regarding the waiver; insufficient program awareness/outreach; and the additional application burden with requirement of tribal enrollment documentation. There will be a positive change in AIAN enrollment with parental eligibility and practical steps are presented that can be taken to improve the process/system.

Conclusion: The California Legislature and MRMIB have made a series of program modifications that are designed to improve the coverage rate and total enrollment of Healthy Families. The AIAN population is a group with special implementation legislation that does not appear to have been reached adequately by those efforts; this research will assist policy makers in improving the coverage of AIAN children and families.

INTRODUCTION

More American Indians and Alaska Natives (AIAN) reside in California than any other single state in the United States¹. There are 107 federally recognized tribes in California, also more than in any other state, except Alaska. There are many non-federally recognized tribes as well. Interestingly, more AIAN who live in California are members of tribes with reservations outside the state than inside the state. For example, California is home to many Cherokee, Navajo (also known as Dine), Lakota (also known as Sioux) and so on. The majority of AIAN in California do not live on reservations, but live in urban areas, with Los Angeles being home to the largest urban AIAN population in the country.

The only recognized “political minority” in the United States, members of federally recognized tribes have special legal rights to healthcare². These tribal members, living on or near reservations, receive universal healthcare at no charge through the Indian Health Service (IHS), a branch of the US Public Health Service³. However, the IHS provides primary care on-site primarily at remote reservations and supports only a limited number of urban Indian clinics. There are urban Indian clinics throughout California, but Los Angeles, home to the largest number of AIAN in the country, does not have one. These clinics may receive a small portion of their income from the IHS, but otherwise compete for resources as any other community-based health provider. In recent years even IHS clinics have begun third party billing to supplement existing resources. AIAN who are eligible for services through the IHS or urban Indian clinics are NOT excluded from participation in Medicaid, State Children’s Health Insurance Program (SCHIP), or any other public insurance program.

In 1997 the federal government initiated the State Children’s Health Insurance Program (SCHIP – called Healthy Families in California). The intent of the program was to provide heavily subsidized health insurance for children whose family incomes were high enough to make them ineligible for welfare-program health insurance (Medicaid), but whose family incomes were still too low to afford private insurance; thus children in families with an income below 250% of federal poverty level (fpl) and whose income is above the Medi-Cal cut-off qualify for Healthy Families. California implemented this program by requiring monthly premiums of between \$8-18 for a child, and co-payments of \$5 per medical visit. As of April 2002 there were over 536,294 children enrolled in the program.

In July 2000 federal regulations were amended to exempt AIAN children from any SCHIP cost sharing (Federal Register, 2001)⁴. This policy stems from the United States’ “trust responsibility” to provide health care to AIAN. States were allowed, but not required, to obtain proof (Certificate of Degree of Indian Blood) of tribal enrollment in a federally recognized tribe from applicants, or other proof of heritage. California has used its discretion and opted to require proof of tribal membership. California is unique in that there are some AIAN who are members of non-federally recognized tribes, however, they are eligible for health programs, including Healthy Families, if they can prove descendency to an ancestor registered in certain U.S. Census rolls or California Judgment Rolls.

Numerous evaluations and studies have been recently published regarding SCHIP and Healthy Families^{5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27}. Notably, there is almost no mention or recognition of the unique legislation for AIAN in the program. It appears that many of the barriers and problems with SCHIP for the general population, such as application burden, hold true for the AIAN population. Differences for the AIAN population include additional documentation requirements and inadequate training.

This study builds on a research study titled *Access to Public Health Insurance Programs for Urban American Indians in California* (Hubbel, 2000)²⁸. A key finding of the study was the lack of awareness AIAN had of the Healthy Families Program. In addition, Healthy Families' staff in county agencies and staff assistants in urban Indian organizations were *not* familiar with the federal waiver for the premium and co-payment for AIAN children. One can deduce from the low enrollment figures compared to the eligible population that something is wrong. With free health insurance one would expect a noticeable increase in enrollment following the July 2000 decision, with consistently high enrollment and participation.

OBJECTIVES OF THE STUDY

This study examined and evaluated policy process and implementation barriers for AIAN children to obtaining Healthy Families coverage. While California has the largest population of AIAN of any state, of whom many AIAN children are eligible for public health insurance programs, the absolute number of eligible children is relatively small compared to other populations in the state. This study addresses key issues that are important to the development of an incremental expanded access health care coverage system in California- for a most vulnerable and often invisible minority group.

Research Questions

- Is the HCFA exemption waiver of cost-sharing for AIAN children being followed in CA?
- What are the consequences of the current implementation/enrollment process regarding access to the program for eligible AIAN children?

METHODS

The principal research tasks and methods focused on five stages: (a) a review of administrative data; (b) the development of eligibility estimates for the AIAN population; and (c) key informant interviews.

a) **Administrative Review (secondary analysis).** We worked with MRMIB to gain access to AIAN data on enrollment and disenrollment characteristics, as well as to identify the extent to which current AIAN Healthy Families enrollees continue to pay premiums and co-payments that they were exempt from. We reviewed MRMIB Healthy Families enrollment data of AIAN for any significant changes since the implementation of the waiver in July 2000.

b) **Eligibility Estimates for the AIAN Population.** We identified and examined several sources of data to develop eligibility estimates: from the school "free lunch" program, California Department of Finance (CA DOF), California Population Survey (CPS), California Health Insurance Survey (CHIS), and Behavioral Risk Factor Surveillance System (BRFSS). We looked at population size, income estimation, and health insurance factors for the AIAN population.

c) Key Informant Interviews .

We interviewed, using an open-ended instrument, a purposive sample of 18 key informants that included clinic's front-desk staff, Certified Application Assistors (CAA), Healthy Families managers, Healthy Families outreach specialists and health directors throughout the state of California (see map). Each mark on the map indicates one or more key informant interviews in the corresponding county. Of the 18 total key informant interviews, three were conducted with MRMIB personnel, three with health clinic personnel, six with individuals from AIAN-serving



institutions, three from state/county agencies, and three from health insurance plans. The majority of issues/barriers identified in these interviews are amenable to intervention. A solutions section will be presented following this section. Interviews were conducted to identify respondents' knowledge and practices when enrolling AIAN applicants and their activities in implementing the AIAN cost-exemption policy. At the conclusion of the interviews, the researcher summarized key points, invited further comment and clarification. Following the interview the researcher, using notes and the audio-recording, generated a description of the issues and themes that arose in response to each question in the interview guide. These themes were incorporated in the coding system for the final level of analysis. Solutions were identified for the issues either by the key informants themselves or by the researcher team.

