The Foundation for Health Coverage Education (FHCE), a 501(c) 3 organization dedicated to helping the uninsured enroll in available health coverage programs, has conducted two surveys of more than 200,000 people nationwide that provide new guidance into the millions of Americans eligible for, but not enrolled in, government-sponsored programs. The authors delve into public health coverage enrollment issues and the pitfalls providers encounter working within the government system. The surveys’ findings, combined with FHCE’s experience working with millions of uninsured Americans and providing point-of-service insurance eligibility screenings, provide important insights to policy makers and health care leaders striving to expand health insurance access to all Americans.

A summary of the survey data was originally published by Health Affairs on Monday, May 9, 2011 entitled Public Coverage Programs: Solving the Enrollment Dilemma.

Data Updated: August 2011
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Introduction

As health care industry veterans, we follow with great interest the nation’s current quest to provide access to health insurance to all Americans. One stark reality troubles us. As the nation continues to talk about the need to provide coverage to the uninsured, research demonstrates that many already have access to free or low-cost government health coverage programs, but are not enrolling. Why not and, equally as important, what can be done to help these people more readily attain available coverage?

Policy efforts to improve access have been made. At the federal level, the Patient Protection and Affordable Care Act (PPACA) changed the rules for the private insurance sector. While some of these changes are already in effect, the PPACA also authorizes a Medicaid expansion in 2014. These changes further reinforce the need to address how public health coverage programs can be better accessed and coverage maintained now and in the future.

The outreach programs developed and research performed by the Foundation for Health Coverage Education (FHCE), a 501(c)3 organization dedicated to helping the uninsured enroll in available health coverage programs, can provide solutions for federal and state legislators on how best to increase enrollment. Specifically, as FHCE board members and staff, we propose instituting a system of point-of-service enrollment. When a person without insurance seeks treatment, a staff member could input his or her data into a site such as FHCE’s CoverageForAll.org website, check for available options, and promptly enroll the person in the appropriate public health coverage programs.
Addressing the “Elephant in the Room”

There was an alarming statistic garnered in 2002 by the Blue Cross Blue Shield Association’s study of the U.S. Census Bureau data that indicated that nearly one-third of the uninsured were eligible for government-sponsored health coverage programs yet not signed-up. In response, FHCE developed a centralized registry of health insurance system regulations and eligibility requirements across the states. The organization launched a 24/7 U.S. Uninsured Help Line and CoverageForAll.org website to help people more easily determine their health coverage options. FHCE’s Eligibility Quiz simplified the enrollment process by asking the uninsured five qualifying questions to determine a list of personalized health coverage options complete with a sign-up checklist, application and contact information for each program for which they were eligible.

Over time, the website traffic grew to an average of 80,000 visitors monthly with 13 percent taking the five-question Eligibility Quiz. To make good use of these numbers, it was decided that the organization should “keep the meter running” on the intake process in a more formalized fashion. The results of these Eligibility Quiz surveys led us to formulate the following solutions for improving the health coverage enrollment process.

CoverageForAll.org Online Survey

From September 1, 2009 to July 31, 2011, 249,867 respondents from all 50 states and Washington D.C. took the Eligibility Quiz from which our team’s findings and conclusions are drawn. The five questions sought information on the following: 1. Current insurance status, 2. Demographic information (including gender and ethnicity), 3. Household income, 4. Age, and 5. Special health conditions.

KEY FINDINGS

- **60.3 percent of respondents were eligible for government-sponsored health coverage.** Most public health coverage programs require individuals to have an income of 200 percent FPL or below or $44,700 for a family of 4 to qualify.

- **22 percent were eligible for private coverage.** This includes individual, group, or COBRA/Mini-COBRA insurance.

- **15.9 percent were eligible for high risk pool coverage.** This includes both state and the newly implemented Pre-Existing Condition Insurance Plan (PCIP) or federal high risk pools.

For a detailed illustration of additional findings, see Exhibit 1.

Point-of-Service Hospital ER Survey

Recognizing the wealth of information that could be gathered, FHCE expanded its outreach by giving the survey at point-of-service to all uninsured Emergency Room patients entering a large hospital system in California. A total of 19,549 “self-pay” or uninsured patients participated in the Point-of-Service Hospital ER Survey from March 8, 2010 through July 31, 2011. Hospital staff asked each patient the same five questions as the CoverageForAll.org Online Survey upon admission and entered the data into a unique website address. Each patient was then presented with a
personalized list of health coverage options, including a sign-up checklist and program contact information.

