

*Affordable Health Insurance:
An Examination of the Texas Children's Health Insurance Program*

By

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Chapter One

Affordable Health Insurance

They come from all different income groups, all different parts of the country, all different racial and ethnic groups as well, but, by and large, they can be low-wage and minimum wage workers. Four out of five of those without health insurance are actually in households headed by workers, and three out of five of the uninsured are full-time, full year workers, so again they tend to be people who are working but who are in low-wage jobs and in jobs that don't have - tend to have health insurance attached to it.

--Susan Dentzer, The Kaiser Family Foundation (1998)

Statement of the Problem

For the past two decades, the growth of health care spending in the United States has drastically outpaced the growth of the rest of the economy. During this same twenty-year period, the number of Americans without health care insurance rose from 2.9 million to 37.4 million (U.S. Dept. of Health & Human Services, 1996). Today, there are more than 44 million people in the United States who are without health insurance coverage (Kaiser Commission, 2000:1). By the end of this decade that number is expected to grow to at least 55 million. Thus, by 2010 one-quarter of working-age Americans and their families could find themselves without health insurance of any type (Hinds, 2000:2).

"Although the nation rejected universal health care reform in 1994, the health marketplace has been undergoing a revolution anyway, courtesy of government's restructuring of its safety net programs, a dramatic increase in the reliance on managed care, and a decline in employer-based health coverage" (Loprest, 1999:2). With profound changes in health care policies currently underway at both the national and local levels,

children have a huge amount at stake. Specifically, health care coverage for children has become particularly vulnerable.

Children are the segment of the population least able to control whether or not they are insured (Starr, 2001:1). They also are the least expensive to cover. In the aftermath of health care reform, the most significant investment the federal government has made in health care is the creation of the Children's Health Insurance Program (CHIP) (Starr, 2001:1). There are now two government programs available to lower-income, uninsured children: Medicaid, which serves our most destitute children, and CHIP, which is targeted toward kids in working-class families.

Regardless of state and federal expansions in children's health insurance programs, over 11 million children, or one in seven, still lack coverage. As of 1996, 63.3 percent (47.4 million) of children younger than 19 years had private employer-based insurance, up from 62.5 percent (45.7 million) in 1993 (Nichols, 2001:5). Despite this increase, most children without health insurance have an employed parent, who either is not offered health benefits by their employer, cannot afford to pay the premium contributions, or simply choose not to buy health insurance (Hoffman, 1999:6).

The most commonly cited reason for lack of health insurance is the high cost of coverage (Kaiser Commission, 2000:1). It is for reasons such as the high cost of coverage and loss of employer-sponsored health benefits, that people like Rose Ann Cervantes, a single mother of three young children, are faced with the dilemma of having no health care coverage for their family. The story of Rose Ann Cervantes, however, is but one example of how so many of the uninsured and their children have fallen through the cracks of our country's health care system.

When Rose Ann Cervantes, of Corpus Christi, Texas, and her husband separated in October 1999, it seemed to make sense for her and her three children, who range in age from 17 years to 2 years-old, to move in with her parents. Sharing their house would help stretch both her paycheck and her father's. Her parents could help her with her children and she could help her ailing mother with housework. For awhile, Rose Ann managed to continue the \$45-a-week payroll deductions for family health insurance, but when the premiums went up to \$70 a week, she couldn't afford to continue the coverage and still meet her family's other needs.

Without health care insurance, Rose Ann takes advantage of whatever programs she can to get her children health care. If one of the children needs to see a doctor, Rose Ann takes the child to the emergency room or to a pediatrician she has known for 14 years. Rose Ann has been trying to get all three children medical coverage through the TexCare Partnership, a new state initiative that enrolls children from families with low to moderate incomes in a variety of publicly financed health insurance programs, including the Children's Health Insurance Program. So far, she has not been able to overcome what she views as formidable bureaucratic roadblocks. "I read about CHIP in the newspaper, and I sent in an application. But then, in May, I got a letter that said we didn't qualify for CHIP, but we might qualify for Medicaid."

The letter from the TexCare Partnership had promised that someone from the state Department of Human Services would evaluate the family's application and contact Rose Ann to discuss it, but no one ever did. After two months passed, Rose Ann called to ask about the status of her application. Although the program's promotional literature claims that families can be screened for eligibility over the phone, Rose Ann couldn't get a straight answer about whether she qualified, or even the maximum income permitted for either Medicaid or CHIP for a family of four. She was told she'd have to make an appointment to come in to talk about it. Busy at work, she hasn't done that yet.

(Shirk, 2000:8-12).

It is estimated that 2.6 million children are eligible for Children's Health Insurance Program but are not enrolled (Perry, 2000:1). Participation rates in expanded Medicaid programs and state-funded programs for children suggest that states need to do a better job getting the word out to working families that a public health insurance program exists for their children (Pulos, 1998:1).

Limitations of the Study

The major limitation of this Applied Research Project is that the participants in this study represent a miniscule segment of the target population. While the study examines attitudes and perceptions among Hispanic parents, the participants in this Applied Research Project consist of only a very small number of parents eligible for, or participating in, the Children's Health Insurance Program.¹

Chapter Summaries

Chapter Two provides a detailed statement regarding the problem of the uninsured, discusses background information on the research topic, and reveals the purpose of the study. **Chapter Three** addresses the literature available on the characteristics of the uninsured—the plight of the insured from poverty to welfare, and welfare reform to health care reform. Additionally, Chapter Three describes the populations who are uninsured and those who are at risk of becoming uninsured. Who are they? How did they become uninsured? **Chapter Four** provides a detailed description of the CHIP program, with a major focus on the program as it exists in Texas. The chapter details the health care outreach efforts of CHIP as they resulted from the devolution of Medicaid to the current efforts of the Texas Legislature and the Texas Department of Health to implement health care coverage for the children of Texas.

¹ A group of five Hispanic women make up the in-person interview group, and a group of 16 Hispanic participants make up the focus group discussion.

Chapter Five introduces the conceptual framework and provides a description of the methodology used in the Applied Research Project, detailing both the strengths and weaknesses of the selected research design. Additionally, this chapter identifies the participants of the study. **Chapter Six** presents the results of the focus group data and the in-person interviews as compared to the conceptual framework. Chapter Six also provides the results of the individual interviews and discusses several unexpected consequences of the research project, concepts that were not included in the conceptual framework. **Chapter Seven** concludes the research project with a restatement of the research purpose, a summary of conclusions, and recommendations that may assist in improving the implementation and outreach efforts of CHIP. The chapter concludes with information on the current enrollment status of the Texas Children's Health Insurance Program.

Chapter Two

Caught Without Health Care Coverage

There are nearly 12 million children without health insurance in the United States. Among these children, nearly 5 million are eligible for Medicaid and another 2 million could receive coverage through their state's Children's Health Insurance Program (CHIP).

--The Kaiser Family Foundation (2000)

Introduction

The purpose of Chapter Two is to provide an understanding of the problem faced not only by our government, but by uninsured parents who are unable to provide immediate or adequate health care to their young children. The discussion of the problem focuses on the impact that welfare reform has had on parents losing health care coverage for their children, and the potential repercussions that lack of health insurance could have on children. The chapter also provides a discussion on the background of the research topic and introduces the specific purpose for this examination of the Texas Children's Health Insurance Program.

Children Without Health Insurance

In the past decade, both the decline of employer-sponsored health coverage followed by the drop in Medicaid participation have had the net effect of adding 11 million more people to the number of uninsured Americans (Hoffman, 1999:1). In 1997, nearly 60% of the uninsured in our country were from low-income families. "About half of the low-income uninsured population are from poor families (with incomes less than the poverty level). The remainder are near-poor; defined here as

having incomes between 100% and 199% of the poverty level" (Hoffman, 1999:2).

Children are less likely to be uninsured than adults, yet almost 12 million children were uninsured in 1997. Consequently, one in every four low-income children is uninsured (Hoffman, 1999:4).

The number and proportion of American children lacking health insurance increased in 1996 to the highest levels ever recorded by the Census Bureau's Current Population Survey (U.S. Census Bureau, 1999). In 1996, 15.1 percent (11.3 million) of children younger than age 19 were uninsured, up from 14 percent (10.3 million) who were uninsured in 1993 (Nichols, 2001:5). Nationwide, the increase in uninsured children is related to an enrollment decline in Medicaid rather than to a decrease in the number of children with employer-based insurance. As of 1996, 21.6 percent (16.2 million) of children younger than age 19 were enrolled in Medicaid, down from 23.5 percent (17.2 million) who were enrolled in 1993 (Nichols, 2001:5). Although the reasons for this decrease are not clear, Klein noted (2001:3) "it is likely that the strong economy has raised the income levels of many families above some current state Medicaid eligibility thresholds, and welfare reform policies have unintentionally reduced the number of Medicaid recipients."

Around the same time, the Medicaid program's coverage of poor families with children was undermined by implementation of welfare reform. Historically, welfare had been closely tied to Medicaid. For example, families who qualified for welfare automatically received Medicaid as well. The 1996 welfare reform law severed this tie, instead requiring that low-income families with children be covered irrespective of their eligibility for welfare benefits. As the states implemented welfare reform, however,

many children and parents lost welfare benefits and, in the process, lost Medicaid coverage.

At first glance, the new welfare law's impact on children's health care seems minimal since the current rules that determine eligibility for Medicaid were maintained. Upon further examination, however, it becomes evident that the new law affects children's health coverage in three significant ways:

1. Distinct population groups (certain legal immigrants and disabled children) will lose their guaranteed Medicaid coverage.
2. Since the Aid to Families with Dependent Children (AFDC) program was de-linked from Medicaid to create a new two-step eligibility process for families, there are difficulties in ensuring that all individuals have access to Medicaid.²
3. The new work requirements will increase the need for providing health care to those families who leave welfare and are working, but cannot afford health care.

(Meyer, 1996:2).

Between 1988 and 1998, the number of uninsured grew by an average of one million per year (Kaiser Commission, 2000:1). In May 1998, the Institute of Medicine Committee on Children, Health Insurance, and Access to Care reported that:

When compared with insured children, uninsured children are more likely to be sick as newborns, less likely to be immunized at appropriate ages, less likely to receive medical treatment when they are injured, and less

² Under the new welfare bill, the AFDC program was eliminated and replaced with the Temporary Assistance to Needy Families (TANF) program. Consequently, there is no longer automatic eligibility for Medicaid through either the old AFDC program or the new TANF program. Instead, states now have the option to require eligible individuals to follow separate application processes for Medicaid and the TANF program (Meyer, 1996:1).

likely to receive treatment for illnesses such as acute or recurrent earaches and asthma. . . . [T]he committee concludes that children's health insurance status is the single most important influence in determining whether health care is accessible to children when they need it.

(Newacheck, 1998:515).

Children without health insurance do not have consistent medical care and thus are more likely than those with insurance to be in poorer health—and to have trouble learning in school. "Two-thirds of uninsured children with severe sore throats and half of those with acute earaches fail to receive medical treatment" (Stoddard, 1994:1421). Additionally, children without health insurance often do not see a doctor until their health problems worsen into emergencies that endanger their lives. For example, "half of uninsured children with asthma fail to see a doctor to minimize their symptoms and thus face a higher risk of respiratory failure" (Stoddard, 1994:1421). Finally, children without health insurance are more likely to harbor long-term health problems that are costlier to treat. "Every dollar invested in preventive care saves \$10 in emergency room use, hospitalizations and treatment of learning difficulties" (Stoddard, 1994:1421).

Background of the Research Topic

The passage by the United States Congress of the Children's Health Insurance Program (CHIP) in 1997 reflected a bipartisan consensus³ that children in this country should have affordable health coverage. CHIP was designed to expand and complement the Medicaid program, which already provided health coverage for 23 million of the

³ Bipartisan consensus is a concept rarely associated with the current U.S. Congress. One policy issue, however, has drawn support from both sides of the aisle in recent years: addressing the plight of the nation's 10 million uninsured children (Starr; 2001:1).

poorest children. By building on this existing foundation, the architects of CHIP hoped to significantly reduce the number of children in the United States who had no health insurance by making from three to five million more children eligible for coverage.

After the passage of CHIP three years ago, however, most state legislatures began making much more of an effort to reach out to eligible kids. This newfound enthusiasm was partially the result of a big public relations push from the White House and health care activist groups, which were eager to spread the word about the new program (Starr, 2001:2). In addition, CHIP provided states with more money and flexibility than Medicaid. Armed with their CHIP funds, many states unfurled glossy ad campaigns, brought state employees up to speed on the fine print of government regulations, and truncated applications (Starr, 2001:2).

Despite these efforts, it's been difficult to make a significant dent in the numbers of uninsured children because there are still a large number of the minority population who are unaware of the program (Texas Department of Health, 2001). In 1997, less than half of Hispanic Americans were covered by private health insurance and one-third lacked health insurance of any sort. This is in stark contrast to the U.S. population as a whole, which has a private insurance coverage rate of 68 percent, with 17 percent uninsured (Schriver, 2000;10).

Some working families without insurance simply assume that they are ineligible for assistance because at least one parent holds a job and some fear the bureaucracy of the program altogether. For example, states with large immigrant populations, like Texas, have found that illegal residents are hesitant to enroll their children in CHIP or Medicaid, even when their sons or daughters are U.S. citizens, for fear that noncitizen family

members could be targeted for deportation or might jeopardize their opportunity to become legal U.S. residents (Families USA, 2001:2).

Although some states report that CHIP enrollment is increasing significantly, these gains have been offset by reductions in children's Medicaid coverage, largely due to welfare reform (Shenkman, 2001:10). "In 1999, two years after the passage of CHIP and three years after passage of national welfare reform, fewer children in the United States are enrolled in federally funded children's health programs than were enrolled in Medicaid alone in 1996" (Perry, 2000:11). Recently released census data for 1998 confirm that, nationwide, there has been no reduction in the number of children without health insurance coverage. The number of poor children declined in 1998, but the number of poor children without health insurance did not (U.S. Census Bureau, 1999:3).

CHIP promises to help find children who are eligible for Medicaid but are not yet enrolled. According to a recent report by Families USA (2001:2), 21 percent of uninsured children come from mixed-citizenship families. Unless program administrators can communicate to these parents that their families will not be penalized for enrolling their citizen children in government health programs, this fear could be a significant obstacle to paring down the number of children without health insurance (Starr, 2001:2). For this reason it is important that program awareness be implemented at every level of the public sector.

Statement of the Research Purpose

This Applied Research Project started with the question of whether parents are aware of affordable health insurance coverage for their children, specifically, CHIP.

Preliminary investigation of the CHIP produced the questions of whether certain people, particularly in the Hispanic population, were even aware of outreach programs such as the TexCare Partnership, Insure-A-Kid or the Texas Healthy Kids Corporation.

Ultimately, the research project focused on both exploring whether Hispanic parents were knowledgeable of CHIP, and investigating the parents' experience with CHIP.

The purpose of this exploratory study of the Children's Health Insurance Program is two-fold. The first purpose is to examine whether eligible parents are aware of the Children's Health Insurance Program. This Applied Research Project attempts to explore whether people who are eligible for CHIP coverage are aware of the program and the benefits that it could provide to their children. The second purpose is to explore participant attitudes and experiences with the enrollment process and subsequent access to health care services.

One way of assessing a program such as CHIP is to determine how confident the parents are that they can get health care coverage for their children when they need it. For purposes of this research project, it was important to investigate how CHIP was working for the parents. Specifically, the attempt of the research project is to understand the parents' experience, if any, with the CHIP enrollment process, and how they feel about access to health care services.

In the process of the literature review, it was determined that the Hispanic population continues to be underrepresented in health care reform. Additionally, the national figures for health care coverage indicate that Hispanics significantly lack health insurance for their families and young children (U.S. Census Bureau, 1999). This Applied Research Project profiles Hispanics, allowing for an examination that correlates

with CHIP awareness and CHIP participation, as well as an investigation of the specific reasons for not having health insurance coverage.

Chapter Three

The Plight of the Uninsured

By far, being able to take your children to see the doctor when they're sick is the most important thing to a parent. Right now, none of my children have been seriously ill, but I just keep hoping that this situation remains like this while I'm waiting to see if I qualify for CHIP.

-- Patricia Estrada (Austin, Texas)

Introduction

The purpose of this chapter is to review literature that provides information on conditions that contribute to the lack of health insurance for poor families and their children. The literature reviewed examines various factors that contribute to the lack of health care coverage among the poor. Additionally, this chapter discusses the disparities in health and health insurance status among poor families and their children. These disparities are discussed in terms of poverty factors, welfare reform, population demographics (racial and ethnic), and statistical information regarding uninsured children in the United States, with a primary focus on the State of Texas. Although the lack of health insurance among the poor is not a new problem to their plight, the growing number of uninsured children has become a major concern for our government. The literature reviewed reflects an emphasis of this focus.

Overview

Ensuring the health of children and families who participate in the child welfare system has become a major concern for our nation's health care administration (Hoffman, 1999:1). In the years following the Welfare Reform Act, our government has undertaken

major endeavors to implement health care coverage and promote health insurance awareness at the federal, state, and local levels (Hoffman, 1999:1). Health care coverage for all children and their families (through the Children's Health Insurance Program, Medicaid, or private insurance) has the potential of preventing American children from ever needing the child welfare system.