FINDINGS

Administrative Review Data

We worked with MRMIB to gain access to AIAN administrative data. This section reviews Healthy Families: (a) unnecessary payment of premiums; (b) enrollment statistics by race; (c) application statistics; (d) ineligibility statistics; and (e) disenrollment statistics.

a) Unnecessary Payment of Premiums

MRMIB reported that as of June 2002, there were 2,215 AIAN enrolled in Healthy Families and from this total 1,170 AIAN children were still paying premiums. MRMIB has sent letters to all AIAN enrollee households to inform them of the waiver program. However, they continue to receive premiums from some households (Sandra Shewry, Director of MRMIB, personal communications). Data was not available to identify those AIAN households that were approved for the waiver that continued to pay their premiums and co-payments.

b) Enrollment Statistics by Race

Before the AIAN waiver was implemented in July 2000 AIAN enrollments were not increasing at the same pace as “all other races.” After the waiver was implemented the pace of increase for AIAN was higher than for “all other races.” This increase leveled out and appears to be the same as “all other races” beginning May 2001 and going through November 2001 (see Exhibit 1).

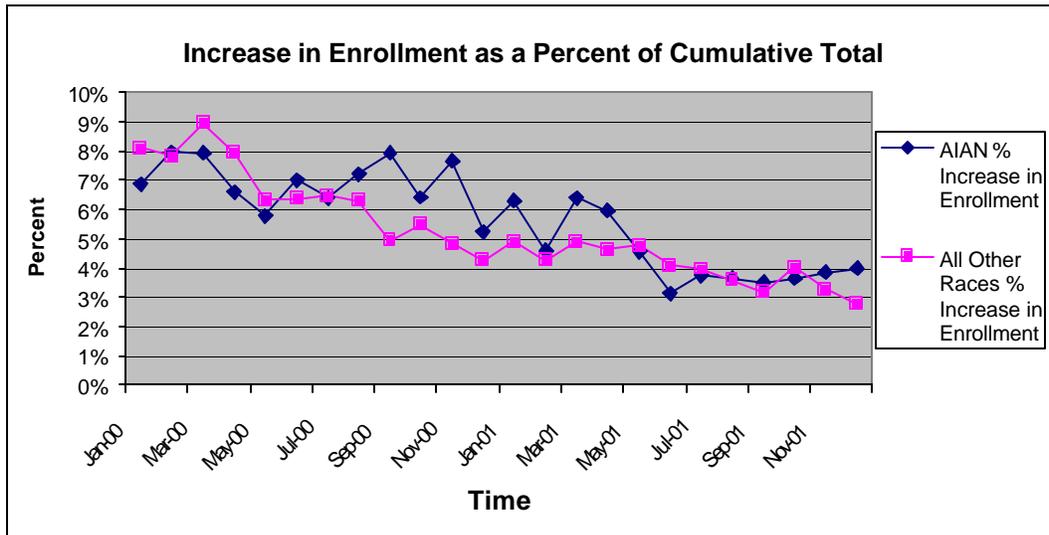


Exhibit 1

c) Application Statistics

Healthy Families – Certified Application Assistors: As of February 2002, 2,816 AIAN and 565,891 “all other races” Healthy Families applications had been received and processed since the start of the program. Applicants can work with a Healthy Families’ Certified Application Assistors (CAAs) or complete their applications on their own. Because the application process is complex, applications with a CAA should be more successful than those without.

Of the AIAN applications processed, thirty-eight percent (38%) were assisted by CAAs compared to fifty-nine percent (59%) of “all other races”, a difference of twenty-one percent (21%). The following data concludes that an AIAN application is more successful with a CAA, but that the approval rate even with a CAA is substantially lower than it should be (Exhibit 2).

Applications With a Certified Application Assistor: There was a seven percent (7%) lower success rate for AIAN applications compared to “all other races,” with all children eligible (65 vs. 72%), even though they used a CAA.

Applications Without a Certified Application Assistor: Similarly, there was a four percent (4%) lower success rate for AIAN applications compared to “all other races,” with all children eligible who did not use a CAA (54% vs. 58%).

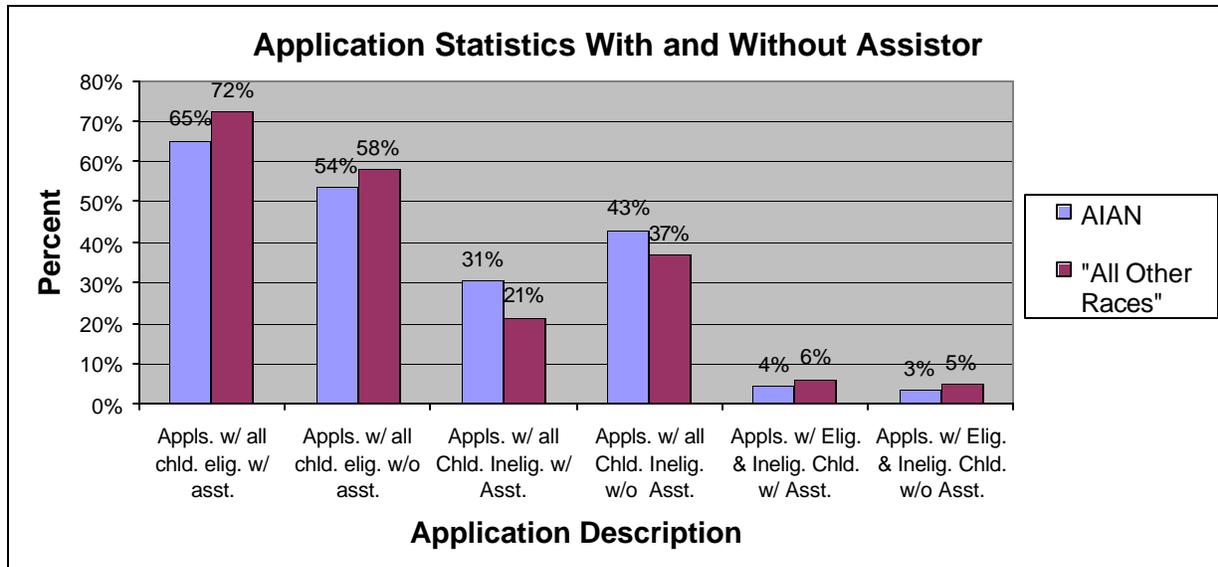


Exhibit 2; AIAN applications assisted = 1,070; “All Other Races” applications assisted = 333,256

d) Ineligibility Statistics:

As of February 2002, there were 2,062 AIAN children, and 329,527 children of “all other races” who applied for and were determined ineligible for the Healthy Families program. There are two basic reasons applications are denied: paperwork problems, and the applicant’s income is too high or too low¹. This section summarizes the major ineligibility problems and any marked difference between AIAN applications and “all other races” applications (see Exhibit 3a-3d).

By far the most common reason that AIAN and “all other races” children were found ineligible is an incomplete application - sixty-five percent (65%) and forty-three percent (43%) respectively. While both groups share the most common reason for ineligibility, AIAN applications experience this about twenty percent (20 %) more often.