KEY FINDINGS

- **80.7 percent of patients were eligible for public health coverage programs.** These government-sponsored programs include the joint federal/state programs, Medi-Cal and Healthy Families (California’s Medicaid and CHIP programs, respectively), and the state’s other programs, Access for Infants and Mothers, Healthy Kids, California Kids, County Medical Services, and Restricted Medi-Cal with income eligibility requirements of 300 percent FPL or below or $67,050 for a family of 4 to qualify.

- **16.3 percent were eligible for private coverage.** This includes group coverage of 2 or more employees, individual coverage with medical underwriting, and COBRA and Cal-COBRA.

- **3 percent were eligible for high risk pool coverage.** This includes California’s Major Risk Medical Insurance Program, which is the state-run high risk pool, and the newly implemented Pre-Existing Condition Insurance Plan (PCIP).

For a detailed illustration of additional findings, see Exhibit 2.

**Getting to the Heart of the Debate**

FHCE was able to direct those eligible for government-sponsored coverage (60.3 percent of the CoverageForAll.org Online Survey and 80.7 percent of the Point-of-Service Hospital ER Survey) to multiple public programs, including Medicaid, CHIP, a variety of cancer treatment programs, and programs for pregnant women and infants.

These findings evoke two important questions at the heart of the uninsured debate:

1. Why aren’t the uninsured enrolling in government health coverage programs for which they are eligible?

2. How can the government more quickly and efficiently enroll the eligible uninsured?

There is a clear issue with the distribution channels of these public health coverage programs to the recipients who qualify. Therefore, it would seem that the primary challenge today is not simply to create new coverage, but to communicate, educate and ensure access to current programs.

Our experience, supported by FHCE’s surveys, has confirmed our belief that there are three major enrollment dilemmas with current government-sponsored health insurance programs that must be addressed in order to successfully lower the number of uninsured Americans.
Dilemma #1: Underfunded Programs

Today's economy continues to erode the availability of resources for an adequate and easily accessible delivery system. Moreover, lack of available funds at a time when people have an increased need for public programs has created even larger gaps in many current government programs. States simply do not have the funds to ensure that coverage is extended to all of those who are eligible.

There is also a significant inequity in the federal and state funding matchup of Medicaid dollars. Rhode Island and New York are budgeted to spend $8,796 and $8,450 respectively per Medicaid enrollee; Georgia and California fund their Medicaid programs at half these amounts - $3,892 and $3,618 respectively per Medicaid enrollee. This inequity in funding is the result of the individual states’ negotiations with the federal government as well as the ability of each state’s legislature to set the amount it wanted to have matched.

Dilemma #2: Bureaucratic Barriers

All states, as well as most counties, have fragmented public program enrollment processes with varying eligibility requirements and application procedures. This lack of a streamlined application process across all states makes it difficult for the average American citizen to navigate the system correctly and apply successfully. After assisting more than two million people with identifying their public health coverage options and referring the uninsured to the appropriate health coverage programs, FHCE has found that most public program application procedures are completed via telephone, the mail-in process, or in-person, with few offering the ability to apply and enroll online. For example, in California where FHCE’s Point-of-Service Hospital ER Survey was administered, Medi-Cal applicants must physically walk into a Medi-Cal office or mail-in an application to successfully enroll.

To examine the complex and ineffective application process, FHCE conducted an informal study in the Spring of 2010 requesting information and mail-in applications from the San Diego Medi-Cal Office. Of the 50 calls made over a three-month period, only 15 calls were answered and addressed. The remaining 35 calls were met by a recording that stated, “Due to an unexpected volume of callers, all of our representatives are currently helping other people. Please try your call again later,” followed by a busy signal and the inability to leave a voice message. For the 15 answered calls, the average hold time was 22 minutes with the longest hold time being 32 minutes.

This study demonstrates the troubling reality that even those uninsured who discover they are eligible for available public programs often have a difficult time getting in touch with the necessary program and navigating the enrollment process. The head of FHCE’s national call center notes that his staff has taken hundreds of calls from people who have tried in the past to enroll in programs, but who found the process so complicated and difficult that they simply quit trying.

The findings also suggest that the current challenges in enrollment may be caused by Medicaid’s past affiliation with welfare. Medicaid grew up as an adjunct to other social welfare programs, including cash assistance and food stamps. Aggressive screening procedures were designed
to avoid fraud and perhaps to deter some from enrolling. However, these archaic, paper-based procedures are now hindering people’s ability to successfully enroll. Sticking to the entrenched policies of the past distracts from developing new approaches that ensure people can enroll in government health plans simply and quickly while also safeguarding the overall system.