Children and families in the child welfare system need access to a complete range of health services. For children with extensive health care needs (including abused and neglected children, children with HIV/AIDS, alcohol- and drug-exposed children, and children with mental health and emotional problems), availability of accessible, affordable, quality health and mental health care services is essential for their healthy development and well-being (Akukwe, 2000:4).

In order to understand how health care coverage, or the lack thereof, has become such an important issue among health care administrators and the public, one needs to understand the social aspects that contribute to the problem. Many studies have indicated that poverty significantly impedes the health, growth, and development of children (Collins, 1997:4).

Poverty: What is Poverty? Who are the Poor?

"Poverty has many faces and exists under various circumstances. Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor." (The World Bank Group, 2001).

Poor people in the United States are so diverse that they cannot be characterized along any one dimension (Dalaker, 1999:v). The most commonly used way to measure poverty is based on incomes or consumption levels (Dalaker, 1999:4). A person is considered poor if his or her consumption or income level falls below some minimum level necessary to meet basic needs (U.S. Census Bureau, 1998:2). This minimum level is usually called the "federal poverty line (FPL)". The U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family, and every individual in it, is considered poor (Dalaker, 1999:5).

In 1998, the poverty rate for the United States was 12.7 percent and the number of people living in poverty was 34.5 million. In this same year, 7.2 million families were poor, and the family poverty rate was 10.0 percent. (See Table 3.1).

Table 3.1				
People Below Poverty by Age in 1998 and 1999				
Characteristic	1999 Below Poverty		1998 Below Poverty	
	Number	Percent	Number	Percent
People				
Total	32,258	11.8	34,476	12.7
Age				
Under 18 years	12,109	16.9	13,467	18.9
18 to 64 years	16,982	10.0	17,623	10.5
Families				
Total	6,676	9.3	7,186	10.0

Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000 (Numbers in Thousands)

According to U.S. Census information, in 1999, the black and Hispanic population was more likely to live in poverty than the white population. Therefore, it appears that minorities (black and Hispanics) are three times as likely to live in poverty

than the white population, since approximately 7 percent of the white population lives in poverty, as opposed to more than 21 percent of the minority population (black and Hispanics). (See Table 3.2).

Table 3.2				
Families Below Poverty by Ethnic Background 1998 and 1999				
Characteristic	1999 Below Poverty		1998 Below Poverty	
	Number	Percent	Number	Percent
Race and Ethnic Origin				
White	4,377	7.3	4,829	8.0
Black	1,898	21.9	1,981	23.4
Hispanic	1,525	20.2	1,648	22.7

Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000 (Numbers in Thousands)

Regardless of how poverty is measured or how many people we have living in poverty, the true experts on poverty are the poor. Unfortunately, many of those experts in our country are children.

Children in Poverty

Despite significant improvements since 1993, there are more children in poverty today than there were two decades ago (U.S. Census Bureau, Population Surveys, 1999). America's children are more likely to live in poverty than Americans in any other age group (Child Poverty Fact Sheet, 2001). Consequently, children have the highest poverty rate in our country.

In 1999, of the more than 32 million families living in poverty, more than 12 million were children under the age of eighteen (Dalaker, 1999:vii). Those numbers transpose to more than 18 percent of children living in poverty, in families with incomes

below the federal poverty line.⁴ Of these children living below the FPL, over 20 percent of children were under the age of six.

Poverty rates vary greatly for different racial or ethnic groups. In 1999, the child poverty rate was highest for African American (36 percent) and Hispanic (34 percent) children. The young child poverty rate follows a similar pattern: 39 percent for African American children under age six, 35 percent for Hispanic young children, and 15 percent for white young children (U.S. Census Bureau, 1999). (See Table 3.3).

	No. (000)	% in Poverty
All Children under Age 18	71,338	18.9
White	56,016	15.1
African American	11,317	36.7
Hispanic	11,152	34.4
All Children under Age 6	23,160	20.6
White	18,227	15.1
African American	3,549	39.6
Hispanic	4,160	35.8

Source: U.S. Bureau of the Census, *Poverty in the United States: 1999*, Report P-60.

Additionally, 7 percent of America's children live in extreme poverty (8 percent of U.S. children under age six), in families with incomes below 50 percent of the poverty line.⁵ Finally, 39 percent of American children live in or near poverty (41 percent of U.S. children under age six), in families with incomes below 200 percent of the poverty line.⁶ Many of the concerns of "near poor" families overlap with those of the poor, *e.g.*, the

⁴ In 1999, the poverty line was \$13,290 for a family of three. (U.S. Census Bureau, 1999).

⁵ In 1999, the extreme poverty line was \$6,145 for a family of three. (Child Poverty Fact Sheet, June 2001).

⁶ In 1999, the poverty line was \$26,580 for a family of three. (U.S. Census Bureau, 1999).

need for well-paying jobs and access to affordable quality child care and health care (Li and Bennett, 1999:1).

Poor Children in Texas

In the late 1970s, the number of poor families in Texas was 198,000. By the mid-1990s, this number had more than doubled to 423,000 (Stewart, 2000:9). In many regions of Texas, the child poverty rate has increased without relenting. Today, the percentage of Texas children in poverty exceeds the national rate. Texas ranks 42nd among the states in the percentage of children living in poverty (Stewart, 2000:11). Across three separate measures of poverty, Texas has a higher percentage of poor children than the nation as a whole. (See Table 3.4).

Table 3.4: Children in Poverty and Working Poor Families in 1998		
	Texas	United States
Children Living in Poverty	24%	20%
Children Living in Extreme Poverty	10%	8%
Children Living in Working Poor Families	31%	23%

Source: Center for Public Policy Priorities: 2001.

Among the more than 12 million children living in poverty today, more than 15% of the children are without health insurance (Texas Dept. of Health & Human Services, 2001). There are many negative effects of growing up in poverty, but the effects of inadequate health care are perhaps the most visible. As shown below in Table 3.5, children who grow up in families that are poor or near poor are more likely to:

- have no health insurance,
- lack full immunization,
- have health problems, and
- receive inadequate, if any, well-child treatment.

(Stewart, 2000:10). Thus, for the children who live in poverty, the risk of health related problems could be extremely high.

Table 3.5		
Child Health: 1998		
	TEXAS	UNITED STATES
Children without health insurance: 1998	25%	15%
Children in working-poor families who lack health Insurance: 1998	35%	23%
2-year olds who were immunized	75%	80%

Source: The State of Texas Children: 2000.

Families need support not only from the federal government, but from their communities to deal with the enormous stress caused by the challenges of poverty (Stewart, 2000:10). For this reason, one must understand the impact of welfare reform and the priority of a successful transition from welfare to work.

Welfare Reform

On August 22, 1996, President Clinton fulfilled his promise to "end welfare as we know it" by signing into law the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (Klein, 1999:1). A primary focus of welfare reform has been to ensure that parents engage in work activities. The transition from welfare to work, however, has the potential for negative consequences. Welfare reform has the potential to help or hurt children in three ways:

- (1) by changing the family income;
- (2) by changing levels of parental stress and/or parenting styles; and
- (3) by changing children's access to basic and specialized services and supports.

(Cauthen, 1999:1).

Since the passage of PRWORA in 1996, welfare programs in the United States have changed profoundly. The enactment of the PRWORA ended Aid to Families with Dependent Children (AFDC), the federal entitlement to assistance for eligible needy families with children, and created the Temporary Assistance for Needy Families block grant (TANF) to the states (Blum, 1998:4).

Foremost among the changes is the dramatic and continuing reduction in the number of individuals participating in the TANF program (as compared to AFDC). In 1998, three million families received cash assistance from TANF, a reduction of 40 percent from the caseload of five million families receiving AFDC in 1994 (Blum, 1999:8). Reductions in this caseload were attributed to PRWORA-mandated changes in immigrant eligibility and movement into the work force. Furthermore, Blum (1998:8) noted that additional reductions in TANF caseload were related to "departures due to sanctions or time limits, and reduced entries that reflected diversion programs as well as participants' reluctance to conform to TANF mandates, particularly the work requirements." In the 1990s, a strong economy and new state waiver programs had already stimulated declining enrollment in AFDC.

Texas was one of the first states to reform its welfare system. In 1995, the Texas Legislature passed landmark legislation (House Bill 1863) in advance of the federal Personal Responsibility Act of 1996. This law established time limits and required that welfare recipients work and sign a Personal Responsibility Agreement (Capps, 2001:1). To meet the goals established after HB 1863, Texas has developed a strong "Work First" message and time limits as short as one year (for the most highly educated and job ready) (Capps, 2001:1).

House Bill 1863 set forth policies emphasizing job readiness, search, and placement services. It did not, however, fully prepare families for some of the assistance they would lose in leaving the welfare rolls. For instance, families leaving the welfare rolls generally receive transitional Medicaid and child care, but only if they know about it and contact the proper child care management services agency to obtain it (Capps, 2001:6). Consequently, parents may seldom know what type of children's services they are eligible for during the transition from welfare. Therefore, the transition from welfare to work is not seamless.

Welfare to Work

In order for parents to make a successful transition from welfare to work--and to remain employed--they need access to affordable health care services for their families. While some families are doing well, many Texas families face circumstances that are too difficult to overcome on their own. Parents moving from welfare to work often find low-wage jobs that fail to provide affordable health insurance, yet pay enough to make them ineligible for Medicaid. Children's health studies that examine the move from welfare to work have found that only about one-fourth of parents moving from welfare to work have employer-sponsored health insurance (Klein, 1999:4). Consequently, almost half of women (49%) and close to one-third of children (30%) are uninsured one year after leaving welfare (Klein, 1999:4).

When recipients leave the welfare rolls, many times they move from cash assistance to low-wage jobs that do not provide employee benefits. For many families, the lack of health care is a significant drawback for maintaining employment (Cauthen, 1999:8). "[S]uccessful welfare reform policies must take into account the

needs of children when addressing the needs of parents, and the needs of parents when addressing the needs of children” (Collins, 1997:4).

Changes now being implemented in welfare policies and programs take many forms, but most of them have one thing in common--they are almost all driven by adult-focused goals (Collins, 1997:3). Two-thirds of cash assistance recipients, however, are not adults, they are children. While policymakers and program directors often recognize this fact, there is little information available to them about how to protect children and enhance their growth and development within the context of welfare reform (Collins,1997:5).

Thus, for parents to make a successful transition from welfare to work and to remain employed, their families need access to affordable health care. Having access to affordable health insurance and other basic supports, such as outreach program awareness, can increase job stability for all low-income families (Cauthen, 1999:7). Without community support and program awareness, the consequences of losing health insurance can dramatically impede the well-being of families who are trying to move into the workforce mainstream.

Losing Health Insurance

Ten million children in the United States have no health insurance (National Maternal and Health Policy Consortium, 1997). There are three ways that children lose health insurance coverage as a result of welfare reform. **First**, children lose coverage when their parents move from welfare to work and they no longer qualify for Medicaid because of their increased financial status (Klein, 1999:4). **Second**, they lose health

insurance coverage when welfare is terminated for any reason, which often results in wrongful losses of Medicaid coverage (Klein, 1999:4). Most children in families losing cash welfare, including families in which parents go to work, are probably still eligible for Medicaid, but a great number of them have been cut from the program. **Third**, families are deterred from applying for welfare because of the complicated rules for application. These enforced rules can result in children losing the opportunity for health coverage (Klein, 1999:4).

Recent health care studies show that rising health care costs continue to destroy parents' ability to purchase private health care coverage. In a 1999 national survey sponsored by the Kaiser Commission on Medicaid and the Uninsured, 41 percent of parents of uninsured children said they postponed seeking medical care for their child because they could not afford it (Hines, 2000:11). The annual increase of uninsured children is alarming.

Data collected from 1995 to 1996 by the U.S. Census Bureau indicates that more than 750,000 new children were added to the list of the uninsured (U.S. Department of Health and Human Services, 1996:108). Of these uninsured children, the majority live with parents earning more than poverty level income. The Current Population Survey estimates for 1995 (see Table 3.6 below) show the following detailed breakdown of Texas uninsured children under the age of 19 according to percent of poverty category:

Age	0-100%	101%-200%	>200%
0-5 years	128,152	144,353	103,190
6-14 years	248,008	262,312	112,061
15-18 years	147,330	88,914	92,687
0-18 years	523,490	495,579	307,938

Source: U.S. Census Bureau, Current Population Survey, March 1999

Many people who are insured, and whose families are insured, cannot understand this crisis. Nevertheless, it is important for all who are concerned to be aware of the alarming numbers of uninsured (adults and children) in our country and state, and to recognize the uninsured. For example, if large numbers of uninsured poor children do not receive childhood inoculations, the entire community could be at risk.

Who Are the Low-Income Uninsured?

The uninsured are predominantly workers and their families, many of whom have low incomes. In 1997, nearly 60% of the uninsured were from low-income families (Loprest, 1999:14). These 25 million low-income uninsured fall into roughly three equal-sized groups. (See Table 3.7).

- one-third are children;
- one-third are parents or other adults caring for children; and
- one-third are adults with no children—both single persons and married couples.

(Hoffman, 1999:2).

Table 3.7	
Low-Income Uninsured by Age & Poverty Level Groups, 1997	
Near-Poor Adults	18%
Poor Adults with Children	16%
Near-Poor Children	15%
Poor Children	16%
Poor Adults, No Children	15%
Near-Poor Adults, No Children	19%
25 Million Low-Income Uninsured	

Poor = < 100% Federal Poverty Level

Near Poor = 100-199% Federal Poverty Level

Source: Urban Institute estimates based on March 1998 Current Population Survey

The chances of not having health coverage are particularly high for minorities with low incomes. Hispanics are the highest risk for being uninsured, with 34% being uninsured in 1999. Over half (54%) of low-income Hispanic adults are uninsured (Hoffman, 1999:5). (See Table 3.8). Low-income black and white non-Hispanic adults have about the same chances of being uninsured. More than a third (35%) of low-income Hispanic children are without health insurance, compared to one in five low-income white children.

Table 3.8: People Without Health Insurance for the Entire Year by Race and Ethnicity (3-Year Average): 1997-1999			
<i>(Numbers in Thousands)</i>		Uninsured	
Characteristic	Total	Number	Percent
Total	271,641	43,427	16.0
White	223,250	32,897	14.7
Black	35,059	7,588	21.6
Hispanic*	31,755	10,894	34.3

*Hispanics may be of any race

Source: U.S. Census Bureau, Current Population Survey, March 1998, 1999 and 2000.

Hispanics today comprise 12% of the U.S. population. This same population comprises nearly one-quarter of our nation's uninsured (Brown, et al., 2000:1). Hispanic's high uninsured rate is driven in large part by lack of employer-based health care coverage, with only 43% covered through the workplace compared to 73% of whites (Brown, et al., 2000:2).

The majority of uninsured Americans are from working families. The large majority (87%) of uninsured Hispanics come from working families (Brown, et al., 2000:2). Having a full-time worker in the family, however, does not improve the chances of having health insurance coverage for low-income families. In 1999, one in every three persons from low-income families, with at least one full-time worker, had no health insurance (Hoffman, 1999:6).

The Uninsured in Texas

Texas ranks at or near the bottom nationally in the percentages of adults and children without health insurance (U.S. Census Bureau, 1999). Research on working families with incomes just above the poverty lines shows an increasing number of families in Texas who are working but near poor. Poor Texans are more likely to work, but less likely to be insured, than their peers in other states. In Texas, the majority of poor families with children have one or more working family members. Additionally, there are 663,000 Texas families with children that are living just above the poverty line (Stewart, 2000:11).

Working families at low and below-poverty income find that fewer and fewer jobs provide health insurance benefits. Low-wage workers have born the brunt of declining

employer-sponsored health insurance coverage. Consequently, low-wage workers are less likely to be offered health insurance than high-wage workers, and are less able to afford increases in premium costs, because the out-of-pocket cost to insure their families is beyond their means (Hoffman, 1999:10). "Lack of health insurance and inadequate access to health care can substantially increase the risks for children. It is estimated that one in four children in Texas does not have health insurance" (Stewart, 2000: 2).

In Texas, there are over 4.8 million persons without health insurance coverage. According to 1999 data, 25% of those uninsured in Texas were below the age of 18 (Stewart, 2000:4). Thus, in Texas alone, there are almost 1.5 million children who have no health insurance coverage. The fact that one-fourth of our state population consists of children who have no immediate benefit of health coverage is staggering.

Notwithstanding these glaring statistics of uninsured adults and children, "Texas spends less per capita than most other states on services for children and needy families and has the second largest percentage of low-income children without health insurance" (Stewart, 2000:2).

More than 500,000 impoverished Texas children are uninsured, despite the fact that most children in poverty are eligible for Texas Medicaid. Lack of outreach, public misconceptions that welfare law changes have reduced Medicaid eligibility, the "work first" policies of state agencies, and unnecessary hassles in Medicaid applications all contribute to this startling statistic.

The Role of Medicaid

Poor single parents with children are most likely to have Medicaid coverage (54%) and less likely among poor families to be insured (31%) (Hoffman, 1999:3). Medicaid coverage of near-poor adults, however, is low, covering mainly those who qualify because of pregnancy or disability (Hoffman, 1999:3).