The second most common reason AIAN and “all other races” were ineligible is that their incomes are below the eligibility cut-off – about twenty-seven percent (27%) of applications total-to-date. Those whose incomes are too low are required to enroll in Medi-Cal. Seven percent (7%) of AIAN and “all other races” applications are missing or provide invalid proof that their employer does not offer insurance coverage.

One marked difference between AIAN and “all other races” is that six percent (6%) of “all other races” applications are ineligible due to immigration status, which is not an issue for American Indians applying for Healthy Families.

¹ Healthy Families reports ineligibility determinations by the following factors: applications are submitted but are incomplete and missing information is not provided within 20 days; applications are missing or have invalid proof that their employer has not offered insurance coverage for the past 90 days; the applicant’s income is under the federal poverty level eligibility level of 100% for children six years old and younger, and 133% for children older than six years old and are therefore eligible for Medi-Cal; the applicant’s income is above the eligible federal poverty level of 251 -300%; the applicants are currently enrolled in No Share of Cost Medi-Cal; the applicant is not eligible due to immigration status; and other reasons not coded.

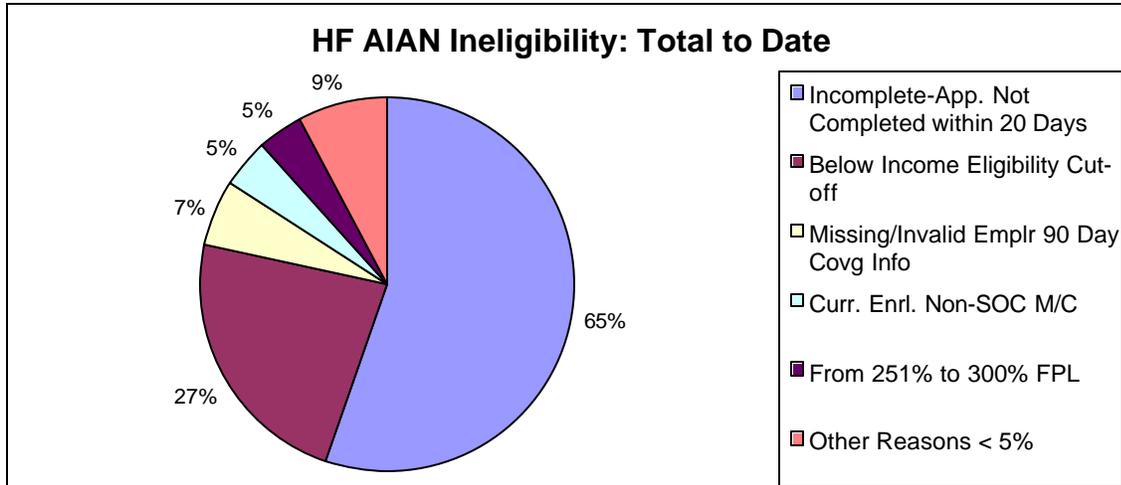


Figure 3a; N=2,062

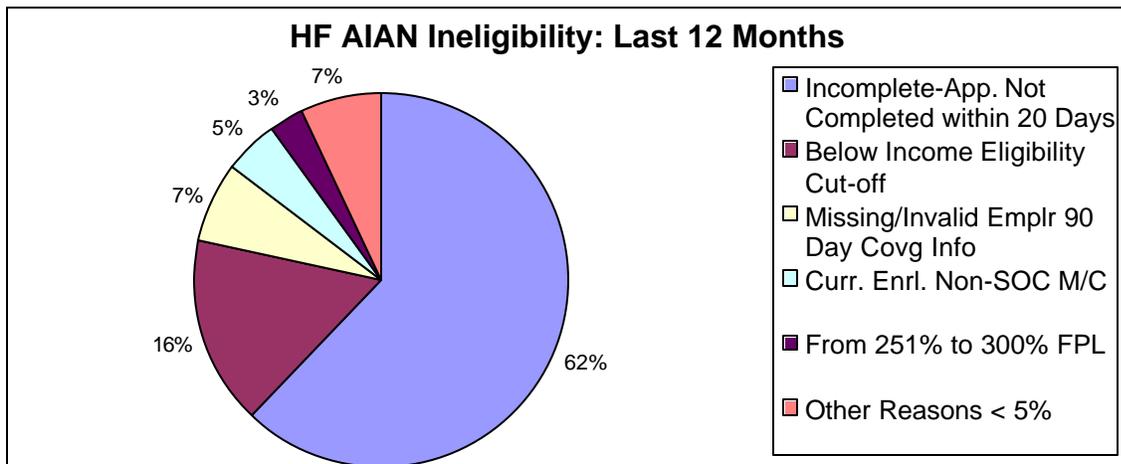


Figure 3b, N=865

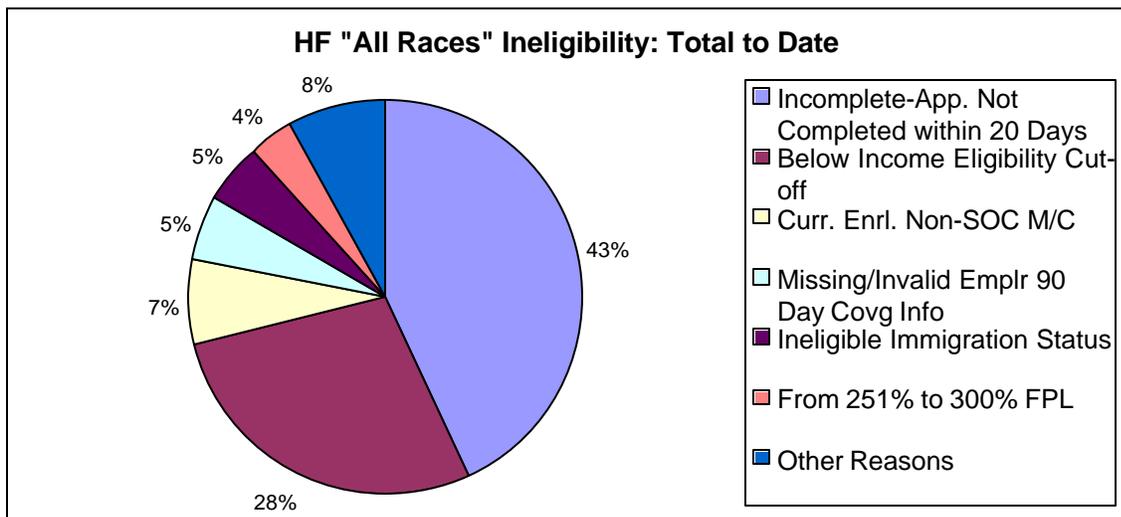


Figure 3c, N=329,527

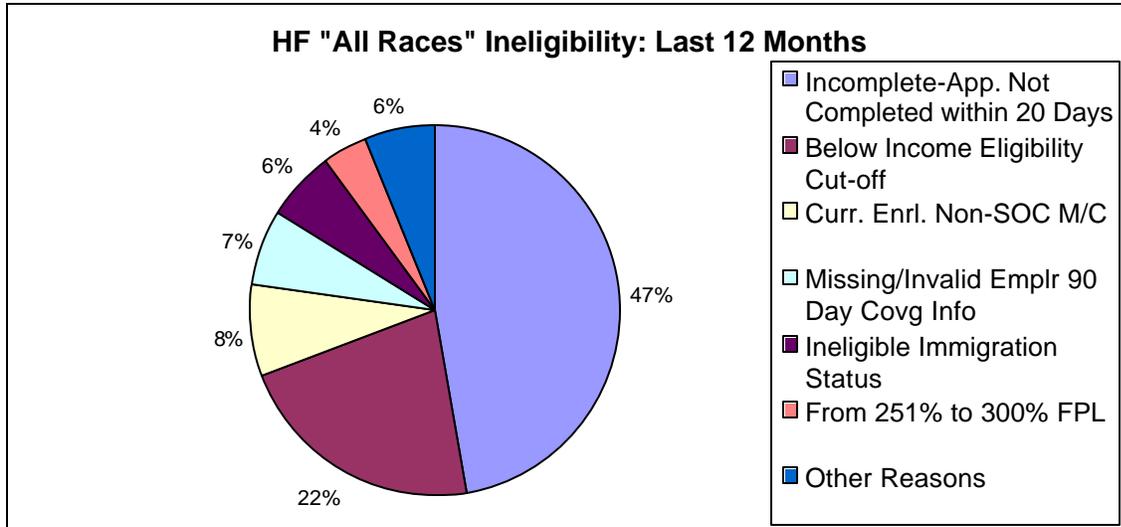


Figure 3d, N=102,591

e) Disenrollment Statistics

From January 2000 through November 2001 disenrollment for AIAN appears to be keeping pace with “all other races”, with one exception. From September 2000 through December 2000 there was a noticeable increase in AIAN disenrollment. The cause of this difference cannot be determined by this data. Possibilities might include confusion regarding the implementation of the waiver at the program’s start (see Exhibit 4).

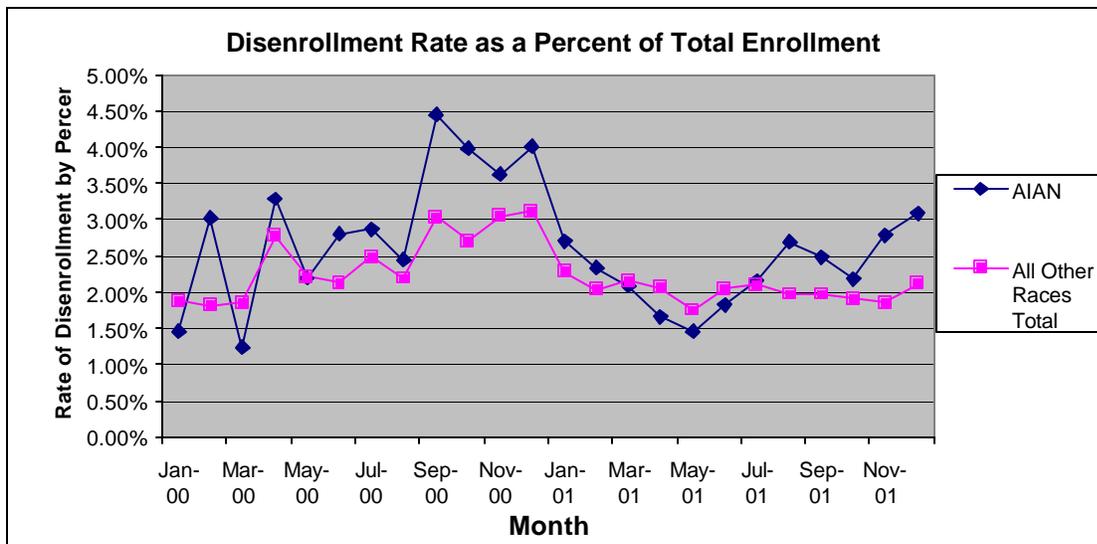


Exhibit 4

Eligibility Estimate Data

We identified several sources of data to develop eligibility estimates: from the school “free lunch” program, California Department of Finance (CA DOF), California Population

Survey (CPS), California Health Insurance Survey (CHIS), the Census 2000 and Behavioral Risk Factor Surveillance System (BRFSS). However, most could not yield sound estimates.

We found that the information for school “free lunch,” which is a federal government subsidized program based on income, does not report race/ethnicity. In addition, the CA DOF and CPS sample are too small for estimates or do not record AIAN income level. These sources proved not to be useful for AIAN eligibility estimates. However, CHIS recently published estimated data on AIAN population in California and AIAN eligibility for Healthy Families. If we start with the 2000 Census data for California, which reports 200,000 American Indian and Alaska Native children, we can use the CHIS estimates to arrive at an estimate of the number of uninsured AIAN children would be potentially eligible under the AIAN Healthy Families waiver. Applying the uninsured rate and ratio of CHIS AIAN children to census data, we estimate that **7,200** AIAN children are eligible, but not enrolled in Healthy Families (Brown et al, 2002)^{29, 30}.