Dilemma #3: Poor Provider Incentives For Enrolling Uninsured Patients

Hospitals lose billions of dollars in claims per year that should have been reimbursed by the public programs for which many of the uninsured patients are eligible. This is due to bureaucratic delays in the application and reimbursement process, as well as the low-amount of compensation received from government-sponsored programs. The American Hospital Association claims hospitals across the nation lost $36.5 billion in uncompensated care due to underpayments by Medicaid in 2009.\(^3\)

In California, hospitals must apply to the state for reimbursement for the treatments provided to eligible self-pay patients within 90 days of the hospital visit. It has been the experience of the hospital system participating in FHCE’s Point-of-Service ER Survey that it routinely takes more than 90 days for the state to enroll uninsured patients into public programs. This is because it is the patient’s responsibility to apply directly to the state program to receive the needed documentation for hospital reimbursement. Once treatment is provided and the medical incident is over, it is difficult to ensure that the patient continues with the enrollment process.

If the patient does escape the bureaucratic delay and enrolls in Medi-Cal, the provider is able to request reimbursement for the patient’s claim. However, public program reimbursement is often so low that hospitals are more likely to only seek reimbursement for patients who are eligible for public coverage that fall into the “treat and admit” category rather than those patients who enter the Emergency Room with minor emergencies or illnesses. Furthermore, hospitals estimate that they receive as low as nine percent of fully-billed charges for Medi-Cal patients.\(^4\) Therefore, the providers have little financial incentive to encourage patient enrollment in public programs.

The Value of Point-of-Service Enrollment

Based on these FHCE findings, our suggestion for solving these dilemmas, as stated above, is through point-of-service enrollment. Through its CoverageForAll.org website, FHCE has demonstrated how effectively a streamlined national online system could be implemented to more efficiently enroll the uninsured when they are in need of care. When a person without insurance seeks treatment, a trained staff member could simply go to an online address, input basic patient data, check for available options, and promptly enroll the person in the relevant government health coverage programs. Point-of-service enrollment would have automated check-points for eligibility and implement a transparent system with fraud controls.

This approach would address the identified enrollment dilemmas—underfunded programs that will continue to struggle for funding; bureaucratic barriers that can be rectified using automatic, online eligibility checks; and complex enrollment procedures that can be simplified and demystified with immediate professional assistance. The final issue—Medicaid hospital underpayment leading to less interest in hospital enrollment and lack of reimbursement—will take longer to resolve. Nonetheless, with an online process able to determine automatic eligibility we predict hospitals would expend greater effort on behalf of all uninsured patients to get them enrolled.
Through point-of-service enrollment, the government could significantly reduce the bureaucratic systems that drain resources. For example, at a recent health care conference it was noted that California has 27,300 employees at an average annual cost per worker of $110,000 responsible for enrolling citizens in public assistance programs, including welfare, Medi-Cal and food stamps. If California could save $3 billion in administrative costs by simply switching to an online point-of-service enrollment system, we estimate the national savings would be equally as significant.

**Conclusion**

Despite the continued debate of the PPACA, the nation remains concerned about improving access to health care. Reforming America’s government-sponsored health insurance enrollment system would go far to address that concern. The enrollment dilemmas we have identified must be addressed before Americans will successfully be able to navigate the system.

An online point-of-service enrollment and reimbursement system would increase the accessibility of public programs, leading to direct enrollment and an increase in provider reimbursement for health care services. In addition, verification would happen quickly after point-of-service enrollment using automated check-points for eligibility and effective fraud controls.

As members of the health care industry and health policy community, we believe that federal and state government cannot simply expand public health coverage programs without addressing enrollment issues. Rather than entrenching the mistakes of the past, processes already proven to work within the health care marketplace of today must be adopted.
Exhibit 1: Detailed Findings of the CoverageForAll.org Online Survey

Total Number of Respondents: 249,867
Time Period: 9/1/2009-7/31/2011 (1 year 11 months)

Geographic Location of Respondents

U.S. BREAKDOWN BY REGION:

South: 31.9%
West: 33.1%
Midwest: 18.8%
Northeast: 14.9%

U.S. BREAKDOWN BY STATE:

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<tr>
<th>State</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Alabama</td>
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<td>Alaska</td>
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<td>Arizona</td>
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<td>Arkansas</td>
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<td>California</td>
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<td>District of Columbia</td>
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<td>Georgia</td>
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<td>Hawaii</td>
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<td>West Virginia</td>
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<tr>
<td>Wyoming</td>
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While some individuals may have entered their own information when responding to the Quiz, there are others who may have responded on behalf of their spouse or children. In addition, individuals may have taken the Quiz more than once.
**Demographics of Respondents by Group Type**

The group types listed in the graph are a major factor in determining eligibility for public coverage. There are specific programs catered to each group type. For example, the uninsured respondents who selected American Indian as a descriptor may be eligible for Indian Health Services. Undocumented immigrants may be eligible for Restricted Medi-Cal or Family PACT, depending on their exact household situation.