Medicaid is the primary source of coverage for poor children, insuring nearly 60% of those with family incomes less than the poverty level. Medicaid expansions beginning in the late 1980s prevented many more children from becoming uninsured at a time when employer-sponsored coverage of dependants was decreasing markedly. Medicaid coverage of poor children has been incrementally expanded by age each year, so that by 1997 all poor children under 14 years old were eligible (Hoffman, 1999:4). Consequently, teenagers are more likely to be uninsured than younger low-income children (32 percent compared to 21 percent). Older children will continue to be at higher risk until Medicaid's age criteria for eligibility is fully expanded to all poor children by the year 2002 (Hoffman, 1999:4). (See Table 3.9).

Total	25%
Age:	
13-18	32%
6-12	23%
Under 6	21%

Source: Urban Institute estimates based on March 1998 Current Population Survey

Health Care Reform

Recognizing that health insurance is crucial to a successful transition from welfare to work, policymakers at the federal and state levels have taken steps to make sure that people leaving welfare can continue to receive health coverage under Medicaid. Since 1988, Congress has required that states provide a period of transitional Medicaid coverage to those who otherwise become ineligible due to increased income from earnings. When federal welfare reform was enacted in 1996, Congress took steps to insulate Medicaid from the new restrictions and limitations placed on welfare (Cauthen, 1999:1). In addition, the legislation gave states a new option to expand Medicaid coverage for low-income working families (Cauthen, 1999:4).

Fortunately, resources that are needed to implement the well-being of young children already exist for state and local policymakers, including:

- Increased federal funding and expanded options to provide health insurance to low-income families;
- Growing state, federal, and foundation investments in comprehensive early childhood programs and initiatives; and
- Increased funding through Temporary Assistance to Needy Families (TANF).

(Cauthen, 1999: 4)

As a result of the efforts to expand health insurance coverage, the share of the population without health insurance declined in 1999, the first decline since 1997 (Mills, 2000:1). Medicaid was the most widespread type of health insurance among the poor, with 39.9 percent (12.9 million) of those in poverty covered by Medicaid for some or all of 1999 (Mills, 2001:3). However, 10.4 million poor people still had no health insurance in 1999, representing about one-third of the poor (32.4 percent) (Mills, 2001:2). Without

child care subsidies and continued access to health insurance, families who leave welfare for work face the same barriers finding and maintaining adequate child care and health care as do other low-income working families (Collins, 1997:3).

To broaden coverage to low-income children, Congress enacted the state Children's Health Insurance Program as part of the Balanced Budget Act of 1997. The CHIP program is a historic milestone in the financing of health care for children. Not since the enactment of Medicaid has there been a greater investment in children's health care (Nichols, 2001:5). Title XXI of the Social Security Act offers an unprecedented opportunity to expand insurance to a large percentage of uninsured children (Nichols, 2001:5).

Chapter Four

Legal Setting

Uninsured children are at least 70% more likely than insured children not to have received medical care for common conditions like ear infections--illnesses that if left untreated can lead to more serious health problems. They are also less likely to receive medical attention when they are injured.

--The Kaiser Family Foundation (2000)

Introduction

The purpose of this chapter is to provide a detailed description of the Children's Health Insurance Program (CHIP). The chapter includes information on the health care outreach efforts of CHIP, as they resulted from the devolution of Medicaid to the current efforts of the Texas Legislature and the Texas Department of Health to implement health care coverage for the uninsured children. The statistical information contained in this chapter is primarily focused on the Texas CHIP.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is the product of a series of policy and political compromises and generates numerous structural and policy issues for states. CHIP entitles states to federal financial aid that will provide health assistance to targeted children, through Medicaid expansions, new program implementation, or a combination of the two. States that elect to operate CHIP programs apart from Medicaid have enormous discretion under the law to determine how they will structure their programs, the services they will cover, the form that benefits will take, and the conditions

of participation and consumer protections that will apply. Determining what approach to take, as well as how to respond to the choices posed by the statute, represents a major test of how states address the needs of uninsured children and families.

Texas CHIP

Although Texas was one of the last states to begin CHIP implementation, it is one of only five states that has implemented a simplified eligibility test for determining health care benefits for children. In Texas, CHIP provides health insurance at a very low cost to uninsured children above the Medicaid income limits, who previously had no options for affordable coverage. The upper income limit for CHIP eligibility is double the poverty income, which was about \$34,000 a year for a family of four in 1997 (Pulos, 1997:4), but has risen to \$35,300 in 2001 (Texas Health & Human Services Commission, 2001).

Like Medicaid, CHIP is provided through managed care insurance plans in larger Texas cities, but in small cities and rural areas CHIP uses a health insurance plan that requires families to use specified health care providers. CHIP is also a state-federal partnership under the TexCare Partnership. In other words, children who qualify for Medicaid must use that program. Only those who make too much (or have too many resources) for Medicaid, but are below the upper income limit for CHIP can enroll in CHIP.

Phase I of the Texas response to CHIP was a Medicaid expansion for teens ages 15-18 or below 100 percent of the federal poverty level that became effective July 1, 1998 (Nichols, 2001:5). Phase II of the Texas CHIP plan is the state's response to the federal CHIP as created by the Balanced Budget Act of 1997 (Title XXI of the Social

Security Act). Furthermore, Phase II of the Texas CHIP is a state-designed program targeted to newborns through 18 years of age at or below 200 percent of the federal poverty level, who are not otherwise eligible for Medicaid (Nichols, 2001:5).

CHIP Benefits and Services

CHIP is offered by private health plans. CHIP health care coverage is comparable to that provided to families who get their insurance through employers. The CHIP benefits package has been designed specifically to meet the needs of children (TexCarePartnership.com, 2001). Doctors, nurses, parents, and other child-health advocates worked with the state to develop this benefit package tailored to children. The Texas CHIP program offers a benefit package that covers the services most needed by children. (See Table 4.1).

Table 4.1 CHIP Medical Benefits
Hospital Care
Surgery
X-rays
Therapies (<i>i.e.</i> ,physical, psychological)
Prescription Drugs
Mental Health and Substance Abuse Treatment
Emergency Services
Eye Tests
Glasses
Dental Care
Regular Health Check-ups
Vaccinations

Source: www.texcarepartnership.com

To encourage responsible use of health care services, families are required to share in the costs of the program by paying small co-pays, premiums, and/or deductibles. Preventive health care services, however, such as well-child exams and immunizations are exempt from cost sharing.

CHIP Eligibility Requirements

In Texas, CHIP eligibility is determined according to income, family size, insurance status, citizenship status, and state residency (Nichols, 2001:3). If a child aged birth through 18 comes from a family making less than 200% of the federal poverty level (\$35,300 for a family of four in 2001) he could be eligible for CHIP. For families over this income level, limited deductions are available for day care/child care expenses. CHIP income requirements are detailed below in Table 4.2.

Table 4.2 CHIP Income Requirements			
Age of Child	Federal Poverty Level	Number of Children	Family Income (Net: Monthly)
Under 12 months	185-200%	1	\$1,325 through \$1,432
		2	\$1,790 through \$1,935
		3	\$2,256 through \$2,439
		4	\$2,722 through \$2,942
		5	\$3,187 through \$3,445
Age 12 mos. To 5 years	133-200%	1	\$953 through \$1,432
		2	\$1,287 through \$1,935
		3	\$1,622 through \$2,439
		4	\$1,957 through \$2,942
		5	\$2,291 through \$3,445
Age 6 to end of month of 19th birthday	100-200%	1	\$716 through \$1,432

Table 4.2 CHIP Income Requirements			
Age of Child	Federal Poverty Level	Number of Children	Family Income (Net: Monthly)
Age 6 to end of month of 19th birthday		2	\$968 through \$1,935
		3	\$1,220 through \$2,439
		4	\$1,471 through \$2,942
		5	\$1,723 through \$3,445

Based on Year 2001 Federal Poverty Income Guidelines.

Source: www.texcarepartnership.com

Parents have to pay some of the costs for enrollment, office visits and prescriptions, but the costs will be small (for example, \$2-\$5 co-payment for an office visit). Additionally, children who are legal immigrants are covered. Consequently, CHIP eligibility information is essential for immigrants.

While almost nine of ten uninsured children who are eligible for Medicaid were born in the U.S., over one-third live with at least one parent who was born in a foreign country (Pulos, 1999:14). Children who are legal immigrants are covered regardless of their parents' citizenship status. Nonetheless, many non-citizen family members fear adverse consequences "based in part on provisions of the welfare reform law that impose new restrictions on the ability of some legal immigrants to benefit from public programs like CHIP" (Pulos, 1999:14). For this reason it is important that non-citizen parents be aware that any eligibility information they provide will not be shared with the Immigration and Naturalization Services (INS). As noted by the TexCare Partnership on its Internet website:

Families who apply for health insurance are NOT considered “public charges.” A “public charge” is someone the INS believes depends on government benefits for support or is likely to do so in the future. If you apply for health insurance for children in your family, your ability to live or work in the U.S. will NOT change in any way.

www.texcarepartnership.com

CHIP Enrollment

To discourage employers or families from dropping existing health coverage, CHIP has established a 90-day minimum waiting period before a child can enroll in the program. If a parent involuntarily loses child health insurance (*e.g.*, as the result of a lay-off), the waiting period is waived.

When CHIP was implemented in Texas in May 2000, the program offered parents a choice of health plans. The state's goal and budgeting for CHIP enrollment in 2000-2001 was very ambitious. The Texas Health & Human Services Commission (THHSC) estimates that the average monthly CHIP enrollment in 2001 will be over 500,000, which is about 67% of all eligible CHIP children.

The number of Texas children currently enrolled in CHIP is 477,631 (THHSC, November, 2001). According to a recent survey conducted by the THHSC, this is a higher level of participation than other states have experienced in their first two years of CHIP (Shenkman, 2001:5). Because CHIP enrollment is not likely to reach the target level, the CHIP budget allocation for 2000-2001 is probably ample to cover a surge in children's Medicaid enrollment.

Families should not have to seek health care in multiple locations because their children of different ages are eligible for different coverage. Additionally, parents should be able to enroll their children in health coverage without unreasonable hassles. Finally,

enrolling children in health coverage should be made as simple as possible. One way to do this would be to allow families to complete one standard application that could determine whether their children are eligible for CHIP, Medicaid or another type of health insurance coverage.

CHIP Management and Initiative

Since the enactment of CHIP in 1997, states have invested significant resources into efforts to find uninsured children and enroll them in either Medicaid or CHIP. More recently, some states have begun to provide Medicaid and CHIP to low-income working parents and to include those parents in their outreach efforts. Due, in part, to these efforts, the number of uninsured children declined modestly between 1998 and 1999 (Klein, 2001:1). In order to maintain a positive trend in health insurance enrollment and participation, states must take steps to help children and their parents keep Medicaid and CHIP coverage once they are enrolled.

As noted by Gauthier (1997:3), states will need to develop plan selection criteria, rate-setting methods, and contract monitoring procedures. In addition, states that contract with multiple plans will need to consider how families with children select among the plan options, how to allocate enrollment for those who do not select a plan, and whether rates for different plans should be adjusted for possible differences in the costs of serving the children in their plans (Gauthier, 1997:3). States should also consider the adequacy of existing Medicaid provider systems and whether using managed care plans will disrupt existing care patterns for uninsured children (Gauthier, 1997:4).

Although reports indicate that CHIP is reaching uninsured children in lower-income families whose income levels previously made them ineligible for public coverage, there are still a large number of the minority population who are unaware of the program (THHSC, 2001). In order to assess the early progress of CHIP and to understand the effects of welfare reform on the health coverage of low-income children, one must understand the community reaction to CHIP, its enrollment process, and its service provisions.

Chapter Five

Conceptual Framework and Research Methodology

I'm trying go get off assistance so I'm trying to get on this CHIP, which is not really looked at as the same thing as Medicaid. I'm trying to pull myself out of being dependent on "the system" for support.

--Patricia Estrada (Austin, Texas)

Introduction

Chapter Five introduces the conceptual framework for this Applied Research Project and describes the selected research methodology. The framework focuses on outreach program awareness, enrollment procedures for health insurance coverage, and access to health care services. The methodology is discussed in terms of the research design, strengths and weaknesses of the selected methodology, and the use of the selected research design. Also included in this chapter is the linkage of the conceptual framework to the research mode of inquiry (see Table 5.1).

Conceptual Framework

The research for this project is exploratory and incorporates loosely defined categories as its conceptual framework.⁷ Included in the framework are categories that pertain to program awareness, enrollment procedures, and access to health care services. The linkage between the loosely defined categories and the literature sources is illustrated below in Table 5.1.

⁷ The categories for the Conceptual Framework are in no particular order.

Individual states vary with respect to changes in numbers of uninsured children based on state economic conditions, state Medicaid eligibility levels, outreach and enrollment activities, welfare reform policies, and the availability of other state health insurance programs. Many families leaving welfare rolls are unaware that their children continue to be eligible for state-assisted health care coverage.

Outreach Program Awareness

Implementing outreach program awareness has been a major effort of our government and health care administrators. Two-thirds of the nation's uninsured children could be covered by either Medicaid (45%) or CHIP (20%) under current income eligibility levels (Kaiser Commission Fact Sheet, March 2001). Through the assistance of outreach programs such as the TexCare Partnership and the Texas Healthy Kids Corporation, contracted community-based organizations, program awareness for CHIP has dramatically increased since the initial implementation of the Texas CHIP in May 2000.

All qualifying Texas families with uninsured children are eligible for assistance in getting health insurance coverage through such outreach programs as TexCare Partnership. Effective outreach is key to the success of both CHIP and Medicaid in improving health coverage to children.

Enrollment Procedure

The enrollment procedure can sometimes be a drawback for eligible children and families. Many parents who have never tried to enroll their children do not know that their child qualifies for coverage and may lack the knowledge on how to apply (Perry, 2000:viii). Parents often feel that gathering all of the required documentation is tedious. Some parents consider that the enrollment process is too complex. Additionally, many parents have never applied for health care assistance because they felt that the process took too long (Perry, 2000:vi).

Federal procedures for CHIP and Medicaid enrollment require a periodic eligibility review. Medicaid regulations require individuals to report changes in eligibility-related circumstances in a timely and accurate manner (Klein, 2001:3). Until recently, most states reviewed eligibility several times a year for families and children enrolled in Medicaid. Some families considered this procedure a nuisance and, therefore, would forego the enrollment process. Federal CHIP regulations issued January 11, 2001 have reduced the eligibility review requirement to at least once every 12 months for separate state CHIP programs (Klein, 2001:3). For children, many states have eliminated the requirement of frequent eligibility reviews.

Access to Health Care Services

Health insurance affects access to health care as well as the financial well being of families (Brown, 2000:1). Because so many of the uninsured are from low-income families, access to health care services is often a barrier for implementing health care coverage. Poor uninsured children have markedly worse access to care than poor

children with Medicaid or private coverage (Kaiser Commission Fact Sheet, March 2001). Uninsured children are at least 70% more likely than insured children not to have received medical care for common conditions like ear infections, a common illness that can sometimes lead to more serious health problems. These same children are also 30% less likely to receive medical attention when they are injured (Brown, et al., May 2000:2).

Racial and ethnic groups, including both children and adults, differ in their access to health care services. Uninsured Hispanic children are twice as likely as white children to have no usual source of care (32% versus 16%) (Brown, et al., 2000:2). High uninsured rates impede access to care for Hispanics, but access disparities also persist between insured Hispanics and whites (Brown, et al., 2000:2). There are a number of barriers to health care for Hispanics including:

- Hispanics tend to work for small, low-wage businesses that do not offer insurance.
- Individual insurance is prohibitively expensive.
- Not enough information is available about currently existing programs, such as TexCare, the state's Children's Health Insurance Program (CHIP).
- Cultural and linguistic barriers exist both in interactions with physicians and the paperwork required for public assistance.
- Hispanics are concerned about being labeled a public charge if they use public assistance.

(Schriver, 2000:12).

Table 5.1. Linking the Conceptual Framework to the Literature and the Modes of Inquiry

Category	Research Method	Discussion Topics	Literature
Outreach Program Awareness <ul style="list-style-type: none"> • Tex-Care Partnership • Texas Healthy Kid Corporation • Insure-a-Kid 	Focus Group Individual Interview	<i>Knowledge of outreach programs; attitudes and perceptions</i>	Bost, 1998 Capps, 2001 Cauthen, 1999 Hinds, 2000 Morton, 1998 Shenkman, 2001
Enrollment Procedures <ul style="list-style-type: none"> • Process Time • Client Service • Comprehension of Information • Eligibility Review 	Focus Group Individual Interview	<i>Experience with enrollment procedure; attitudes and perceptions</i>	Capps, 2001 Hinds, 2000 Hoffman, 1999 Klein, 2001 Perry, 2000
Access to Health Care Services <ul style="list-style-type: none"> • Financial Barriers • Non-Financial Barriers 	Focus Group Individual Interview	<i>Experience with health care access; attitudes and perceptions</i>	Brown, 2000 Cauthen, 1999 Hoffman, 1999 Klein, 1999 Klein, 2001 Shenkman, 2001

Methodology

The Research Design

As earlier noted, the purpose of this research is to explore whether Hispanic parents are knowledgeable of CHIP, and investigate the parents' experience with the program. The research design selected for the Applied Research Project is a combination of self-contained focus groups⁸ and face-to-face interviews. The key design of self-

⁸ The initial design for this research project was solely focus groups. A letter was sent to the target population, which was the parents at San José Catholic Church in Austin, Texas, inviting their participation in this study. There were, however, no responses received from this initial target population. Consequently, it was determined that face-to-face interviews would also be relative to the research project. Thereafter, a different target population was solicited from a group of adult students in an English-as-a-

contained focus groups is not the absence of other methods of research, but their ability to use the data collected from the focus group interviews as "a sufficient body of knowledge" (Morgan, 1999:21). Furthermore, "focus groups have been used with poverty programs to assess current services and explore the types of programs that are most effective" (O'Sullivan, 1999:42).