Key Informant Interviews

The organizations interviewed for this project represent a variety of different organizations including: a) rural and urban health centers, and b) state and local government agencies. This section describes their organizations including service population and services provided.

American Indian and Alaska Native (AIAN) Serving Institutions

Rural

Respondents affiliated with rural AIAN serving institutions described their organizations and services broadly. Two of the three rural respondents reported that they serve primarily low-income communities with 25-35% eligible for Medi-Cal. Client bases ranged in size from 200-20,000, serving primarily persons under 19 years old and the elderly. All respondents stated that they or their clinic programs served both Indian and non-Indian clients.

Of the rural respondents interviewed, only one provided direct health services and adjunct services, such as transportation, teen programs, and traditional health services. The others provided health services through member’s tribal health programs, and contract health care. Two respondents reported having two Certified Application Assistors (CAA) on staff.

Urban

Of the three urban AIAN agencies interviewed, all provided services to low-income populations, which account for 72% to 100% of their client populations. Two respondents stated that they provided direct health services. One provided referrals for health care. All agencies provided a variety of adjunct services to their clients including, behavioral health, WIC/Nutrition, job training, tutoring services, senior and traditional health programs.

Two respondents reported having three or more CAAs on staff, while one reported not currently having a CAA. The majority of respondents reported serving all populations regardless of race/ethnicity. However, one stated they provide services only to AIAN clients whom are members of federally recognized tribes because of funding limitations. Two of the respondents were Federally Qualified Health Centers.

Non-AIAN Serving Institutions

Both respondents provided direct health and adjunct services to clients regardless of race/ethnicity. One respondent reported that they served an entirely low-income population. Respondents also reported serving predominately Central American and Latino populations. One respondent stated that they accepted any type of insurance including Medi-Cal, Medicare, Healthy Families, private insurance and sliding scale. The other respondent reported not accepting any forms of insurance because they are a free clinic. Both respondents did not know if or how many American Indian clients they served.