![Demographic Graph](image)

**Gender & Family Size**

The largest number of respondents were from a family size of 1 representing 47.1%, followed by a family of 2 representing 26.3%, a family of 4 or more representing 14.4% and finally a family of 3 representing 12.2%.

**Age of Respondents**

The majority (33.1%) are Early Retirees. They represent the group of individuals from ages 50-64, who are uninsured just before they may become eligible for Medicare coverage. According to HHS, this group is defined as "an individual, who, among other criteria, is not an active employee of an employer maintaining or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such a plan."

![Age Graph](image)
Health Status of Respondents
63% of the 249,867 respondents indicated that they had no pre-existing conditions, which is a factor in determining eligibility for private coverage.

Listed pre-existing conditions include pregnancy, serious physical or mental medical conditions/disabilities, chronic illnesses or genetic disorders, cancer, hyperalimentation, kidney dialysis, and AIDS/HIV.

Federal Poverty Level
Many public programs require that a household income fall below 250% of the Federal Poverty Level (FPL). This chart shows average FPL percentage by family size.
Income Level

Income is a determining factor for public program eligibility. The results below demonstrate that 46.9% of the 249,867 respondents had an income level between $0 and $20,000/annually.

Number of Respondents Out of Total 249,867

- $0 through $20K (Low Income): 46.9%
- $20 through $40K (Moderate Income): 30.9%
- $40 through $60K (Moderate Income): 12.4%
- $60 through $80K (Moderate Income): 4.5%
- $80 through $100K (High Income): 2.5%
- $100K+ (High Income): 2.8%

Number of Health Coverage Options Available per Respondent

98.1% of the 249,867 respondents were eligible for at least 1 health coverage option (includes public, private individual and group coverage). Additionally, 71.2% were eligible for at least 2 health coverage options.

Type of Health Coverage Programs Available to Each Respondent

- 60.3% were Eligible for Free or Highly-Subsidized Public Coverage
- 22% Eligible for Private Individual or Group Insurance or COBRA
- 15.9% Eligible for High Risk Pool Plans
- 1.9% Not Eligible for Public or Private Coverage

ii. Public coverage includes Medicaid, County Medical Services Program, CHIP, HIPP, Breast/Cervical Cancer Program, and Access for Infants & Mothers. For full details, view the breakdown of public programs on the following page.

iii. Respondents found ineligible for public or private programs because they stated that they had lost their previous coverage due to fraud of failure to pay monthly premiums.
A Deeper Look into Public Program Eligibility

45.2% of the 60.3% eligible for Free or Low-Cost Public Coverage were eligible for their states’ or the federally-run high risk pool. Health Care Reform established high risk pools in every state across the country for individuals who are U.S. citizens, have been uninsured for the last 6 months, and have been turned down previously due to a pre-existing health condition. 18.7% were eligible for COBRA coverage, which is offered to individuals who have lost their group health coverage due to a number of qualifying events, which are outlined on the Department of Labor website.

FHCE is partnered with the American Cancer Society to help lower the number of uninsured cancer patients across the country. Our Eligibility Quiz was able to refer 18.3% of its respondents to a variety of cancer assistance programs.
Exhibit 2: Detailed Findings of the Point-of-Service Hospital ER Survey

Administered in Four Emergency Rooms at Point-of-Service (San Diego County, California)
Total Number of Patients: 19,549
Time Period: 3/08/2010-7/31/2011 (1 year 4 months)

Demographics of Patients by Group Type

The group types listed in the graph above are a major factor in determining eligibility for public coverage. There are specific programs catered to each group type. For example, the uninsured patients who selected American Indian as a descriptor may be eligible for Indian Health Services. Undocumented immigrants may be eligible for Restricted Medi-Cal or Family PACT, depending on their exact household situation.

Gender & Family Size

Women represented 46% while men represented 52% of uninsured patients. This is an inverse ratio to that of the national survey of women versus men looking for coverage.