Although enacted by Congress in 1997, CHIP has only been implemented in Texas since May 2000. Thus, research regarding the effectiveness of the program remains new and the use of focus groups is appropriate to explore the impact and implementation of the program. "The principal benefit that focus groups have to offer to a project based on participant observation is a concentrated insight into participants' thinking on a topic" (Morgan, 1997:3). Individual or face-to-face interviews allow researchers to ask more complicated or sensitive questions and perform in-depth probing (O'Sullivan, 1999:187). Additionally, when the goal is to learn about the informant personally, then the in-person interview offers a great advantage to gathering this detailed information (Morgan, 1997:11).

Uses of Focus Groups

Focus groups are useful for exploratory research when little is known about the topic of interest. David Morgan (1997) cites other basic uses of focus groups for social science research. These basic uses include research of self-contained methods, where focus groups are the primary method of collecting qualitative data. Another use of focus groups can be to provide supplemental data to the research project. "For example, they

Second Language class in Grand Prairie, Texas. There was a sufficient response received (16 respondents) to conduct the focus group discussion with this alternate target group of participants.

can be used to generate survey questionnaires" and also be a source of information that supplements vague survey results (Morgan, 1997:3).

Strengths of Focus Groups

In comparison to other types of research, focus groups provide a number of advantages. Focus groups provide an opportunity to collect data from a group of people in a short period of time and are more feasible than interviewing each individual separately. The use of focus groups allows the researcher to interact with the participants, which provides the opportunity to get clarification of answers and probe for more information to responses. For exploratory research purposes, such as this project, focus groups allow for group interaction in which participants “can spark a lively discussion among themselves without much guidance from either the researcher’s questions or the moderator’s direction” (Morgan, 1997:40).

Another strongpoint of focus group research is that it provides the researcher with an opportunity to collect data from groups discussing the topics that are of interest to the researcher (Morgan, 1997:16). The hallmark of focus groups, however, is the group interaction (O’Sullivan, 1999:193). This type of interaction can produce information and give insight to the research that would otherwise not easily be collected by another research technique, such as the individual survey.

Weaknesses of Focus Groups

The small number of participants used in focus groups limits the generalization to the larger population and the “group itself may influence the nature of the data it

produces” (Morgan, 1997:15). Additionally, Morgan states, “The group’s influence on the discussion can also raise questions about the ability of any particular set of participants to discuss a particular topic” (1997:15).

In addition, the moderator may bias the results by knowingly or unknowingly providing cues about what types of responses and answers are desirable (Morgan, 1997:14). Two problems exist with the interaction of the group participants with one another and with the researcher: (1) group member response is not independent of one another, thus restricting the generalizability of results; and (2) group member response may be biased by a very dominant or opinionated member. Furthermore, the data collected in focus groups may be difficult to summarize and interpret due to the qualitative and open-ended nature of the responses (Morgan, 1997:18).

Selection of Focus Group Technique

The general purpose of the study was to explore individuals' perceptions and attitudes regarding CHIP awareness and the CHIP enrollment process. Due to the exploratory nature of this research project, the focus group methodology was identified as the most appropriate research tool. In addition, the occurrence of group dynamics in the focus group may encourage members of the group to contribute their perspective based on their own experiences. The focus group technique is well suited for those participants who had only a limited amount of time to contribute to this research project. Use of the focus group technique enabled the researcher to gather data in a short amount of time and at a more feasible cost than conducting several individual interviews.

Implementation of Focus Groups

In order to access this information, it was determined that the most appropriate method of investigation for this fairly new program, CHIP, was to target low-income minority families.⁹ As earlier noted, the initial attempt was to establish two or three focus groups from San José Catholic Church in south Austin. The San José parish consists largely of low-income, minority parishioners. The parish has over 4000 registered families. According to information obtained from Rev. Kirby Garner, pastor of San José Church, 99% of the registered families (over 22,000 members) are of Hispanic origin.

Parents of children enrolled in the Religious Education program at San José Church were invited to participate in the group discussions. A letter was distributed to parents with children enrolled in the religious education program for this parish.¹⁰ (*See Appendix "A"*). As earlier noted, this researcher was unable to acquire sufficient responses from the parents who were invited to participate in the study. Consequently, an alternate focus group was selected.

When no response was received from the initial focus group target population, it was decided that conducting in-person interviews would be an appropriate and beneficial alternative form of research methodology. What resulted was an enlightening experience for both the researcher, the focus group facilitator, and several of the participants.

⁹ In Texas one in four persons is Hispanic, and 40% of the Hispanic population in Texas is uninsured. (Schriver; 2000:14).

¹⁰To the researcher's dismay, none of the parents, except for one, responded to the invitation to participate in the focus group discussions.

The women who participated in the focus group discussion were students of an English as a Second Language (ESL) class taught at an elementary school in the Grand Prairie Independent School District.¹¹ The facilitator for the focus group discussion was Lucy Cantu.¹² The focus group participants consisted of sixteen people from the ESL class. Of these sixteen participants, seven members were parents of children enrolled at the elementary school that was the sight of the focus group discussion. The other nine participants were from different areas of Grand Prairie and their children attended different schools.¹³

In addition to the focus group discussion, a brief questionnaire consisting of CHIP eligibility factors was distributed to the participants. (*See Appendix "B"*). The confidential questionnaire serves as a means of providing demographic information about the research participants. This information is evaluated and the data included in **Appendix "C"** of this study. Furthermore, the questionnaire was implemented as an exploratory tool that attempted to provide information relative to the experience of the participants in connection with health care outreach program awareness, CHIP enrollment, and access to health care services.

¹¹ The ESL class consisted of 22 men and women. The class was informed that the research project was part of a study being conducted to complete a college course. The class was also informed of purpose of the research study. Thereafter, all 22 of the ESL class members were invited to participate in the discussion. All but six of the class members volunteered to participate in the study.

¹²Lucy Cantu is an independent educational consultant, who also has experience in health care management and has worked extensively with the cities of Dallas, Grand Prairie and Laredo. She currently works as an educational consultant on a contract basis with the Grand Prairie Independent School District.

¹³The native country for all of the participants in the group is Mexico. The ages for the focus group participants ranged from the 20's to the 40's. There was, however, a grandmother, a woman who appeared to be in her 60's, who was the legal guardian for 4 of her young grandchildren who attend elementary school.

The questions for the focus group interview are included in this report and are attached as **Appendix "D"**. The transcript from the focus group interview is attached as **Appendix "E"**.

Individual Interviews

The in-person interviews were conducted with five different women. Two of these interviews were audio-taped. The other three were conducted without the use of an audio recorder.¹⁴ All of the individuals interviewed were women with young children who would be eligible for CHIP coverage.

The first mother interviewed was Jeanette Valdez. Ms. Valdez was the only mother to respond to the letter sent to the parishioners at San José Catholic Church. Ms. Valdez is an employee of the City of Austin Health Department, working for the WIC program at the south Austin facility. She is a single mother of four children (two of the children are eligible for CHIP coverage). The interview with Jeanette Valdez is attached as **Appendix "F"**.

The second mother interviewed was Patricia Estrada. Patricia is a 25 year-old working mother and single parent of 4 young children, who range in age from 2 to 8 years-old. Although Ms. Estrada works as a legal secretary, she cannot afford the high premium of dependent health care coverage offered by her employer. While she has, in the past, been eligible for Medicaid coverage, Ms. Estrada is trying to become independent of public welfare. The transcript from the interview with Patricia Estrada is attached as **Appendix "G"**.

¹⁴ Of the three interviews that were not taped, two were conducted in-person, the third was conducted over the telephone.

The third mother interviewed, Mary Lou Rodriguez, is a working mother and wife. Her children range in age from 4-years to 13-years old. Two years ago, her husband developed an unexpected and debilitating illness. Consequently, he lost his job and health care benefits for himself and his family. The interview with Ms. Rodriguez was not taped, however, her comments have been incorporated in the results tables.

Two additional women, Johnnie Mata and Cordelia Mendoza, were also interviewed. Ms. Mata is a non-working mother with four small children. Although her husband is employed, his company does not offer health care coverage. She currently is enrolled in Medicaid. Ms. Mata's interview was conducted over the phone. Cordelia Mendoza is a single parent and working mom. Ms. Mendoza's interview was conducted in-person. Neither of these two interviews was audio-taped, however, the women's comments are included in the results tables.

Interview Guidelines

In this applied research project, there was no pre-constructed interview guideline or survey. The interviews, however, were guided by the concepts outlined in the conceptual framework. "When the basic issues are poorly understood or existing knowledge is based on researcher-imposed agendas, then an unstandardized interview guide will provide the opportunity to hear the interests of the participants themselves in each group" (Morgan, 1997:40). Therefore, for purposes of this research project, group discussions and individual interviews made it easier to conduct less structured interviews. Table 5.1 above illustrates the linkage of the conceptual framework to the method(s) and sources used to conduct the research.

Chapter Six

Results

It's very important to eliminate the stigma of welfare and of considering health insurance welfare, because families who are working are very proud of what they are doing, and while they want to provide health care for their children, they don't want to feel like this is public assistance.

--Jeanette Valdez (Austin, Texas)

Introduction

This chapter discusses the results of the focus group interview and the in-person interviews. The results of these interviews, which are the individuals' perceptions and attitudes, are analyzed with respect to the key concepts of this study: **program awareness, the enrollment process, and access to health care services**. Included at the end of this chapter (See Table 6.4) is a selection of the interview questions and response excerpts from the individual interviews.¹⁵

Results from the study showed that lack of insurance is perpetuated by the difficulty in filling out forms as well as a general lack of knowledge of the program(s) and program eligibility. These obstacles not only increase the burden of the uninsured, but also put the health of children in jeopardy.

Program Awareness

The examination of the research data revealed that 30% of the participants were familiar with CHIP. Although the majority of the mothers in the focus group interview

¹⁵ When the participant has authorized that their name be used for purposes of this research project, the name will follow the excerpt.

were unaware of the outreach programs, the participants who were familiar with CHIP had heard of CHIP either on the radio or seen advertisements for the health insurance on the television. (See Table 6.1).

While all but one of the mothers who participated in the one-on-one interview had heard of CHIP, none of the mothers had their children actively enrolled in CHIP during the time of this investigation. As a result of this study, two of the mothers who were interviewed have been in contact with CHIP representatives. The CHIP representatives are working to expedite the applications and enroll the qualified children of the candidates in the health insurance program.

Table 6.1 Results Pertaining to Program Awareness	
Category	Outreach Program Awareness <ul style="list-style-type: none"> • TexCare Partnership • Texas Healthy Kid Corporation • Insure-a-Kid
Focus Group	None of the participants was familiar with any of the outreach programs.
Individual Interview	All of the women interviewed were familiar with at least one of the outreach programs. Three were familiar with the TexCare Partnership. One was familiar with Insure-A-Kid. None of the individuals were familiar with Texas Healthy Kids Corp.
Comments:	
<i>I initially saw signs about CHIP along with Insure A Kid around the DHS office when I would go to my appointments and then I started seeing it advertised almost everywhere. Then I saw the commercials on TV about TexCare Partnership.</i> --(Anonymous)	

CHIP Enrollment Process

Results from focus group discussion showed that many people eligible for CHIP coverage did not sign up for the insurance because they did not understand the process.¹⁶ The reasons for lack of insurance range from losing health insurance coverage to not wanting to go through the hassle and time-constraints of applying for CHIP coverage. Those participants who indicated that they were aware of CHIP often stated that the process of having to apply for Medicaid first and then reapply for CHIP coverage was frustrating. (See Table 6.2).

In some uninsured families in which children might qualify for CHIP coverage, the bureaucratic obstacles of the application made some parents hesitant or unwilling to follow through the enrollment process. Additionally, the uninsured are sometimes wary of government-funded insurance programs for which they may qualify because they feel that their residence in the United States may be in jeopardy. In my interview with Jeanette Valdez, she stated:

Their lawyers or other friends have told them they can't qualify or they shouldn't ask anything from the government. They're afraid to come and ask to be put on WIC because they feel that it's part of government. And, if they qualify and they get put on WIC, there's a chance that they might not get their papers. Which is not true. We don't report that. Just like CHIP doesn't. . . . So, it's a lot of misinformation that they're getting. It's just we have to talk to them and tell them that we don't report this. And I think CHIP has to do the same thing. Once it's a government thing, they feel like okay, I can't apply for this because I'll be deported or I won't be able to get my papers. Because what they want to see is that they can stand on their feet and they can support themselves.

¹⁶ Only two participants in the focus group were enrolled in the CHIP program. It was evident by the responses on the questionnaire, however, that each of the participants who had children was eligible to receive health coverage assistance from CHIP.

Table 6.2 Results Pertaining to Enrollment Procedures	
Category	<p>Enrollment Procedures</p> <ul style="list-style-type: none"> • Process Time • Client Service • Comprehension of Information • Eligibility Review
	Perceptions and Attitudes
Focus Group	<p><i>Depends on the type of assistance. Because when I got CHIP coverage, I got it primarily because I had an emergency. At that time, I had no insurance. . . . I completed the application and then brought the paperwork that I needed to bring. I was told that when I qualified, I would pay coverage. But in two months, no, one month, I had insurance.</i></p> <p><i>I have been sent various applications from CHIP. But, I haven't sent them back because my husband was not working. But the second time, I did fill one out. However, when I was waiting for the response, then the wait was a long time. . . . Now, it's been over a month. And I have a feeling that I'm not going to qualify because of the situation with my husband. Because he's the one who had insurance when he was working, but now that he's lost his job, we have no insurance.</i></p> <p><i>I finished completing the application. I mailed it in. And in two weeks they responded and requested additional information. They also told me that it hadn't been a long enough period that I'd been without insurance. But, then after my time without insurance had passed, then the process was rapid.</i></p>
Individual Interviews	<p><i>You call Insure-A-Kid. Get together your paperwork. You fill it out and send it to them. They want to know if you've had Medicaid within the last 3 months. And you tell them yes. Then, they want you to go back to Medicaid. Reapply for it all over again. And get a denial paper from them. Which is a hassle. I have had moms tell me, and even myself, have done this. Where you ask them how much of the guidelines and how much do you have to qualify in order to keep your children on Medicaid? And some of them will tell you. So when they know this they won't go back and reapply, especially if they know about the money amount. So when they go and try to apply for CHIP, CHIP wants them to go through the process all over again of applying for Medicaid. Get the denial. And send it to them. Which is more of a hassle because when you go to DHS, it's about a four-hour wait.</i></p> <p>(Jeanette Valdez)</p>

Table 6.2 Results Pertaining to Enrollment Procedures	
Individual Interviews (Cont'd)	<p><i>The enrollment process seems like a lot of paper work. I mean that they tell the parent it's a simple one-time application. But they don't tell you that you need to go back and apply for Medicaid first. They shouldn't say that it's just one application, if it's not.</i></p> <p>(Johnnie Mata)</p>
	<p><i>I applied the first couple of weeks in July. And the next I heard was in August where I got sent this letter to answer these three questions because they were reviewing my application. Or you could call the number and answer the questions. So, I did that. I called the number and then I found out from the person there that I shouldn't even fill this out because they still need proof of my income. So, then I had to fax proof of income. . . . And they said that was all that they needed. So I faxed that on the 17th of August. So this is like probably a month and a half after I applied. And since that date, I haven't heard anything back.</i></p> <p>(Patricia Estrada)</p>

Access to Health Care Services

The first indicator of health care accessed was linked to financial barriers. The findings of this study revealed that many of those participants who were without healthcare coverage found that in certain instances it was more feasible for them to take their children to a health care provider outside of Texas (*i.e.*, Mexico). Some of the mothers indicated that treatment for their children was less expensive in their native country. (See Table 6.3). Other participants noted that they felt more comfortable with a doctor who was familiar to them and who knew their child's medical history. For these participants who felt that it was less stressful to take their children to clinics in Mexico, they indicated that even the cost of driving from their homes to the doctor was more beneficial to them.

The second indicator of access to health care related to non-financial barriers. It was learned that for many mothers it was not only the location of the health care facility that was a barrier for them, but also the length of time that they spent waiting for treatment. (See Table 6.3). Mothers who are single parents with full-time jobs often felt pressured by having to take the time away from work.

During an interview with one of the individual participants, it was learned that she had children with special needs.¹⁷ She indicated that often it was difficult for her to leave work to take the children for their treatments. In her case, the treatment process was lengthy and required that she be away from work for several hours. (See Table 6.3).

Women in the focus group were asked if the health care assistants and providers in their clinics were able to communicate with them in their primary language, Spanish. The responses to this query were overwhelming favorable, and one participant even noted that the bilingual communication abilities of the health care workers often surpassed those of the patient. (See Table 6.3).

¹⁷ Three of the children are asthmatic and require the use of a nebulizer to assist them in their breathing.