State/County

Respondents represented an array of different types of organizations including state agencies, health plan providers, and county enrollment assistance programs. Two of the respondents were health plan providers contracted by the state to administer insurance plans such as Healthy Families or Medi-Cal. Their services include contracting with providers, case management, outreach, customer service and referrals. One respondent stated they have 206,000 plan members of which 416 are AIAN. Another respondent stated they have 750,000 plan members of which 7,500 are Healthy Families and of that 7,500 only one is AIAN.

Only one respondent provided services to AIAN populations by way of local assistance funding to California tribes for health services and personnel. Another respondent stated that their function is to develop Healthy Families and Medi-Cal outreach for the state. One respondent's agency provides insurance information and application assistance via telephone operators, including Healthy Families in a county-wide program.

In our 18 key informant interviews 10 issues/barriers to Healthy Families enrollment were reported repeatedly by respondents. Some of these 10 issues included (a) perceptions and the value, and awareness of AIAN features/components of Healthy Families; (b) inadequate outreach to AIAN community; (c) administrative barriers; (d) insufficient training regarding Healthy Families; and (e) program expansion to adults. In this section we will summarize informant's responses relating to these issues/barriers as well as provide excerpts from selected interviews to illustrate key points.

Issues/Barriers of Enrollment

Of the 18 total key informant interviews, three were conducted with MRMIB personnel, three with health clinic personnel, six with individuals from AIAN-serving institutions, three from state/county agencies, and three from health insurance plans. The majority of issues/barriers identified in these interviews are amenable to intervention. A solutions section will be presented following this section.

A) Perceptions and the Value, and Awareness of AIAN Features/Components of Healthy Families

When the various stakeholders were asked what challenges their agencies faced educating, enrolling and outreaching to American Indian families, the main challenges they reported were overcoming AIAN communities' perceptions, and ensuring that premiums and co-pays were waived for AIAN families.

Perceptions of Healthy Families

Many respondents reported that AIAN families believe enrolling into Healthy Families is too difficult. One stakeholder reported,

“What they [AIAN families] may know about Healthy Families is that it’s hard to sign up.”- AIAN-serving institution

Another deterrent reported by stakeholders was AIAN’s access to free health clinics, including local tribal clinics and safety-net providers. The easy availability and access to these free clinics made enrollment in Healthy Families less attractive, and even unnecessary. AIAN families were not aware of the added value of Healthy Families coverage over the free clinics, even though Healthy Families provided additional coverage. Also, AIAN families’ preferred health care providers were frequently not on the Healthy Families plan, and provider’s hours were inconvenient.

In some communities seasonal and underemployment means that Medi-Cal and Healthy Families were very important to AIAN access to care. Job-based barriers, such as working multiple jobs or having no sick-leave benefits, were barriers to accessing routine preventative care – a major component of Healthy Families. These barriers lead to accessing health care in crisis at the emergency room, not covered by Healthy Families.

Unnecessary Premiums and Co-Pays

Another reported barrier to AIAN families’ enrollment into Healthy Families was premiums and co-payments. Although several stakeholders reported that premiums were not a barrier to AIAN family enrollment in Healthy Families, other stakeholders felt that premiums and co-pays were a barrier. One respondent reported that there would be no interest in Healthy Family enrollment without waivers for tribal members, and another reported that premiums and co-pays were offensive to some AIAN.

When asked if they had seen an increased enrollment of AIAN in Healthy Families since the implementation of the waiver program, interview respondents reported that they had not yet seen an increase, but that it might be too early to tell. Furthermore, respondents reported that there was no comparison data on AIAN enrollment and that there were too few AIAN to get a good sample in contrast to other racial and ethnic groups.

From our interviews, we found that many AIAN families were paying unnecessary Healthy Family premiums. MRMIB reported 1,170 out of 2,215 AIAN enrolled still paying premium as of June 2002 but they stated that most AIAN families are still sending in premiums. When asked what MRMIB did with the monthly premiums, they reported depositing the premiums.

B) Inadequate Outreach to AIAN Community

Given the low/slow enrollment of AIAN into Healthy Families and their lack of knowledge of the program, outreach is an important component that needs to be addressed. In our interviews with Healthy Families’ stakeholders, we discovered what challenges existed, and what outreach practices stakeholders employed to attract AIAN families.

Challenges to Outreach

There were numerous challenges to outreach reported by Healthy Families stakeholders. Among the most commonly reported challenges was: a lack of resources and staff; a lack of statistical information on AIAN families; and the absence of Healthy Families coverage for AIAN parents. The subsequent quote illustrates the need for more outreach resources, as well as more effective outreach targeting AIAN families in general:

“... It’s interesting that we implement a program that they do not market.” – Government agency

Several reported issues regarding the lack of statistical information on Healthy Families eligible AIAN. According to one stakeholder:

“[We] don’t have and have never been given data on the number of American Indians that are eligible for the Healthy Family Program. Realistically, health plans are not going to invest money in marketing to a pool of people they are not sure exists.” – Non-Indian serving institution

The above respondent also expresses the belief, shared by some health care providers, that there are too few AIAN in California to warrant targeted outreach resources or efforts. While the absolute number of AIAN children is small compared to some other groups, California has more AIAN than any other state and has treaty responsibilities to provide services to them.

Concerning the Healthy Families insurance product, a few stakeholders reported that the lack of coverage for parents had been a barrier to enrolling children. Other outreach challenges that were mentioned included a lack of coordination promoting Healthy Families (e.g., providers and tribal programs unaware of promotional materials they could use), lack of experience outreaching to AIAN populations, difficulty locating AIAN populations, the perception among some tribal members (i.e., elders) that Healthy Families was too incremental and not worth the cost, and distrust of government agencies. Distrust of government and AIAN agencies, as well as confidentiality concerns, were reported as challenges almost as frequently as the lack of resources and staff for stakeholders to serve the population. One related comment:

“There seems to be an undercurrent of distrust of IHS that has a bad spill-over effect for Healthy Families getting the word out.” – Government agency

Outreach Strategies to AIAN Families

The most commonly reported outreach strategy to increase Healthy Families enrollment was disseminating information during community events, such as pow-wows, health fairs, conferences, and school events.

“We need more outreach workers to go to reservations and educate American Indians of the health system that’s available and to gain American Indian trust.” – Non-Indian serving institution

The second most common outreach strategy was the use of advertising, such as posters and brochures. Many stakeholders used AIAN specific advertisements, while some used general advertising materials for Healthy Families. These advertisements were posted at health facilities and community events. Brochures, developed by several stakeholders, were also used

to advertise the program. Stakeholders also sent letters, newsletters and made phone calls to current members to keep them informed of program changes. One respondent reported going to a local radio station to advertise the Healthy Families waiver and another developed an informational Healthy Families video.