The largest number of patients was from a family size of 1 representing 49% which is consistent with the national data, followed by a family of 4 or more representing 21%, a family of 2 representing 18% and finally a family of 3 representing 13%.
**Age of Patients**

The majority, 45.4%, are “Young & Invincibles.” Much like the rest of the United States, data shows the highest percentage of uninsured patients were ages 18-34. This demographic has been named the Young and Invincibles, as many can afford an individual plan, but do not believe they will get sick or hurt.

![Age of Patients Chart](chart.png)

**Health Status of Patients**

86% of the 19,549 patients indicated that they had no pre-existing conditions prior to the accident or illness that lead them into the ER for their current visit. Review and underwriting of an individual’s health status is a major factor in determining eligibility for private coverage.

![Health Status of Patients Pie Chart](chart2.png)
Federal Poverty Level
Most government-sponsored health coverage programs in California require that a household income fall below 300% of the Federal Poverty Level (FPL). This graph of average FPL and annual income by family size shows most of the uninsured patients made less than 120% of the FPL and met many public program income requirements.

Income Level
Income is also a major determining factor for public program eligibility. Our data showed that 55.4% of the 19,549 "self-pay" patients who entered the San Diego County Emergency Rooms, both for individuals and families, had an income level between $0 and $10,000/annually.
Number of Health Coverage Options Available per Patient

Nearly all 19,549 patients were eligible for at least 1 government-sponsored or privately-provided program and 81.3% were eligible for 2 or more programs. Nine patients were found to be ineligible for public or private programs because they stated that they had lost their previous insurance due to fraud or failure to pay monthly premiums.

Type of Health Coverage Programs Available to Each Patient

80.7% were Eligible for Free or Highly-Subsidized Public Coverage\textsuperscript{iv}, 16.3% Eligible for Private Individual or Group Insurance or COBRA, 3% Eligible for High Risk Pool Plans and .05% Not Eligible for Public or Private Coverage\textsuperscript{v}.

\textsuperscript{iv} Public coverage includes programs funded by the state or federal government, including Medi-Cal, County Medical Services Program, and Healthy Families.

\textsuperscript{v} 9 of the 19,549 patients indicated that they had lost their previous insurance due to fraud or failure to pay monthly premiums, so therefore were not eligible for any sort of coverage.
A Deeper Look into Program Eligibility Options

The following graph shows the breakdown of California health coverage program eligibility. The results demonstrate that a significant percentage of patients were eligible for one or more of the public programs available in San Diego County prior to their visit into the Emergency Room. Based on lack of pre-existing conditions (see page 14), most patients were also eligible for private individual plans.

19,273 of the 19,549 patients indicated that they were from California. The 276 patients who indicated that they were from states outside of California were shown to be eligible for various programs specific to their state, including Medicaid, high risk pool programs, CHIP programs, and cancer assistance programs.

Other Public Programs includes: Indian Health Services, VA Medical Benefits, HIPP, Adult Medical Program, California Kids, California Children’s Services, Family Pact, GHPP, and the Breast & Cervical Cancer Program.
Exhibit 3: Eligibility Quiz Survey Questions

The five question Eligibility Quiz begins after the respondent/patient selects his/her state of residence and concludes with a list of personalized health coverage options, contact information for each program, approximant monthly cost, a sign-up checklist and a link to most program applications. The following are the five eligibility determination questions:

1. Do any of these apply to you?

(Patient/Respondent may choose multiple options from this list):
- You are uninsured
- Had company-sponsored insurance within the last 63 days
- Could be turned down for health insurance because of a health condition
- Lost your insurance due to fraud or failure to pay your monthly premium
- Work at least 20 hours per week and your employer does not offer coverage
- Work at least 20 hours per week and your employer does offer coverage
- Receive Supplemental Security Income (SSI) or Trade Adjustment Assistance (TAA)
- Not eligible for/exhausted your COBRA coverage
- Owner or employee of a small business with 2 or more employees

2. Which of these describe you?

(Patient/Respondent may choose multiple options from this list):
- American Indian descent
- Parent of a dependent child living in a household (or full-time student in college)
- Undocumented immigrant
- Veteran
- Woman
- Man

3. What is your family size and income?

(Patient/Respondent may select their family size and enter their income annually, monthly, semimonthly, biweekly or hourly)

4. How old are you?

(Patient/Respondent may select from a drop-down list of ages)

5. Do you have any of the following health conditions?

- Pregnant
- Medical Condition or Disability (Physical or Mental)
- Chronic illness or genetic disorder
- Cancer, hyper alimentation, or kidney dialysis
- AIDS/HIV
Sources


5. California Health and Human Services. E-mail to FHCE, Nov. 4, 2010.