Table 6.3 Results Pertaining to Health Care Access	
Category	<p>Access to Health Care Services</p> <ul style="list-style-type: none"> • Financial Barriers • Non-Financial Barriers
	<p>Perceptions and Attitudes</p>
Focus Group	<p><i>For instance in my situation, I don't go to any doctor here. I always go to Mexico to see the doctor. When I need to take my children, because I'm a single parent and I have no help here and feel that no one can help me with my children's insurance . . . so, instead I go to Mexico. Sometimes, my family there can help. But very little.</i></p> <p><i>. . . Because it's too expensive here. See, my problem is that I had already taken my children to the doctor over there (in Mexico) and they have their records there. And over there the examinations are less expensive. Even though you spend money to go to Mexico, it's still a big difference in what I would pay here and what I pay over there in doctor's fees.</i></p> <p><i>Si, todo los Americanos aprenderon Engles. Yes, all of the Americans in the doctor's office learned how to speak Spanish so they could communicate with their Hispanic patients. Wherever you go, it seems like most of the doctors do know how to speak Spanish. Some, more than the Mexicanos.</i></p>
Individual Interview	<p><i>You see my youngest is two. So, she's already past that where they get the earache every couple of months and they get, you know all that stuff. . . They have to take a nebulizer treatment. . . So, I've had to take them in for that and also just for check-ups and stuff.</i></p> <p>-- Patricia Estrada</p> <p><i>For me, it is very hard when I have to take my children to the doctor. I don't have a car right now and rely on the bus or friends to take me places. When I have to take my babies to the doctor, I try to take them all at once, unless it's like an emergency or something. The clinic isn't close enough for us to walk. The bus ride isn't easy with little kids--especially when one of them is really sick.</i></p> <p>-- Anonymous</p>
Individual Interview (cont'd)	<p><i>I don't have any problem with access to medical service. But, my kids are on Medicaid so I just take them to the clinic. Also, Medicaid offers patients rides to the clinic. We have only one car, but if my husband can't take me, I can always ask a friend. But it's comforting to know that if I need a ride, I have one.</i></p> <p>-- Johnnie Mata</p>

Summary of Findings

Overall, the focus group participants were not familiar with CHIP. Only 20% of the participants had heard of the program. These parents had enrolled their children in the program. The individual participants, on the other hand, had at least heard of CHIP.

None of the participants from the focus group or individual interviews were familiar with the Texas Healthy Kids Corporation. All of the individual participants, however, had some knowledge of either the TexCare Partnership or Insure-A-Kid outreach program.

The enrollment procedure for CHIP was described as frustrating for those individuals who were trying to get coverage under the program. The mothers felt that the process was invasive, lengthy and, in some instances, vague. The overwhelming response by the participants, however, was that the process was a “hassle.”

As for their attitudes toward health care services, 70% of the participants felt pleased with the accessibility and service of their health care facilities. Some of the individuals in the focus group expressed a preference for taking their children to clinics in their native country of Mexico, however, these parents did not have their children enrolled in CHIP. Overall, all of the participants expressed satisfaction with the staff and treatment they received at the health care clinics.

Conclusion

The interviews and the focus group discussions were instrumental in this exploratory research project. While the initial attempt to target a specific population of

parents from south Austin did not garner the response expected, or in fact, any response at all, the result of interviewing the women from Grand Prairie was extremely productive.

After the focus group discussions were conducted, Ms. Cantu, who had been the moderator for the discussion, contacted health management representatives in Dallas and Grand Prairie. She currently is working with an outreach program at a Dallas hospital in an effort to implement a health care awareness seminar for parents with CHIP-eligible children.

Additionally, one of the mothers that was interviewed has now applied for CHIP coverage.¹⁸ Another participant has been able to make direct contact with a CHIP representative in an attempt to expedite the enrollment process and get health insurance coverage for her children.

Finally, and perhaps one the most rewarding outcomes of this Applied Research Project, the church parish that was the initial target for focus group participants is looking into the possibility of conducting a seminar for parents of children who may be qualified for CHIP coverage. The reaction by the parish administrators and religious education coordinators of the church to the lack of the parents' response to participate in this study was one of both disappointment and concern.

After a meeting with Anne Dunkelberg, a policy analyst from the Center for Public Policy Priorities in Austin and co-author *The State of Texas Children: 2000*, she provided me with contact information for coordinators and program directors of CHIP outreach programs in Austin. Thereafter, a meeting with the Director of Insure-A-Kid

¹⁸ This is a woman whom I have known for several years. Her husband lost his job due to a sudden and deteriorating illness. Consequently, she and her children were without health coverage. In a casual conversation, I told her about my Applied Research Project and CHIP. Thereafter she completed the CHIP application and is currently awaiting a response from Insure-A-Kid.

and other outreach program coordinators was scheduled for December 8, 2001. This initial meeting will begin the coordination efforts for a CHIP awareness program at San Jose Catholic Church.

Table 6.4 Interview Questions and Selected Excerpts from Responses	
<i>Attitudes and Perceptions</i>	
Q:	Are you familiar with the Children's Health Insurance Program?
<u>RESPONSE 1:</u>	<p><i>I was vaguely familiar with the program before I met with the representative, but I still had a number of questions to ask. I met with the representative and although she answered my questions, she was very condescending. She spoke to me like I didn't know anything at all and as if it was an inconvenience for her to be wasting her time with me. At one point during the meeting, she began discussing her credentials and some of the awards she has received. I don't know why, but I felt like she was implying that being a TANF representative was beneath her. Overall, I am pleased with the program, but not very impressed with the staff.</i></p>
<u>RESPONSE 2:</u>	<p><i>I heard about it from several school bulletins at the beginning of the school year. I then called and got some additional information and filled out an application. I have yet to hear back from them although they did say it could be at least six weeks or so to be approved. I'm keeping my fingers crossed that it is approved. You mentioned about having to apply for Medicaid before the CHIP program. I was unaware of that since nothing was ever mentioned when I applied.</i></p>

Table 6.4
Interview Questions and
Selected Excerpts from Responses

Q: If your children do not have health care insurance, can you tell me why?

RESPONSE:

"It's not worth it. I have him on a dental plan, and he's on the insurance plan through school during football season, but otherwise I can't really see the sense (nor do I have the money) in paying money for insurance that never gets used. My son hardly ever goes to the doctor. I've been told that I make too much money to qualify for most plans, but don't really make enough money to get an individual plan and pay for everything else. Most doctor's will take payments."

Q: Can you tell me about your experience with the CHIP enrollment process?

RESPONSE NO. 1

"I applied the first couple of weeks in July. And the next I heard was in August where I got sent this letter to answer these three questions because they were reviewing my application. Or you could call the number and answer the questions. So, I did that. I called the number and then, I found out from the person there that I shouldn't even fill this out because they still need proof of my income. Cause whatever I had been doing wasn't good enough or something. . . . And they said that was all that they needed. So I faxed that on the 17th of August. So this is like probably a month and a half after I applied. And since that date, I haven't heard anything back. " -- (Patricia Estrada)

RESPONSE NO. 2

My experience with any type of social service has been a disaster that made me feel, "I don't need it that bad." My children are all small and I am working trying to make ends meet. I am recently divorced and I am having to do what I have never done before . . . that is to humiliate myself by asking for public assistance. I didn't get the health care insurance. The person interviewing me for assistance use a calculated outline with income as a guide and I was over their guidelines. She no more wanted to hear of any hardships that I was facing. After being told that I didn't qualified, I got mad for the lack of knowledge and experience and training the person interviewing me had. . . . This employee belittled me making me feel like I was worthless. I did it for my children. From that point on I made up my mind that I would work 3 jobs if I had too but I would never go into any kind of program sponsor by the state or government. Being of Hispanic origin, I can say that I am fortunate enough to know to speak and write in the English language and I could make a point across. I have more education than most people looking for assistance for their children and if this is the treatment they receive then no program will ever be successful.

Table 6.4
Interview Questions and
Selected Excerpts from Responses

Do you currently have access to adequate health care services?

I do have access to health care service, but I still don't have insurance coverage for the kids. So it's a matter of being able to afford the doctor's bills. My husband lost his job last year and I had to go back to work. My employer paid for health insurance, but I was only part-time. I would take the kids to the clinic near my mom's house which was more affordable. I never thought that I would be in a situation like this--where I had to worry about whether or not my kids get sick and then whether I'd be able to afford to take them to the doctor. The kids are all in school right now and I'm waiting to see if I can qualify for CHIP. I can't afford to pay the \$450.00 that it cost under my employer's health insurance plan.

How do you feel about the health care access for your children?

RESPONSE 1:

I wish that it wasn't so difficult to get health care for my children. It doesn't matter how accessible the facility is if a person doesn't have insurance or the money to pay for their kid when she's sick, well . . . most doctor's won't see you. You can't go the emergency room for just regular check up or a simple earache. That's when you know that things aren't so easy--when you have to see your baby crying when it's ill.

RESPONSE 2:

The doctors and staff at my regular clinic are very qualified. For me it's a matter of not having my children covered by insurance. This is what is the most frustrating for people in this situation, we have to look for affordable health care. Right now, while I'm waiting to see if I qualify for CHIP, I'm trying to find an affordable place to get my 14-year old daughter immunized. I tried taking her to a clinic someone told me about that does vaccinations. I went after work because I was told this clinic stayed open until 7:00 p.m.. I got there right at 5:30 and the receptionist was closing the window. I was so upset because I thought they would accommodate me since they were supposed to be open late. But, no. She was very rude. So for me, this would not be acceptable service or care from a health care facility.

Chapter Seven

Conclusions and Recommendations

You can pick up a million people here, a million people there, but you can't really do something to -- in a concerted way -- get health insurance coverage into the hands of many people. If the primary reason people don't have health insurance is that they can't afford it, that problem is obviously not helped -- indeed, it's made much worse as health insurance continues to grow more and more expensive.

--Susan Dentzer, The Kaiser Family Foundation (1998)

Introduction

Chapter Seven discusses the main conclusions that resulted from the Applied Research Project and offers several recommendations based on the results of the investigation on how to better implement CHIP awareness, not only among the Hispanic population but in the state of Texas as well. The chapter also provides suggestions for certain strategies for successful health care reform and implementation of affordable insurance. Finally, concluding remarks are offered in this chapter, along with a statement reflecting the current enrollment status of participants in the Texas CHIP.

Restatement of the Research Purpose

The purpose of this exploratory study of the Children's Health Insurance Program is two-fold. The first purpose is to examine whether eligible parents are aware of the CHIP program. This Applied Research Project attempts to explore whether people who are eligible for CHIP coverage are aware of the program and the benefits that it could

provide to their children. The second purpose is to explore participant attitudes and experiences with the enrollment process and subsequent access to health care services.

In the process of the literature review, it was determined that the Hispanic population continues to be underrepresented in health care reform. Additionally, the national figures for health care coverage indicate that Hispanics significantly lack health insurance for their families and young children (U.S. Census Bureau, 1999).

This Applied Research Project profiles Hispanics, allowing for an examination that correlates with CHIP awareness and CHIP participation, as well as an investigation of the specific reasons for not having health insurance coverage.

Summary of Conclusions

Two principal conclusions emerged from this study. **First**, it was discovered that overall, the participants in this study were familiar with CHIP. Unfortunately, while the majority of the participants had heard of CHIP, most of them did not have their children enrolled in the program. **Second**, it was determined from this study that many people feel uncomfortable with coming forward and applying for CHIP coverage.

An interesting point made during one of the interviews was that Hispanic people tend to have a lot of pride and often are not comfortable with discussing their personal problems. This may be a reason that the parents from San José Church did not respond to the initial focus group solicitation.

Another point that was brought forward in an interview was that many people from the Hispanic culture hesitate to ask for public assistance, either because of personal pride or because they are uncertain about the procedures for some of the public assistance

programs. Consequently, they may not come forward to participate in programs such as CHIP. In order for CHIP to serve those qualified people who are not participating in the program, outreach and enrollment efforts must address barriers such as cultural differences.

The focus group discussion and individual interviews suggested several reasons that uninsured children do not obtain public coverage. The reasons included confusion about the eligibility criteria, frustration with the enrollment process, the negative image associated with enrolling in a program so closely linked to welfare, and concerns about the quality of health care services available through public programs. An additional issue for immigrant families in Texas was the concern that enrollment could threaten their immigration status. Informing the parents who participate in public assistance programs like WIC or public school lunch programs that their uninsured children are eligible for public coverage may be one part of the solution.

Recommendations

During the individual interviews, each participant was asked to make a recommendation for improving the enrollment process for CHIP. The recommendations herein include both the researcher's and individual participants' suggestions.

First, the various outreach programs such as TexCare Partnership and Insure-A-Kid should seek to allow the use of certified enrollment specialists to enroll persons in CHIP at area schools, churches and local health and welfare offices. By doing this, it would perhaps eliminate the lengthy process of enrollment and avoid some of the confusion connected with the Medicaid guidelines.

Second, the Texas Department of Human Services should be required to develop training opportunities for non-English speakers and representatives of different cultures in Texas communities to become enrollment specialists. The availability of a culturally competent enrollment specialist to streamline the enrollment process would be a beneficial to the outreach programs for those parents eligible for CHIP.

While it appears that health care access is not a cumbersome issue for the parents, in certain populations, increasing access to health care would be helpful. This would be particularly helpful to non-English speaking immigrants who may not feel that the health care services in Texas are able to adequately accommodate their medical needs.

People performing these jobs have to be trained that they are public servants and should never treat anyone as if they are giving handouts. Like I told those people at the welfare office, I have worked all my life to pay taxes to allow someone else to receive needed public services. Personally, when I hear of new programs I feel for those that have to turn to them because I really haven't heard anyone say that the procedure is any easier, that those taking the applications are any friendlier. You hear that millions are allocated, but to me the administration is the one that benefits from such programs, not the poor.

--Cordelia Mendoza (Austin, Texas)

Third, the CHIP advertisements need to be more explicit. One of the suggestions made by an individual participant was that CHIP should be more forthright its message regarding the simplicity of the application. The participant was specifically referring to requirement of having to first apply for Medicaid before enrolling in CHIP. She said that CHIP made it sound like all that the parents have to do is complete one simple application. Yet, when they fill out the application, they are told that they must determine if they qualify for Medicaid. Many of the participants expressed frustration with this part of the enrollment procedure.

A **final** suggestion for CHIP implementation would be to offer retroactive coverage for women and children who are present with a medical condition to any licensed health care provider. If the person with the medical condition satisfies the requirements for Texas CHIP coverage, they would receive coverage benefits for that initial visit.

Successful Health Care Reform

While health care reform has been a national dilemma in our country, there are no clear-cut solutions to alleviating the problem. "Success in reducing the number of uninsured children in the years to come will require not only reaching out to the 11.1 million who are now uninsured, but retaining coverage for the millions of children currently insured by Medicaid as well" (Pulos, 1999:2). Because so many uninsured are from low-income families, the success of any new policy to expand health coverage largely depends on how well it addresses the barriers to health insurance faced by the poor and near-poor (Hoffman, 1999:9).

It is important to bear in mind that eliminating barriers to enrollment is only the first step in providing health insurance coverage and assuring access to health care services for low-income children and their families. Advocates of CHIP and existing Medicaid programs need to make the enrollment process more family-friendly (Pulos, 1998:1). Once enrolled, it is essential that parents learn about their health care choices and how to navigate the system to access care (Perry, 2000:24).

Common strategies such as communication strategies, help for families in financial crisis due to welfare program changes, cross-training initiatives, improved

program and systems coordination, and community-wide monitoring systems need to be implemented to achieve the goal of health care reform, which is to provide coverage to all people in our country (Collins, 1997:5). Efforts to understand the interaction between programs, map potential and real effects, and make necessary changes in policies and program structures must be ongoing. Success in reducing the number of uninsured children in the years to come will require not only reaching out to the 11.1 million children who are now uninsured, but retaining coverage for the millions of children currently insured by Medicaid as well (National Maternal and Child Health Policy Consortium, 1997:2).

Concluding Remarks

The problem of the uninsured in our country does not appear to be one that can be resolved with any one program or by one single Act. As more and more people are faced with the possibility of losing health care coverage, it will become even more important to find a method to provide affordable health care coverage not only to the impoverished uninsured, but also to those who recently have lost their jobs and are seeking private health insurance coverage.

The quality of early childhood experiences has an impact on children's growth and development and on their future life chances. State and local welfare reform efforts have the potential to affect children's growth and development significantly (Collins, 1997:3). Health care reform that takes this fact into account and works to improve the lives of families in holistic ways, holds the greatest promise of success for this and future generations (Collins, 1997:3). Nonetheless, Medicaid and CHIP programs face a

challenge if they are to succeed in reducing the number of children without health insurance.

Every child deserves a healthy start in life. As emphasized in this Applied Research Project, without health care coverage, children are at greater risk for disease and lack access to preventive health care services or treatment. Consequently, affordable health insurance is imperative not only for our children, but for all people.

To date, the estimated number of children enrolled in Texas CHIP is 477,631 (Texas Health & Human Services Commission, November, 2001). According to a recent radio announcement on News Radio KLBJ590 (Austin, Texas, October 25, 2001), the CHIP program is nearing its enrollment capacity. It is estimated, however, that there are still thousands of children in Texas who remain without health insurance. The challenge ahead for implementing affordable health insurance lies in making these programs like CHIP work effectively, as insurers of low-income children (Perry, 2000:24).

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www.texcarepartnership.com

www.worldbank.org/poverty/mission

(The World Bank Group: Understanding Poverty)

APPENDIX "A"

Rossana A. Barrios

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September 25, 2001

Dear Parent(s):

I am a fellow San José parishioner and a graduate student at Southwest Texas State University. I am completing my graduate work this semester for a Masters in Public Administration. Currently, I am working on a research project for which I would like to request your assistance. Parents of children ages 18 years-old and younger are invited to participate in the focus group interviews for this Applied Research Project.