Another strategy the stakeholders employed was developing partnerships with other agencies and community-based organizations to pool resources, share ideas and assist each other. In one case, a tribe chose to share contact information for eligible members to a clinic for targeted outreach. Here a respondent describes a partnering approach, however, it should be noted that this strategy is not to target the AIAN community. In fact, we found little outreach to the AIAN community by non-Indian organizations, including MRMIB:

“[Our] agency has limited funding so we partner with other agencies, county offices, WIC, schools, and other CBOs.” - Non-Indian serving organization

The least reported outreach strategies were the use of incentives to increase AIAN enrollment, development of a resource center that provided resource materials including Healthy Families information, and hiring additional staff to perform outreach.

MRMIB plans to develop more AIAN specific materials but does not yet have details for this activity. In addition, MRMIB personnel attend meetings and present information to Tribal leaders and other interested stakeholders twice a year in Reno, Nevada to encourage stakeholder participation. They are considering hosting their own conferences to outreach and increase program participation.

C) Administrative Barriers

The interviewees were asked about administrative and process barriers to the program. The major areas highlighted below are: administrative problems at the MRMIB level; issues surrounding tribal heritage documentation; and issues for those people who have recently migrated to urban settings.

Administrative Problems at the MRMIB Level

The most common response was that the Healthy Families program still had enrollment and administrative process barriers. Examples of these were: AIAN receive a standard insurance card that does not indicate a \$0 co-pay as it should, which results in confusion and inappropriate co-payments at doctor's offices; the application is cumbersome; there are literacy issues for applicants; and lengthy delays in enrollment approval by MRMIB. It was also reported that AIAN clients need more explanation and assistance in completing the application process than other client groups.

“...[AIAN] need to be assisted as if you would assist your own child in doing their homework...because of the educational level of Indians ... they must be walked through the process.” - AIAN serving institution

“An applicant's experience depends on who assisted them with the application. One agency may be helpful and answer all their questions while one isn't so helpful.” – Non-AIAN serving institution

“Who knows what their federal poverty level is; these ‘cheap tricks’ to control costs make it difficult to attract people to Healthy Families. American Indians have had access to no cost insurance for over a year, but yet they’re not running to sign up for it.” – AIAN serving institution

Perspectives and Difficulties with Tribal Heritage Documentation

The interviewees were asked about their perspectives of the state imposed proof of tribal enrollment. We also asked them to describe their own experiences in assisting clients with the paperwork documentation for tribal enrollment. The stakeholders reported that in general, *any* documents and records for program eligibility is a problem. Adding the tribal heritage documentation added to the AIAN applicant’s burden and makes the Healthy Families Program less attractive.

Stakeholders also stated that they would like MRMIB to revisit the issue of documentation for the waiver; other states do not require documentation. MRMIB described that they originally did not intend to require documentation, however, they were encouraged to add this requirement at the request of tribal representatives. The representatives held concerns that non-AIAN children might be covered on the waiver if documentation was not required. This concern was not consistent with what we were told by the vast majority of stakeholders interviewed. Through follow up questions we learned that MRMIB had been given this perspective through limited consultation from primarily one viewpoint.

A secondary and critical issue was reported: if the Healthy Families program was successful, tribal leaders were concerned that the federal government might consider SCHIP to meet the U.S.’ treaty obligations to provide healthcare to AIAN. They feared this could lead to the dismantling of the Indian Health Service system of care.

“[Congress could say] See you don’t need as much IHS money.”

Furthermore, according to respondents, some AIAN families may not be willing to go through the Healthy Families enrollment process, because they insist the federal government uphold their legal right to health care through a direct process.

“There is sometimes an expectation that once they walk in the door we will provide all the services that are necessary or needed, there will be no payment on their part and that they don’t need to sign up for extra programs [because AIAN insist on their legal right to healthcare].” – AIAN serving institution

“...[American Indians] believe that health care is an entitlement and they do not have to fill out paperwork. Approximately forty percent of non-reservation California Indians of varying ages with no land base believe this to be true.”- AIAN serving institution

Process Issues with Tribal Heritage Documentation

Most interviewees found the tribal heritage documentation process complex and difficult. Difficulties included: some families had missing documents; the application did not describe the acceptable documentation; EDS had erred in processing AIAN applications; and often AIAN clinics were confused about the documentation process, including one clinic inaccurately believing they were not permitted to supply the letter of tribal heritage or assist a non-literate

person in filling out their forms. An example of missing documents was provided: some younger people have never needed paper proof of their individual tribal enrollment because they live in a household and community with grandparents or other relatives who are known in the community as AIAN.

“A person who processes applications probably doesn’t handle AIAN applications very often and doesn’t do it very well because of the infrequency.” - AIAN serving institution

All respondents and their agencies were willing to help AIAN with their tribal documentation. There were disparities in how far one clinic would go to help compared to another. Assistance they provided included: providing the standard MRMIB voucher of tribal heritage letter; advising applicants where and how to get the appropriate documentation from their tribe; and following up with the applicants if their application was pending.

“An application was rejected because the applicant didn’t provide their tribal enrollment number. But the applicant provided a letter from a federally recognized tribe. The enrollment number is not required according to the Healthy Families application [or CAA manual]. It’s stupid. On the Healthy Families application, there’s only one place where it asks if the applicant is American Indian and nothing about tribal enrollment or a number [or the waiver].” - AIAN serving institution

An inconsistent practice and structural disparity was related to access to a tribal heritage voucher letter for urban Indians. Currently MRMIB only accepts voucher letters from urban Indian organizations that receive funding from the Indian Health Service. Some urban Indian organizations were under-trained regarding their role in this process, resulting in disparities for their clientele.

However, the greatest disparity was for those urban Indians who do not live near an IHS funded clinic – a large portion of AIAN in the state. There may be non-IHS funded organizations, including state funded organizations, in their area; but MRMIB currently only accepts letters from IHS funded organizations. This creates a geographic disparity for AIAN children. Arguably for those children who need the program the most, as they do not live near an AIAN IHS funded health clinic.

People Who Have Recently Migrated to Urban Settings

AIAN who had recently migrated from a reservation did not know how to “navigate the system” in an urban setting. These people did not understand health insurance at all, and they had expectations that health services should be freely accessible, as on the reservation. It took targeted outreach, and knowledge of reservation health care delivery systems, in order to bridge this gap and enroll these people in Healthy Families or Medi-Cal.

D) Insufficient Training for Healthy Families Staff

From their responses we found that not all stakeholders had the necessary training to explain premiums and co-pays to potential AIAN Healthy Families families. When respondents were asked about Healthy Families premiums and co-pays, several did not know about the waiver for AIAN, including the AIAN serving institutions, and a few were not sure if there was a difference in premium and co-pay requirements for AIAN.

Approximately 50% of the study respondents reported receiving Healthy Families training, while the other 50% reported no Healthy Families training. Of those who did receive Healthy Families training, the majority also reported receiving training on enrollment and eligibility rules that were specific to AIAN Families; a few of those interviewed reported receiving this training from the California Rural Indian Health Board.

Only two respondents felt that training was not at all necessary, because they were confident in their understanding of the program. One commented further that they had been involved with the state's HCFA application, and therefore did not need additional training. However, we found that even these respondents were not correct in all aspects of the waiver program. As the two following excerpts illustrate, inadequate training can be detrimental to AIAN enrollment.

“Once the American Indian client is told that there is a cost many do not come back or reapply. This creates a barrier to outreach because of the conflicting [information] individuals receive.”
- AIAN serving institution

“It is very damaging if people get wrong information. It sets them back.” - Government agency

From the perspective of urban and tribal providers, the most common request was the need for additional staff to assist AIAN with the application process. Other problems respondents reported were; that Healthy Families providers do not provide culturally competent care, that getting tribal clinics interested in Healthy Families is a struggle, and that provider's are confused about covered services.

An important component of successful training is for the trainee to have a positive relationship with the trainer. When stakeholders were asked whom they would turn to if they required assistance enrolling AIAN children, the majority reported they would turn to MRMIB. However, they did not see MRMIB as being effective in enrolling AIAN children, “MRMIB has been very helpful, but not very effective.” Second to MRMIB, they would turn to the Indian Health Service, the California Rural Indian Health Board or an urban Indian health program. Respondents also reported collaborating with peers, talking with supervisors, the county program, the Center for Health Education and Advocacy, and finally the local health plan initiative.

E) Program Expansion to Adults

Note: At the time our interviews were conducted, the parental component of Healthy Families was under review by HCFA and has since been approved. However, the Governor has delayed the implementation date indefinitely due to budgetary constraints.

The interviewees were asked their views about the expansion of Healthy Families to parents. The major areas highlighted below are: their excitement and how they were planning program changes accordingly.

Respondents stated that expansion to adults was a positive addition to Healthy Families and many were “excited” to start enrolling clients. Some respondents were already informing clients of the program. The second most common response was that expansion to adults would cover current age and gender gaps.

“Fathers will have insurance for the 1st time ever.” - AIAN serving institution

“[We are] already informing families. The main point is coverage and it is the goal of [our agency] to make sure American Indian families and children get help.” - AIAN serving institution

Many agencies still need to develop program implementation plans and protocols for enrolling adults. Several respondents suggested including the Healthy Families application process in the client Registration/Intake process through a benefits counselor.

Respondents noted the need to conduct more in-reach for expanding Healthy Families to adults, including increased reliance on information technology to track clients and inform them of eligibility. Several respondents reported a need to expand the network of providers available to clients. One respondent felt that there would be no changes to the process.

MRMIB plans to revise the trainings to include the adult component. They will develop a one-page form to allow parents to be added and send out a letter to explain the program. With the expansion of the program to adults, the waiver will apply to any member of AIAN family regardless of race.

“Any member of AIAN family will get the waiver, not just one or two.” - MRMIB

Solutions/Recommendations

During the interviews respondents were asked to provide solutions and recommendations to the major barriers to enrollment. This section briefly describes the respondent’s solutions and recommendations. They are presented for both MRMIB and AIAN serving institutions to consider. In addition, two model programs that have been successful in enrolling large numbers of AIAN in Healthy Families were identified and their strategies are reported below.

Problems and Solutions

1) Problem: AIAN experience the same administrative barriers as any Healthy Families applicant.

MRMIB Solutions/Recommendations:

- Presumptive eligibility for the program
- Retroactive billing (clients are approved for waiver and billed later if documentation is not submitted after a period) for clients to date of application if approved
- Streamline the application for appropriate reading and comprehension
- Monitor and assure that AIAN applications in Electronic Data Services are processed appropriately
- Provide enhanced waiver instructions in the CAA training and manuals
- More AIAN parents do not use CAAs- provide enhanced AIAN waiver instructions for self-applications

AIAN Serving Organization Solutions/Recommendations:

- Offer case management of clients and Healthy Families application
- Colored envelopes to denote an AIAN application

2) Problem: Proving tribal heritage is a burden for applicants, more so in some areas of the state.

MRMIB Solutions/Recommendations:

- Eliminate proof requirements, as in other states
- Presumptive tribal eligibility
- More AIAN parents do not use CAAs- provide enhanced AIAN waiver instructions for self applications

AIAN Serving Organization Solutions/Recommendations:

- Allow and encourage all AIAN organizations to provide letters of tribal heritage to MRMIB

3) Problem: Half of waiver eligible families continue to send in premiums and MRMIB deposits their checks.

MRMIB Solutions/Recommendations:

- Return the checks and explain they are not required, do not accept them
- Ensure co-pays are not being collected at provider visits

4) Problem: AIAN children receive standard insurance cards listing an office visit co-pay of \$5, when there actually is no co-pay.

MRMIB Solutions/Recommendations:

- MRMIB require accurate insurance cards are provided listing the co-pay of \$0

5) Problem: The training for Certified Application Assistors regarding the waiver program is inadequate.

MRMIB Solutions/Recommendations:

- Support evaluations of the training to identify and target problems
- Revise trainings to include more about the waiver
- Increase training opportunities
- Support training of Healthy Families and EDS staff quarterly
- Support AIAN trainers for tribal and urban Indian organizations training

AIAN Serving Organization Solutions/Recommendations:

- Support training of CAA's quarterly
- Support AIAN trainers for tribal and urban Indian organizations training

6) Problems: Lack of awareness and inadequate outreach

MRMIB Solutions/Recommendations:

- Support small community grants that focus on personal communication strategies
- Develop culturally specific social marketing tools: "One poster is not enough"
- Advertise the added values of Healthy Families over reliance on safety-net providers
- Attend community events and outreach at reservations
- Fund CAAs in urban Indian organizations
- Consult with stakeholders regularly which will help gain the trust of AIAN

- Host conferences, in addition to piggybacking on other conferences
- Partner with tribes and urban Indian organizations for in-reach
- Require outreach to AIAN and other small groups by Initiatives/HMOs

AIAN Serving Organization Solutions/Recommendations:

- Tribal chairs should promote the program
- Hire eligibility staff responsible for screening clients for a variety of programs and services
- Advertise the added values of Healthy Families over reliance on safety-net providers
- Attend community events and outreach at reservations
- Consult with MRMIB regularly
- Monitor CAA staff for cultural sensitivity
- Partner with tribes and community organizations for in-reach

7) Problems: Healthy Families medical provider issues: existing hours inconsistent with need; clients have a lack of choice, especially for culturally centered care; under-trained regarding Healthy Families

MRMIB Solutions/Recommendations:

- Encourage providers to offer office hours that match working families schedules
- Provide cultural competency trainings
- Monitor and require cultural sensitivity of providers
- Improve provider information regarding the waiver

AIAN Serving Organization Solutions/Recommendations:

- Change hours to accommodate clients, specifically working parents
- Increase assessment of AIAN needs
- Improve training and benefits materials and manuals
- Provide cultural competency trainings

8) Problems: Lack of parental coverage; issues once program in place

MRMIB Solutions/Recommendations:

- Implement the waiver to entire family regardless of race, to avoid mixed household status, and reduce enrollment barriers for families of mixed tribal heritage
- Increase funding for informational technology and web based applications

Other Key Issues to Address

The majority of urban Indian clinic clients are Medi-Cal eligible-at or below 133% of the federal poverty level. This means that the organizations will need to expand their target population to a slightly higher income bracket.