The topic of the research project is "**Affordable Health Insurance: An Examination of the Texas Children's Health Insurance Program.**" There are two purposes for this research project. The first purpose is to examine whether parents of eligible children are aware of the CHIP program. Therefore, even if parents are not familiar with CHIP, participation will still be helpful to the research project. The second purpose is to explore the attitudes and experiences of the parents with the CHIP enrollment process and access to health care services.

The interviews will be conducted in small groups and the discussions will be open-ended, so that parents can freely give details of their knowledge and experience of CHIP. All information will be kept personal and confidential. Consequently, **all participants will remain anonymous** and the names of the parents **will not** be published in the report.

If you are interested in participating in this research project, please contact me at any of the telephone numbers listed above or at my email address. The deadline for your response is **Friday, October 5, 2001.**

Thank you for your consideration. I look forward to meeting you.

Very truly yours,

Rossana A. Barrios
San José Parishioner & SWT Graduate Student

APPENDIX "B"

Questionnaire

*Information provided in this document is privileged & confidential.
Please do not write your name on this document.*

Determining Eligibility: *In Texas, CHIP eligibility is determined according to income, family size, insurance status, citizenship status, and state residency.*

What is your monthly household income?	\$	
How many members in your family?		
How many children?		
How many of your children are under age 18?		
	YES	NO
Do you and/or your spouse have health care insurance?		
Do your children have health care insurance?		
Are you a U.S. citizen?		
Do you legally reside in Texas? (<i>You are not a U.S. citizen, but are authorized to live in the U.S.</i>)		

Outreach Program Awareness

	YES	NO
Are you familiar with the TexCare Partnership outreach program?		
Are you familiar with the Texas Insure-A-Kid program?		
Are you familiar with the Texas Healthy Kids program?		
How did you learn about these programs? [CHECK ALL THAT APPLY]		
Newspaper___ Radio___ Television___ School___ Church___ Friend___ Other___		

Enrollment Procedures

	YES	NO
Are you familiar with the CHIP enrollment process?		
Did you understand the application?		
Was the application too long?		
Was the CHIP representative able to answer your questions?		
Was the CHIP representative courteous?		
Was the application offered to you in English and Spanish?		
Did you feel that you were treated fairly in the enrollment process?		

Access to Health Care Services

	YES	NO
Do you think that your current health insurance plan is affordable?		
Is the cost of your child's doctor visit affordable?		
Do you speak English?		
Does your provider or someone in their office speak Spanish?		
Is the doctor's office in a convenient location for you?		
Are you able to travel to/from your health care provider's office?		

APPENDIX "C"

Focus Group & Individual Participants

Demographic Profile

All of the participants in this study are of Hispanic origin.

1. Monthly Household Income

Less than \$500	5%
\$1,000 - \$1,500	70%
\$1,501 - \$1,999	20%
\$2,000 - \$3,500	5%

2. Household - Number of Members in Family

2 members	5%
4 members	15%
5 members	25%
6 members	50%
7 members	5%

3. Children - Number of Children in Family

1 child	5%
2 children	25%
3 children	15%
4 children	35%
5 children	20%

4. Number of Children Under 18 years of age

1 child	5%
2 children	25%
3 children	15%
4 children	35%
5 children	20%

5. Health Insurance - Participant and Spouse

75% of the participants reported not having insurance for either their self or their spouse.

6. Health Insurance - Children

90% of the participants reported having no health insurance for their children

7. Citizenship

70% of the focus group participants reported that they were not a U.S. citizen.

100% of the individual participants were U.S. citizens

8. Legal Residency in Texas

98% of the focus group participants reported that they legally reside in Texas.

100% of the individual participants legally reside in Texas.

APPENDIX "D"

Interview Questions

1. Are you familiar with the Children's Health Insurance Program (CHIP)?
2. If you are familiar with CHIP, can you tell me how you learned about the program?
3. Are your children enrolled in CHIP?
4. If your children are enrolled in CHIP, describe your experience with the enrollment process.
5. If you are not enrolled in CHIP, do your children have coverage under another plan?
6. If your children do not have health care insurance, can you tell me why?
7. Do you currently have access to adequate health care services?
8. How do you feel about the health care access for your children?

APPENDIX "E"

TRANSCRIPT FROM FOCUS GROUP DISCUSSIONS
(Translated from Spanish to English)

Facilitator: Lucy V. Cantu

Respondents: A group of 16 Hispanic women (most of the women are non-English speaking)

FACILITATOR:

Do you understand that this is voluntary and not mandatory? You do understand?

RESPONDENT(S):

Si. Yes.

FACILITATOR:

Okay. The first question is "Are you familiar with the Children's Health Insurance Program." They call it CHIP. I'm going to write it here on the board. It's called the Children's Health Insurance Program. The short name is CHIP.

Are you familiar with this program? Yes or no?

RESPONDENT(S):

{Hearing responses of yes and no}.

FACILITATOR:

Someone said yes. One person. Anyone else?

RESPONDENT(S):

I said yes. (Someone else is saying "I said no.")

FACILITATOR:

Okay, you're not? You're familiar? Two persons?

RESPONDENT(S):

Yes.

FACILITATOR:

Okay, but two persons are familiar? Okay. The second question is are you familiar with the TexCare Partnership Outreach Program? {Facilitator is writing out the name of the outreach program on the board}. This is the name of an outreach agency. Are you familiar with this program. Yes or no?

RESPONDENT(S):

No. (All responding at once).

FACILITATOR:

Okay. Next question. So nobody is familiar with this other program?

RESPONDENT(S):

No.

FACILITATOR:

Okay so you're not familiar with this program. You haven't even heard about it on the radio?

RESPONDENT(S):

No-no.

FACILITATOR:

Okay. Next question. Are you familiar with the Texas Insure-A-Kid program? {Writing the name of the program on the board.}

RESPONDENT(S):

No. (All answering at once).

FACILITATOR:

No one? Okay. Another question.

Are you familiar with the Texas Healthy Kids program? **Texas. Healthy. Kids. Program.** (Facilitator is writing this on the board--repeating one word at a time). This is the program for Texas children without insurance.

Yes or no. Are you familiar with this?

RESPONDENT(S):

No.

FACILITATOR:

Okay. The next question is . . . Two of you were familiar with CHIP. Are your children enrolled in CHIP? One, yes? Are your children enrolled in CHIP?

RESPONDENT(S):

No.

FACILITATOR:

Okay. The rest of you no. If your children enrolled in the CHIP program. . . .

RESPONDENT(S):

No. No. (hearing several "no" responses at once.).

FACILITATOR:

Okay. One yes. Okay the rest of you no. Okay. If your children are not enrolled in CHIP, do your children have coverage under another plan?

RESPONDENT(S):

Some answering no. Some answering yes.

FACILITATOR:

How many yes. (Counting: 1-2-3.) That are under another insurance plan? Three. The rest of you don't have any (insurance)?

RESPONDENT(S):

No.

FACILITATOR:

So . . . (Facilitator is counting 1 thru 12). Twelve who are not insured-twelve who are not insured.. One does not have a child. Actually, two. Ms. Bustamante you don't have any children, correct?

RESPONDENT(S):

No. (She does not have children).

FACILITATOR:

Okay. So, (laughing) . . . Two of you do not have children. Okay of those of you who are familiar with CHIP. You say your child is in CHIP. If you don't mind answering this question. What was your experience with the enrollment process? Did you feel the process was too long? Was the process too quick?

RESPONDENT(S):

Depends on the type of assistance. Because when I got CHIP coverage, I got it primarily because I had an emergency. At that time, I had no insurance. They gave me the application for CHIP. I called. No, I didn't call. They gave me another appointment right after I picked up the application. I went. I completed the application and then brought the paperwork that I needed to bring. I was told that when I qualified, I would pay coverage. But in two months, no, one month, I had insurance. But for the emergency, I could not use my insurance. I didn't have to pay for the emergency treatment right away. However, I did have to pay once I was qualified for CHIP.

FACILITATOR:

So, they didn't charge you for the emergency, but when you signed up for CHIP, then they did charge you? But the enrollment process, did it seem long to you?

RESPONDENT(S):

No, because at the time that I filled out the application I was told to complete it and you will be qualified.

FACILITATOR:

So, that was at the emergency? So they told you that your process would be speedy.

RESPONDENT(S):

Yes.

FACILITATOR:

Okay. Anyone else who is covered under CHIP. Okay, but if you have any comments, please speak up because my tape is about out. (Laughing).

RESPONDENT(S):

Okay. (Respondents laughing).

FACILITATOR:

Okay.

RESPONDENT(S):

I have been sent various applications from CHIP. But, I haven't sent them back because my husband was not working. But the second time, I did fill one out. However, when I was waiting for the response, then the wait was a long time.

FACILITATOR:

How long has it been since you sent the form in?

RESPONDENT(S):

Now, it's been over a month. And I have a feeling that I'm not going to qualify because of the situation with my husband. Because he's the one who had insurance when he was working, but now that he's lost his job, we have no insurance.

FACILITATOR:

And he was the one who provided the family's insurance. And the first CHIP applications you were insured?

RESPONDENT(S):

Yes. And I filled out the application indicating that we had insurance but they did keep sending me applications. And, when he lost his job. I filled out the form and provided all the paperwork. But, now I haven't heard anything back at all.

FACILITATOR:

And now this is a big concern for you?

RESPONDENT(S):

Yes.

FACILITATOR:

How were you treated by the CHIP representatives.

RESPONDENT(S):

I was treated very well. They were very courteous.

FACILITATOR:

Very courteous. Was this all by telephone?

RESPONDENT(S):

It was by telephone and all soon in person.

FACILITATOR:

The persons that you talked to on the phone. How did they treat you?

RESPONDENT(S):

Very well.

FACILITATOR:

Do you feel that you were given adequate attention?

RESPONDENT(S):

Yes.

R:

Okay.

FACILITATOR:

Did you feel you were treated fairly?

RESPONDENT(S):

Yes. I think so. But, I have to say that sometimes I've called over there and have been treated indifferently.

FACILITATOR:

Okay.

RESPONDENT(S):

I finished completing the application. I mailed it in. And in two weeks they responded and requested additional information. They also told me that it hadn't been a long enough period that I'd been without insurance. But, then after my time without insurance had passed, then the process was rapid.

FACILITATOR:

So, it was processed quickly. Do you have to reapply next year?

RESPONDENT(S):

Yes, we have to reapply yearly.

FACILITATOR:

Okay. Each year you have to renew your insurance coverage.

RESPONDENT(S):

Yes.

FACILITATOR:

Okay. Did you understand the enrollment form? Did you understand what they were asking?

RESPONDENT(S):

Yes.

FACILITATOR:

Was the form or were the forms available to you in Spanish?

RESPONDENT(S):

Yes.

FACILITATOR:

Was the information explained to you in detail so that you could understand the process?

RESPONDENT(S):

Not exactly, on the form. But we did receive a lot of information in the mail, both in English and Spanish. And that gave us the opportunity to read the information before we completed the application.

FACILITATOR:

Okay. But you understood the process, right?

RESPONDENT(S):

Yes.

FACILITATOR:

Were you informed that you need to be reviewed at least once a year to renew your eligibility in the program?

RESPONDENT(S):

Yes.

FACILITATOR:

Two say yes? Okay. Did you feel the review was unfair or inconvenient?

RESPONDENT(S):

For me, I thought it was fine. I went in for the review and basically nothing was different in my information, so in an hour. I spent an hour talking to the representative and I was told that if I wanted to, I could change to another program. But, that seemed to me. . .

FACILITATOR:

You mean change to a different agency?

RESPONDENT(S):

Yes, to a different agency (outreach program), but the same insurance (CHIP). But, there was no inconvenience on my part.

FACILITATOR:

So you feel like everything was fair?

RESPONDENT(S):

Yes.

FACILITATOR:

Yes. And it was convenient? You still don't have to renew for eligibility? (Facilitator is looking at a different participant for response).

RESPONDENT(S):

No. I'm still under my current year of the plan.

FACILITATOR:

Okay. Now this question is for everyone and if you can, please respond. If you currently do not have access to health care services, what are the reasons? So, please take your time and think about this for me. Please be sincere about your concerns and responses.

RESPONDENT(S):

Well, I . . . my husband had insurance through his job. But, he the company changed health care providers and then the insurance was much more expensive. Then, we couldn't afford the coverage under the new health care carrier.

FACILITATOR:

So, the new insurance was more expensive?

RESPONDENT(S):

Well, my husband does have insurance through his job and we are all covered under his plan.

FACILITATOR:

So, you guys do have insurance?

RESPONDENT(S):

Yes, we do.

FACILITATOR:

Okay, so as far as you are concerned, this question doesn't really apply to you because you still have insurance, right?

RESPONDENT(S):

Yes.

FACILITATOR:

The persons who don't have insurance coverage or who don't go to health care providers, I want you to tell me your reasons. Why don't you go to a doctor or to the clinic?

RESPONDENT(S):

For us, my husband also had insurance before. But, his company changed carriers and they also were asking for more in coverage payment. {Cannot hear tape}. Then, at the time, we had only one child. But we were still concerned about something happening to our son.

FACILITATOR:

So, for you also the coverage was too expensive.

RESPONDENT(S):

Yes. After that, we didn't have insurance.

FACILITATOR:

So, right now, you don't have any insurance of any kind? But, when you need medical services, where do you go?

RESPONDENT(S):

Well, I pay if we need to go. If we take the children, I pay.

FACILITATOR:

So you pay directly to the provider? Okay. Anybody else? Any of you go to a medical facility, clinic?

RESPONDENT(S):

Yes. (Several people answering yes at once).

FACILITATOR:

You pay directly out of your pockets?

RESPONDENT(S):

Yes. (Several people responding at once).

FACILITATOR:

But, you don't have insurance of any kind?

RESPONDENT(S):

No. (Several people answering at once). No, of any kind. For instance in my situation, I don't go to any doctor here. I always go to Mexico to see the doctor. When I need to take my children, because I'm a single parent and I have no help here and feel that no one can help me with my children's insurance . . . so, instead I go to Mexico. Sometimes, my family there can help. But very little.

FACILITATOR:

Okay. Does anybody else take your children to Mexico when they need medical services?

RESPONDENT(S):

I go to the dentist. Every year.

FACILITATOR:

To the dentist? Only to the dentist? Nobody else here takes their children to the doctor in Mexico?

RESPONDENT(S):

Um-hum.

FACILITATOR:

Okay, Olga?

RESPONDENT(S):

My husband also . . . became ill. (Can't hear tape). The payment is very high.

FACILITATOR:

But with what you are paying to go to Mexico, why don't you pay that to go to the doctor here?

RESPONDENT(S):

Because it's too expensive here. See, my problem is that I had already taken my children to the doctor over there (in Mexico) and they have their records there. And over there the examinations are less expensive. Even though you spend money to go to Mexico, it's still a big difference in what I would pay here and what I pay over there in doctor's fees. For example, in one doctor's visit here, I may have been charged \$86.00 or \$125.00. In a visit over there, I may pay \$20.00.

{Several people talking at once}. It's a big difference in what we pay here compared to medical services in Mexico.

FACILITATOR:

Okay, so it's more here.

RESPONDENT(S):

Si. (Yes).

FACILITATOR:

But, if you have insurance, then it's better to come here to the doctor.

RESPONDENT(S):

(Some say yes. Some say maybe.) The last time that I had to go to the doctor, it cost me over \$200.00. Well, with \$200.00, I can go to Mexico for that money.

FACILITATOR:

Yes, but that was for yourself. I'm talking about the doctor visits for your children. I want to know if you regularly take your children to the doctor here.

RESPONDENT(S):

(Some saying yes, some saying no). Yes, I do take my children to the doctor here, but I pay for everything.

FACILITATOR:

You do pay for everything yourself?

RESPONDENT(S):

Yes.

FACILITATOR:

Okay, this is the next question. Is the cost of the doctor more than you can afford?

RESPONDENT(S):

Respondents are saying yes.

FACILITATOR:

Okay these are questions unrelated to the health insurance coverage, but they are personal just for this research. Do you speak English?

RESPONDENT(S):

Several people are answering yes and there is lots of talking. Some people are saying "poquito".

FACILITATOR:

Yes, "poquito", a little? (Everyone laughing).

RESPONDENT(S):

A little. I can understand, but don't speak well.

FACILITATOR:

No, don't say yes because you're embarrassed.

RESPONDENT(S):

(Some saying yes, some saying no.)

FACILITATOR:

Some yes, some no, some a little. Okay. If you don't speak English, does your medical provider or someone in his office, speak Spanish?

RESPONDENT(S):

Si. (Almost everyone is answering yes). Si. Si.

FACILITATOR:

Okay, I heard one or two people say no, is that correct.

RESPONDENT(S):

Si.

FACILITATOR:

Okay, but the majority of you are saying that saying that someone does speak Spanish?

RESPONDENT(S):

Si, todo los Americanos apprenderon Engles. Yes, all of the Americans in the doctor's office learned how to speak Spanish so they could communicate with their Hispanic patients. (Lots of laughter from the group). Wherever you go, it seems like most of the doctors do know how to speak Spanish. Some, more than the *Mexicanos*.

I think that there are many more doctors and people in doctor's offices that are now speaking Spanish.

FACILITATOR:

Yes, but I'm talking about the doctors here, not over there (referring to Mexico).

RESPONDENT(S):

The ladies are responding, *Si, aqui.* (Yes, here).

FACILITATOR:

So you're saying they know more Spanish than you know English?

RESPONDENT(S):

(Lots of laughter). Several people saying yes. (Much more laughter).

FACILITATOR:

Okay, the next question. Is the doctor's office in a convenient location for you?

RESPONDENT(S):

Everyone answering yes.

FACILITATOR:

Are you able to travel to and from your health care service providers?

RESPONDENT(S):

Lots of people answering yes. (Some talking among the group, but it cannot be heard on the tape.)

FACILITATOR:

If your children don't have insurance then it's because of the cost? Is that correct?

RESPONDENT(S):

(Lots of discussion but cannot hear on this part of the tape).

FACILITATOR:

How do you feel about the health care access for your children?

RESPONDENT(S):

Overall, I'm satisfied with the access.

It's not so much the access of health care service for me, but it's the cost of medication. Sometime, the doctor's visit is affordable, but then what they charge for the medication is so much. It's very hard to afford even with our insurance.

FACILITATOR:

Okay. This part of the discussion is over. I'm going to ask you now to fill out a brief questionnaire. Again, this is confidential and I do not want you to put your name on the paper. Understand? We don't want to know your names. Just answer each question. I will read the question to you in Spanish and you tell me if you need more time before I go on to the next question. Okay. Let's begin with the first question.

[The questionnaire completion begins now].

- End of Focus Group Interview -

APPENDIX "F"

Transcript

October 11, 2001

INTERVIEW WITH JEANNETTE VALDEZ (WIC):

Jeannette Valdez is a Lactation and Nutrition Consultant with the WIC program in Austin, Texas. Ms. Valdez was a consultant in an Austin hospital for eight years and has worked for the City of Austin WIC office for the past 10 years.

Rossana Barrios (RB):

In order to complete the program at SWT we all have to do a research project. I first became interested in the CHIP program when I first learned about it one of my classes about a year and half ago. I wrote just a brief paper on it at the time. But, the program is brand new. I mean in Texas because -- uh-- it's only been implemented since, I think, May 2000.

Even though Clinton had really pushed like in January 2000 to get the awareness out through school and I think through a couple of awareness programs, we still weren't getting a lot of out. Now, I understand through what I've read just to familiarize myself with the program that it has take off a lot more. And that probably more parents are using the Children Insurance. I have a meeting scheduled with a lady who's a public policy analyst for the program next week, but again, I wanted to get your incite on how you felt. You know, you said you feel like parents are very much aware of the program.

Through what you provide at WIC, maybe?

Jeanette Valdez (JV):

Well, I do classes here, but they go through a process of evaluation of mothers to get put on the program. So that's one of the questions that they ask the moms. If they have a clinic card, if they have Medicaid. If they have Medicaid, they automatically qualify. But, if they don't have Medicaid, then they have the pamphlet of CHIP.

RB:

Uh-hum.

JV:

And then they'll explain a little bit to them.

RB:

Right

JV:

So we offer it a lot to our moms.

RB:

Do you see that that's being taken advantage of, though--from what you're offering the mothers here? Or do you feel like . . . ? Uh. What I understood from just a few women that I've talked to is that they feel like it's more of a hassle to apply for the CHIP coverage. Because they get sent back to Medicaid to see . . . First, you have to not qualify for Medicaid to qualify for CHIP. And so, they, they kind of just throw their hands up and get frustrated and say "I'm not going to do this. It's too much red tape." Uh.

JV:

I get about 25% that feel way. How would I say? We try to explain to them that it's very important that the children go see the doctors for personal checks-ups. Cause our computer automatically lets us know that the baby needs a 6-month check-up and that's right around . . . A lot of times mothers don't qualify for the clinic card. A lot of times they don't have -- they're not from the United States and then they have to go through and see if they can qualify for CHIP.

RB:

Do you know that they don't have to be from the United States for the children to qualify for CHIP? There's a website, and I don't know if you have access to the Internet or not. But, TexCare Partnership has a statement there that says that that's one of the drawbacks . . . that perhaps it is one of the drawbacks to people not applying. That some of the immigrants may feel that they might be at risk for deportation because they aren't United States citizens. But, CHIP to tries to enforce that that's not what it's about. You know. It's not there to get rid of the parents and send them back to their country--to Mexico. It's there to provide the coverage for the children and any child, regardless if the parent is immigrant or not, still qualifies for the CHIP coverage.

JV:

Well, my understanding with that. Especially the ones that are trying to get their papers.

RB:

Right.

JV:

The ones that are starting out. Their lawyers or other friends have told them they can't qualify or they shouldn't ask anything from the government. Because we get a little bit of that too. That they're afraid to come and ask to be put on WIC because they feel that it's part of government. And, if they qualify and they get put on WIC, there's a chance that they might not get their papers. Which is not true. We don't report that. Just like CHIP doesn't.

RB:

Right-right.

JV:

So, it's a lot of misinformation that they're getting. It's just we have to talk to them and tell them that we don't report this. And I think CHIP has to do the same thing and a lot of the mom don't realize that. Once you . . . once it's a government thing, they feel like okay, I can't apply for this because I'll be deported or I won't be able to get my papers. Because what they want to see is that they can stand on their feet and they can support themselves.

RB:

Right.

JV:

But even us that we live here on this side (in America) and we don't make enough.

RB:

Because the cost of health insurance is rising so much. I mean I work for a law firm where if I had to -- they provide health care coverage for myself. But, to add dependent coverage, is almost \$500.00 a month. That's a lot of money. I mean, my husband has a real good health plan which is way, way less. But it's still a lot for people. You know, you have to meet -- clearly, you have to fall below the poverty level to qualify -- so anybody below that. You know, \$50.00 a month is too much. But, I think that that's real important though. What I was reading . . . when I saw that people may be afraid to fill out the papers or to come in and apply because they might be at risk of being deported. Well, that was just a big eye opener for me. And then I wondered if because our church is so much . . . I mean there are so many *mexicanos* at San Jose. I wondered would the parents be hesitant to participate, you know, on this end. I mean . . .

JV:

You get the Father to talk about and announce it -- especially when he does the Spanish mass. You might be able to get more out of it. Because I have gone on a Sunday where it's so packed that there's no where to sit. We've got almost 80 percent from Mexico going to mass then. So, he might be able to mention it at that mass to let them know.

I see a lot of my clients there. That even over all, I have seen a lot of times that nutritionists that we have here they're not Spanish-speakers. And us that are clerks, every now and then they'll grab us to help explain to them. So, when we go to the process, you'll find out that they have maybe one or two children that were born here and the rest are born in Mexico.

RB:

Right.

JV:

And we have to make them understand. Okay, that child might qualify for Medicaid. But their children from Mexico won't be able to qualify. So we have to sit there and justify to them, it ain't going to hurt for you to go and see if you can qualify for CHIP. But, it is a lot of hassle for them and a lot of red tape.

I have had moms tell me, and even myself, have done this. Where you ask them how much of the guidelines and how much do you have to qualify in order to keep your children on Medicaid? And some of them will tell you. So when they know this they won't go back and reapply, especially if they know about the money amount. So when they go and try to apply for CHIP, CHIP wants them to go through the process all over again of applying for Medicaid. Get the denial. And send it to them. Which is more of a hassle because when you go to DHS (Department of Human Services), it's about a four-hour wait.

RB:

I didn't realize that.

JV:

And that's a hassle for moms. Me, myself, I have gone through that. With my twins turning 18. Since, I don't get medical here.

RB:

Okay.

JV:

So, I have to go through Medicaid. When my twins are minors, I'd qualify under my income. But when they turned 18 and graduated at the same time, they wanted to use their income. Which I had only had one working and my income. And I asked them that--out of curiosity.

RB:

Right.

JV:

They told me I can only make less than \$1,000 to qualify for my youngest one, which she's eleven. So I figured why go and apply again. Just like the other mothers. You call Insure-A-Kid. Get together your paperwork. You fill it out and send it to them. They want to know if you have . . . if you've had Medicaid within the last 3 months. And you tell them yes. Then, they want you to go back to Medicaid. Reapply for it all over again. And get a denial paper from them. Which is a hassle.

RB:

Right.

JV:

Because some of these moms have to work. And to spend 4 hours in DHS just to get a denial paper.

RB:

I agree with you.

JV:

And then go through that long process. And you have moms who are not willing to do that. I'm sorry.

RB:

I think they have a lot moms that are not willing to do that. I mean from the few people that I've talked to, individual moms. That's been they're same response is that it's such a hassle. The red tape; the time. Very few people have commented that they . . . one of the questions that I was asking on the survey was if people could tell me, you know, how'd they'd been treated. Because I had read, you know, sometimes people felt like – if they

were non-English speaking—that there was frustration perhaps. And maybe not, you know . . . and I don't know if that's here in Texas.

JV:

No, it's here too in Texas. Because I have a lot of moms and even over the years when I've applied even for Medicaid. You'll get one of them telling you something different all the time. You never get the same answer. You get one . . . it's like a roller coaster. Okay, you're doing what one counselor says and then you go reapply and you found out that that's not what it's supposed to be. So, are they going to penalize you or not? Because you're following what the other counselor said. And they're like. . . “Well ma'am, I have to report this. You've been not reporting this for such and such time.” Which you can fall back on the case workers but you have to want to send this stuff back.

RB:

Because of a mistake that the clerk . . .

JV:

A mistake that the counselor or clerk made from the previous interview. So that you'll have some moms that don't want to go through a hassle. I have moms that sometimes that they'll just go to the church to get food and stuff.

RB:

Okay.

JV:

Because it's like I say, you've got a four-hour wait. And I understand that they're short-staffed at DHS. But, it's not really the client's fault.

RB:

Oh, exactly.

JV:

But, you have to go through that process.

RB:

Exactly.

JV:

You know, here when we certify, it can take anywhere from between an hour to an hour and half. Depending how many people we serve. Because we try to see people every fifteen minutes and they go in the back and they see at least 3 people.

RB:

In 15 minutes?

JV:

We see someone . . . we call someone every 15 minutes.

RB:

Okay.

JV:

They'll go through the process of seeing the clerk first to see if they qualify. Then they have to go to the nurse. And then they have to go to the nutritionist. By the time they get all that entered into the computer, it can take up to anywhere between an hour, an hour and a half. Sometimes it does. Because here we see close to – per month—I think we see close to 3,000 (people).

RB:

My goodness!

JV:

Our numbers are going up because they do a survey on a month.

RB:

Well you know one of the things that they say here – you, know because we are such a big state. But our poverty level is so high and also every report that I've read so far still shows that we're behind most other states in getting children insured through CHIP or Medicaid. Medicaid seems to be doing a better job but I think it's because people were already there. And if they can stay there, they're going to. But I think they realize that eventually you're going have to come off of Medicaid. I mean you're either going to have to get your insurance the Children's Health Insurance Program or you're going to have to get it through private insurance because of the welfare reform being like it is . . .

JV:

That's true—that's true. But I also think a lot of these jobs . . . I feel that they should make it mandatory for them to have insurance [*referring to the employer being made responsible for providing employee with insurance*]. I'm sorry. I've been with WIC 10 years and I don't have it. Unless I become a clerk. And I don't want to be a clerk.

RB:

And WIC is a program through the county?

JV:

City.

RB:

City. Okay.

JV:

WIC is through the City . . . (can't hear tape) . . . I get to know my mothers more in the classrooms. Which is good.

RB:

So as far as like involvement in something like this (this type of study), what's your opinion on why people didn't participate [*referring to the focus group study offered at San Jose Church*]. I tried to make . . . I didn't want to make my letter (to the parents at San Jose Church) too broad, but I needed to make it clear enough so that they (the parents at San Jose Church) would realize that it was part of a school project. I started to do the letter in Spanish, but the RE Director advised me that she thought it was enough just do it in English. And we didn't go through the process of announcing it at Church mass because Father Kirby wanted me to target the classrooms individually. He just thought maybe that was better. When he and I talked, I said that if I made an announcement at the end of mass . . . a lot of people just want to get out (laughing). They don't want to listen to somebody in the last 5 minutes (of Mass) talking about CHIP. (*Laughter*)

JV:

That's true in some ways. But I just came from church last night because they have the parents participating for their child's first communion. And I was hearing one of the teachers . . . she was saying something about that every Sunday she teaches the children, but she also wants to have one session with the parents and the child once a month. So she sends letters with these children. Parents don't come back. It's like it's a lot for them to come back one time a month to see what the child is learning.

RB:

So it sounds like some it is a lack of parental involvement. You know, maybe, mom and dad not caring enough about the welfare of the child. Because we say that through child abuse. You know the negligence. I've got a friend of mine that could afford private health insurance but doesn't don't it (buy the insurance) because it's too expensive for her even though by the standards of qualifying for CHIP or Medicaid she makes 4 or 5 times as much. So, you know, people who are desperate to have insurance, that would make this kind of money, would say, "Why don't you have your child insured?" You've got one child and she still doesn't do it because of the expense. And again – she works for a law firm – and it's about \$400 to add the one dependant, but she doesn't get the insurance because of that (the cost). So she has insurance for him through school insurance at the school where he's at . . . she'll have him insured that way but she will not have full coverage on him through her employer because of the expense—cost. And even though she could go buy private insurance for I guess half of that, she still won't do it because then it's another \$150 and to me. I mean I have one child. But I'm just – my attitude is like – I think that even if you have healthy children, it's a risk . . . It's like not having insurance on your home – what if it burns down? You know a lot of people don't do that (have home insurance). So, I don't know. I mean maybe it's part of the culture *Mexicanos*. (Laughter) My husband doesn't believe that you need insurance for everything. You know . . .

JV:

I can say that you do need it (insurance) because I have my children under life insurance. It's making me broke from what I get paid, but I'd rather have that. But, health insurance, I don't have it. Not through WIC (her employer). I have to go out and get the clinic card. When my twins turned 18, I had to pay 25 percent.

RB:

So basically you're telling me that parents are being made aware of CHIP. It's a matter of the red tape . . .

JV:

It's more of the hassle and the paper work and the red tape and then what you were suggesting. A lot of them feel that they can't qualify because they think it's automatically government. Which I'm not sure if it is but ____ (*cannot hear tape*) it's that they're trying to make the clients understand that they're not going to get deported. That's what they should do.

RB:

I'll bring you some information that I have which talks about immigrants – the concern for the immigrants to be aware that they should not fear the risk of deportation because of

the application. I mean they say that that's not what they do. I think its real hard – you know when I read the statement – I think that it would be real hard to convince people who are already in the country feeling that they may have to go back to Mexico, that they don't have to worry about anything like this if they fill this out for their kids. To me it's like if you're nervous about being sent back, you're not going to do something like this or anything to risk going back (to Mexico). I don't care if it is for the benefit of you're family. I don't know.

JV:

We get a lot of moms with between the age of 1 and 4. We find out that they're not taking the children to the doctor because they can't afford it. And then they feel like the clinic card, the Medicaid, CHIP, just asks too many questions—too many personal questions, too much red tape and too much of their personal lives—that they're not willing to look -- to see that its worse for their children to go without. I've been like blue in the face—especially when the nutritionists get clients back there—I have to sit there and make them understand don't do it because you feel that your children are never going to get sick or – I feel that you should take them to regular health check-ups, the clinic every 6 months. It's important. Regardless if you feel like they're never going to get sick. I have to try to make them understand that these things are necessary. I had one the other day that was—something about their tonsils—and it was hard for the baby to swallow. Apparently, the baby was about three years old and the mom said that it looked like they were flaring up. But she said that her husband would not go and apply for anything because she says that they want too much from him. They want too much paper work. And it's hard for him to collect all this stuff. Especially when you've got bosses that don't want to fill out paper work. Because the bosses feel like they're going to get in trouble.

RB:

I understand.

JV:

Like if we give them a piece of paper and they get paid cash. We give them a piece of paper, have your boss fill this out so that you won't have any problems when you come re-certify. A lot of times they'll stop this because they don't want to get in trouble.

RB:

This is a very interesting point. I had not even thought about that because we have so many people who do that contract labor, or that . . .

JV:

So they don't mess with it. And then you know they get scared. We have some that come back and some that don't. We have – I think we have another paper that we go around it – for the father to fill out himself so that we can figure out what he makes. But then you also have to sign this and it has to be legal. It has to be . . . how do I say this?

RB:

Notarized? Acknowledged?

JV:

Right. You have to swear to it. But overall you won't get a lot of bosses that will do this.
{*Discussion leading in different direction*}

Medicaid will not do this and I'm not sure about Insure-a-Kid. Insure-a-Kid you've got to do everything through the mail and sometimes you can call them. I had a client tell me that they sent her a letter and they wanted to know three things. They wanted to know if she had a vehicle that was worth less \$3,000.

RB:

Right. They do ask you that.

JV:

And then she said they wanted to know if she had Medicaid within 3 months. She said she tried calling them and it's like their phone line was going crazy. That she couldn't get through. And she tried it for 3 days so that her and her husband just gave up.

RB:

They do ask that question. They want to establish that if you have—I guess if you have a car that's over \$3,000, then you're making too much money.