By MRMIB only accepting tribal heritage letters from IHS funded organizations, they are missing many opportunities with non-IHS funded organizations, and structurally creating barriers to the program from children from some areas of the state.

Model Programs

United Indian Health Services in Humboldt County and Redding Rancheria Clinic are two American Indian health clinics that were identified by the Leader's Workshop Participants as having been successful in enrolling AIAN children in the Healthy Families program. They shared the strategies they have been using that have helped them enroll AIAN children. Both clinics reported using incentives, Certified Application Assistors (CAAs) and insurance screening to help enroll AIAN in Healthy Families. Incentives were viewed as very helpful in encouraging patients to sign up. Additionally, both clinics provide documentation of American Indian heritage to MRMIB for Healthy Families waiver eligibility.

Redding Rancheria Clinic

At the Redding Rancheria Clinic, all patients are asked to sign in before using any of the clinic's health services. During registration, patient's insurance status is determined. If a patient indicates that s/he/the child doesn't have insurance, one of the four CAAs will help the patient determine if s/he/the child is eligible for Healthy Families or other health insurance program. Once determined eligible for Healthy Families CAAs will help patients with the paperwork. If uninsured patients are missed at registration, the billing department will flag the casefiles and refer them to the CAAs who will then contact the patients and follow-up. The clinic is opened 8:00 to 6:00 p.m. and CAAs are available at those times to assist patients with enrollment. In addition to the above described *in-reach* efforts, the Redding Rancheria Clinic also conducts *outreach* in the community. Flyers are distributed to inform AIAN about Healthy Families. Staff attends American Indian functions, the Head Start program, and the monthly employee orientation at One River Casino to enroll AIAN in Healthy Families. Current enrollees also help by telling their friends and families about the Healthy Families program.

United Indian Health Services at Humboldt

Similar to the Redding Rancheria Clinic, United Indian Health Services at Humboldt also screens patients for health insurance eligibility at check-in. If patients are uninsured, one of their three CAAs will inform the patient of Healthy Families if they are eligible. CAAs are available to assist patients with Healthy Families applications from 8:00 to 5:00 p.m. The clinic advertises Healthy Families in their newsletter.

Dissemination of Project Findings

Community Meeting

At the conclusion of the research study, we held a community meeting to disseminate the findings and to receive input. Advertisement for the meeting was disseminated through flyers and e-mail correspondence. The meeting was held at United American Indian Involvement (UAI) in Los Angeles and included participants from the surrounding Los Angeles/Orange County area.

We presented some of the common issues and solutions that were raised from our key informant interviews, which participants could take back to their community to address and implement. In addition to the dissemination of our research findings, representatives from health plans and AIAN-serving institutions were present to answer questions regarding Healthy Families and how to enroll. Community members provided feedback and input. Some

comments included how pleased they felt that we identified and documented issues that they have experienced themselves. They agreed that the the Healthy Families assistor training was not standard and not effective. Many questions were asked regarding the different public health insurance programs and it was recognized that a community training on public health insurance programs, such as CHAMPS, sponsored by Healthy Families.

Stakeholders Workshop

A workshop was organized to disseminate our research findings and to create an opportunity for community leaders throughout California to share their experiences, to strategize a plan to improve healthcare coverage for AIAN children, and to build a coalition. Every tribal health program and urban Indian clinic throughout the state were invited. Participants, who were financially constrained, were given a travelling stipend to encourage a representative attendance that included members throughout California. The one-day workshop was held at the University of California at Los Angeles (UCLA).

There were 16 participants which included Healthy Families specialists from AIAN-serving institutions, health care providers, representatives from MRMIB and the DHS. These participants were well representative from throughout California; six participants came from northern California, six from southern California, two from central California, and two from Arizona. After a brief introduction of the guests we presented an overview of Healthy Families, the history of the AIAN waiver, the present implementation of the Healthy Families waiver, the issues that were raised during the interviews, and Healthy Families enrollment data. Along with the issues, solutions to improve coverage to Healthy Families for AIAN were shared as identified by the key informant interviews. Participants gave input to our study, including interpretation of data, and shared their successes and failures in outreaching to AIAN to improve health care access for this population.

Many great ideas and partnerships to improve healthcare coverage for AIAN were generated from the workshop. Plans included ways to better market Healthy Families to AIAN, improve Healthy Families assistor training to better address the waiver, evaluate the effectiveness of the Healthy Families assistor training, improve communication between various stakeholders, and identify and replicate enrollment strategies from successful clinics. A specific outcome was that an AIAN representative was identified to participate in the revision of the assistor training curriculum. Participants volunteered to take responsibility to follow up on specific agenda items they had created.

Electronic/Web Dissemination

The final study report will be available on the Center's website. An e-post card/fax announcement will be sent out to every tribal health program and urban Indian clinic throughout the state, as well as the Center's dissemination database as appropriate.

Conclusion

Federal regulations have acknowledged the unique Federal relationship with Tribal governments and the AIAN people by waiving all premiums and copayments for AIAN under the Healthy Families program. Yet we find that the implementation of this waiver has been incomplete and not effective in substantially increasing AIAN enrollment in Healthy Families. Given the fiscal

crisis in California's state government in 2002, and the impending leadership transition in Healthy Families, it is critical that attention to improving AIAN enrollment in Healthy Families not be reduced.

The California Legislature and the Healthy Families administrative unit (MRMIB) have already begun a series of program modifications that are designed to improve the coverage rate and total enrollment of Healthy Families. This responsiveness of MRMIB to the AIAN community has helped build trust in MRMIB, and the agency is seen as supportive in the community. Additional steps recommended by this research should further enhance the enrollment of AIAN children in Healthy Families. Key measures include simplifying the eligibility process under the AIAN waiver (e.g. presumptive tribal eligibility, allowing any AIAN organization provide eligibility letters, or eliminate extra documentation all together); improving the certified assistors' training and increasing the availability of certified assistors for AIANs; and increase AIAN outreach/inreach. Most of these measures can be accomplished with low cost or administrative changes to the current system. Lessons learned from targeted efforts to improve AIAN enrollment can also serve as models for other groups that evidence low enrollment rates, allowing these efforts to help improve the access to health care for all of California's low-income uninsured children.

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