JV:

Medicaid does that too. Medicaid if you have any car that's a 90's model, you can't qualify. For some reason, it depends what kind of car you have. And a lot of people have told me that – you know let's say if you're my sister, I'm going to keep the car in your name so that I can qualify for Medicaid because that's the only way they can qualify. The only reason they purchase cars is because now a days mechanics charge an arm and leg and sometimes when you buy a newer car, it takes a little while for it to break down. So, it doesn't mean that they're made of money (because they have a reliable car).

RB:

I mean that was another one of my questions. If you're asking people in order to qualify for CHIP whether or not they have a vehicle that's of a certain car. You know if that vehicle, even if it's less than \$3,000, is that vehicle reliable? And if it's not reliable, then how do you even get to and from your health care services. That could be another hassle for people, I thought. You know if you don't have immediate access to where you need to take your child to the doctor. I mean if your doctor is across and you don't have a car or it's a bus ride with a sick baby. Do people want to do that? I mean I don't know. I'm not aware enough about the providers through CHIP. I think it's pretty much that you can go any doctor, but I'm not certain.

JV:

You can. You can pretty much go to any doctor. It's just like Medicaid is what I was told. So that you can pretty much go to any doctor. I'm not sure how they do the renewal and I don't know if it's just like Medicaid. Because Medicaid you can renew every 3 months to 6 months, depending on your income going up or down. But, overall, they're pretty much the same when it comes to reapplying. But the only thing that I don't understand is why would they care if you have Medicaid for 3 months. Because if a mother knows-- that you know you're aware that you're not -- that in the next 3 months you're not going to be able to qualify because you already know how much money you're going to have. Why go and put the mother through all that?

RB:

Right. I agree with you. I hadn't thought of all that.

JV:

But you'll get a lot of them (moms) that you could get too much into their personal life and the moms get upset.

RB:

That's what I've heard moms say. That it's just too much -- that not only is it the red tape but they start to make you feel like --

JV:

We have too many people on welfare. You know I have moms that will barely let me know and I understand that a little bit -- that they want them to go back into work, back into the street within a month after delivering . . .

But, as part of my job in talking to moms, I have to do that. I have to offer it to them. Make them be aware that it is out there for their children. And try to make an appointment for them to take the child for their checkup. We have a gap for some reason

in between 1 and 4 where moms don't take the dentist because they're afraid that the dentist is going to get upset with them because the babies are still on pacifiers or bottles. So we have to juggle with that . . . try to help the mom wean the baby off the bottle and the pacifier.

RB:

Right.

JV:

So it's one of those things – okay that's not a reason not to take the baby to the dentist. We have to show these children. We have to encourage them to come off of WIC.

RB:

I think that its just that – You know I listen to you talking. I've never -- I mean all my career has been in an office. Pretty much clerical. So, I've never had to deal with the everyday person . . . I'm losing track of what I wanted to say. But, I keep thinking that it's a lot of red tape. Is the system working? Because that's always a question that I think that anybody involved in public affairs or community affairs, such as yourself. I mean you get to see more of "Is the system working?" I mean the people will tell you, your clients will tell you their frustrations with the system—if they think the system isn't working.

But if would step back and say, you know . . . I look around and think to myself "The system's not working." When you see moms that are still struggling to keep food on the table for their children. That the babies are sickly. I look around even in our church at times and see the young moms in mass with their very small babies and wonder what is it that we're not doing?

JV:

Well, we're not doing enough to help them. We did a 4-month health care awareness program and showed the moms where they could take their children for checkups. We talked to them about the important of taking their children for regular well check visits. We gave them all the necessary information on how to apply for health care insurance and where to apply. But, it's all a question of the mom doing it. Because like I say again, they didn't go. Because they said it was too much red tape and they feared they would be deported. They also felt like it was too much of an interference in their personal lives.

RB:

I think those are the primary reasons that we're getting from people who aren't participating in CHIP.

JV:

A lot of moms are not steady with their husbands. They're with them. They're not with them. You'll get many families that are like that. My husband—sometimes I'm with him; sometimes I'm not because he can't make his mind if he wants to be here. He doesn't want to be here. Then, we're barely making it with what we get. Especially with the economy of the rent here in Austin. I've seen clients where there are 3 couples with children, all living in one household. So, when we sit down to interview we have to figure out if we need to count all 3 incomes or count one as a family. So that all it came down depending on how they buy their food.

If they buy it individually, then we just count that one family – husband, wife and children. But if they all share bills and share food, then we have to count all the incomes of those people who are living together in one home. So, you'll get some moms after the first year, when the child turns one, some of them don't come back.

Like today I have to do a child's class. I always make this important to my moms. Okay. For every individual mom that we get in the program, even children, it'll keep WIC going to help other moms. So whoever's not on WIC, if you know somebody who's not on WIC, ask them—to see if they come qualify. Try and encourage them to stay on WIC all the way up to five years. Because it's just like CHIP.

RB:

Right. You have the budget . . .

JV:

Every person that you get, I think the government pays for that.

RB:

Exactly. The state has been allocated all this money for CHIP, but it has to be able to enroll and meet its quota. I'm sure very much like what you're having to do—is to keep up a quota of your clients in order to keep getting your assistance.

JV:

But a lot of times what I'm hearing is too much red tape. And Insure-A-Kid you do everything through the mail . . .

RB:

I think Insure-A-Kid is another outreach program just like TexCare Partnership. It's getting people to enroll in CHIP but through that outreach program, which is Insure-A-Kid. The other outreach program is the TexCare Partnership and there's one more

outreach program, whose name I can't think of it right now. I think they do it through the schools, like AISD.

JV:

I thought that was a good way of getting them through there too. You know, get the moms. But if you don't . . . I feel that Insure-A-Kid should have an office or have them go out and do their outreach. See the mothers and tell them why it's there.

RB:

So you're saying it be like helpful if you had Insure-A-Kid in, like perhaps, city and county health offices.

JV:

Yeah. Because this calling the office and moms trying get through. It just gets the moms frustrated. It's going to make them frustrated and not want to mess with it. One of the things that I do in my training with the moms is show them a video and then I talk to the moms to see if they understand what they've just seen. That's what I think would be good for Insure-A-Kid to do.

RB:

You mean like have an orientation or informative presentation?

JV:

Yes. Talk to them (emphasis added). Tell them what they expect out of them. Tell them what you want. Getting so much involved in mom's lives and telling them what they need to do and that they can't make this much money and getting on their backs—it's like they have to answer to you. Medicaid drags you through that. You wait a long time.

But why is it like that? Why are they making it so hard. Why is the government doing that? I understand that they want to reduce the welfare rolls and cut back on the funds. Not dish all this out to people who may not need it. If you don't want to give Medicaid to these people, then get all these government jobs, any jobs they have, and make these employers give insurance to these families.

It would save money. Forget whether they're part-time. If the person's there, then insure him. It will get rid a lot of headaches for Medicaid.

- END OF INTERVIEW -

APPENDIX "G"

Transcript

October 12, 2001
Interview with Patricia Estrada

Rossana Barrios (RB):

You have applied for CHIP coverage?

Patricia Estrada (PE)

I applied. Uh. When did I apply? I can't remember exactly when it was, but it was a few months ago. I think . . . actually it was in July.

RB:

This year?

PE:

July of this year. And I remember I had to wait because I was on Medicaid. I don't want to be on Medicaid anymore. And I had to wait 90 days from the last date that my kids had insurance before I applied (for CHIP).

RB:

They do make you do that. Yeah. I'm aware of that.

PE:

That's what they told me.

RB:

That's a lot of frustration too, for moms I understand.

PE:

Yeah. Well for three months the kids don't have insurance. Right now, my kids still don't have insurance. They've been without insurance of March of this year. I don't have insurance.

RB:

So.

PE:

Anyway, I applied the first couple of weeks in July. And the next I heard was in August where I got sent this letter (Patricia shows me the letter from TexCare Partnership) to answer these three questions because they were reviewing my application. Or you could call the number and answer the questions. So, I did that. I called the number and then, I found out from the person there that I shouldn't even fill this out because they still need proof of my income. Cause whatever I had been doing wasn't good enough or something because it didn't have . . . um . . . like for the child support payment, it didn't have the dad's name. Or something like that. So, then I had to fax proof of income and then I had to get the Paternity Decree so that can see exactly what was ordered for him to pay. And they said that was all that they needed. So I faxed that on the 17th of August. So this is like probably a month and a half after I applied. And since that date, I haven't heard anything back.

RB:

Have you tried calling them?

PE:

I have not called. I have a reminder note at my desk to call. But I have just because (sigh). I mean it seems like such a hassle.

RB:

That's what I keep hearing a lot of. From one of the few people that I've talked to that it is a hassle. There's another lady. A woman I know about your age who's got 4 children herself and a fifth on the way. And her frustration was in the Medicaid process. You know that you had to go to Medicaid first. And then she did not want to be without insurance because she had an infant at the time. So she was like, "I can't not have insurance."

PE:

You see my youngest is two. And she was 2 in August. So, she's already past that where they get the earache every couple of months and they get, you know all that stuff. And they were pretty healthy and I felt that they were okay to be without insurance. For some reason I could just tell that they would okay while I was in this process. You know. It was not something urgent that was going to come up and sure enough, I mean they've been fine. They have to take a nebulizer treatment. Like when the weather changes

because they start having a hard time breathing. So, I've had to take them in for that and also just for check-ups and stuff.

RB:

But you haven't had to take them while you've been without insurance?

PE:

Yes.

RB:

You have.

PE:

And I tell them that I have this (the CHIP application) pending. I don't have Medicaid anymore. I have to pay. I have to pay for it. But, hopefully, if I get this (referring again to CHIP), I think, if they're like Medicaid – that they may pay for three months.

RB:

So, you've yet to be determined through TexCare Partnership that you qualify for CHIP? You're still waiting?

PE:

I'm still waiting.

RB:

How did you hear about TexCare Partnership?

PE:

Um. I heard about TexCare on the news. I think that I heard about CHIP on the TV.

RB:

Have you heard or rather, do you know about Insure-A-Kid or Texas Healthy Kids Corporation?

PE:

I haven't heard about Texas Healthy Kids--nothing at all. I have heard about Insure-A-Kid. It's here on the TexCare newsletter and I think I heard about it through a friend of mine also.

RB:

Okay.

PE:

And I think I probably heard about it before. Because like I said, I've been going to Medicaid for years already.

RB:

Did Medicaid talk to you about it (CHIP)?

PE:

I don't think that they talked to me about it. But you see the signs and stuff in the office.

RB:

Okay.

PE:

Nobody said anything about try to get this. The thing was I still qualified for Medicaid and I may still qualify for Medicaid. That's why I waited. Because I don't want to qualify Medicaid. I want to get on something else.

PE:

Right.

PE:

So, that's why uh . . . so anyway that's how I heard about it and then I had been seeing the advertisements and I was like, I'm going to call. Because I like I said, it's a hassle to go through Medicaid. I can't take off of work every couple of months when I have to go to a Medicaid appointment. And I have to go all the way up to north Austin.

RB:

To the Department of Human Services?

PE:

Yeah.

RB:

That's what a woman that I talked to in another interview said that a lot of moms complained because it's such a long wait and it's sometimes it can take up to 4 hours in the process.

PE:

Yeah. And I mean I've been through it so many times. So many times in all these years. Going to an appointment and I know exactly what you have to bring. I know exactly what you have to do. And, you know I'm always prepared. I don't ever go without my stuff. So they're two things they give me a hard time about. The child support payment because they're not consistent. Sometimes he pays more in one month and he won't pay for a whole month. But that doesn't matter. Whatever you get in that month is what they figure it.

RB:

So, like he's backlogged a month or two and you get a big payment in the third month, then they're looking at that?

PE:

Yeah. But that's not real. {RB and PE both taking at the same time} So that's one thing that makes me mad. And then another thing is, uh, for my other kids, they want me to file child support on their father. Which I haven't because he makes this whole big ordeal about . . . He's not even on their birth certificate. I mean we've tried to work stuff out. We were together, yes. But, in my mind, it was never like we're husband and wife. He's their dad. I mean it was not, as far as paper and stuff goes. Because I'm not dumb. Because I know that if I take him to court, he would want to see my children. But, if I don't think he's a good person, he's not going to. Because he is way too in to so many other things that my kids are not going to be around him.

RB:

Right.

PE:

And it's not just like if you're not with me, you're not with my kids. It's not that!

RB:

So, are you saying that the enrollment process gets too much in to your personal business?

PE:

No. This is Medicaid. The thing was that they wanted me to file for child support and I said, "No, I'm not going to." But they think and I can understand that, of course, that some people are with him and that they don't want to file it. You know what I mean? But the reason I don't (file for child support) is because I don't want to go through that whole child support ordeal to try to get money of him when he doesn't ever work anyway. I'm not going to ever get any money and he gets rights to see my kids. I'm not going to do that. I don't want any money from him! And I had a protective order on him once or twice. And so I would tell him, I was told that as long as I'm not getting AFDC. And if I'm only getting Medicaid. I do not need to fight to get a piece of paper to sign it that would automatically apply for child support and I would always decline. And they would always give me a hard time. And I would have to say, bring your supervisor in here and I will tell them.

RB:

The people at AFDC or Medicaid you mean?

PE:

Yeah.

RB:

Okay.

PE:

And I would say bring them in here because I know what I'm talking about. I'm only on Medicaid. I'm not on AFDC and I do not have to file for child support and I'm not going to. I have a protective order and you have it in my file.

RB:

So, when you made a decision to apply for CHIP and I know you said you didn't want to be on Medicaid anymore. What . . . is there a reason?

PE:

Well, it's because of all that. The whole process. Because every single time you go back, it's the same old thing.

RB:

How often do you have to go back?

PE:

It depends. Sometimes they're certify you for six months.

RB:

Right. I've been reading that the review process is six months.

PE:

And sometimes it's three months. If you're income goes up and you have to go in or something is different, you have to go in. So, but still. Even if it's every six months and you're trying to do all that and go through all that. And people are giving you a hard time about that kind of stuff when you know what you're talking about in your life. I mean "you're not in my shoes and you don't know." You don't know. That's why it made me very mad. Because I have to go through that and I don't want to. So I'm looking for something that may be a little . . . a process that will be easier, not so much hassle and to have good insurance. And I don't mind paying some amount, like for insurance. I don't want it free. I mean if you want to give it to me free, fine but I don't mind paying a portion, which I think that's what CHIP does.

RB:

I think you're right. I think it's like eighteen dollars a child or so much for . . . or just a little bit less for additional children. I don't know the exact amount.

PE:

Yeah. So, I don't mind paying that but I wouldn't mind paying it through work if it wasn't \$500 a month.

RB:

It also sounds like they're not making it easy for you to qualify for CHIP. I mean that sounds like a big drawback to me from the people that I have talked to is just that. You know here we are trying to promote this program. It is a federal program. And yet,

we're still making it hard for qualified parents to get the coverage for their children that they need. That's why I keep hearing from, again, like what you just said.

PE:

Yeah. I don't even know if I'm qualified. And when I talked to this person when I called about this letter and they told me I needed some proof of income. I said—I asked, well am I qualified? Does it look like I may be qualified? Or if you have this proof of income what? I don't know if he did some figuring or he really didn't want to.

RB:

What are the three questions that they ask you?

PE:

It says, "In the last six months, did you get a denial letter from Medicaid because you had an accident? I said no. Do you have two or more cars (trucks, vehicles) worth more than \$6,650 each? No. Does anyone in your household have more than \$2,000 in bank accounts or anywhere else? No"

RB:

Did you find that question on the vehicles interesting? Because I know that someone else that I talked to wasn't sure why they were asking their vehicles.

PE:

I think its because . . . if it was just one vehicle, I would have thought it was odd. But, I guess since it's two. I guess maybe they're like, do they really need two vehicles.

RB:

Some people are asked if they only have one. And if it's \$3,000, less than \$3,325. So it looks like maybe on your letter, it was doubled. And I don't know why they would have thought that you had two vehicles. Maybe it's because of the number of children. I don't know. But what they're trying to establish is that you don't have assets.

PE:

Um-hum.

RB:

Okay, you're aware of that.

PE:

Yeah. So, anyway. So I knew. But what he said was, well it looks right now like that you will qualify. And he goes well maybe for the two-year-old it may not because they have to reach a certain age by a certain time. He said something like that. I think they _____ before her birthday (couldn't hear tape here). And he said she won't qualify because she's under two or something.

RB:

She won't qualify for CHIP?

PE:

I think so. (Meaning that she thinks her daughter won't qualify for CHIP coverage).

RB:

But CHIP is for children newborn and up to the last month of your eighteenth year of age. So that you could have your child covered up till almost when they're nineteen. And at 19, obviously it's a cut off. But, this is . . . CHIP is for (both of us talking). That's something you should back and check on to see if (both of us talking again) . . . That doesn't seem accurate.

PE:

So I've been having a note up to check. And they gave me my CHIP ID number. And so I have it written down and so that I can call. {Can't hear tape again} . . .

I don't know what the deal is. And somebody called me after that and said that they received my fax that I sent them. And I think they didn't get all the pages or something. So I had to re-fax some pages.

RB:

And you sent them 21 pages of documents? (I am looking at her stack of documents that she sent to TexCare, along with the cover page indicating the number of pages.)

PE: (Laughing)

Well yeah, because I sent the whole Paternity Decree because I didn't want them to get that one page and not know where it came from. So I just faxed the whole thing.

RB:

So are you more less frustrated with the process?

PE:

I'm frustrated because I thought . . . I mean yes it's for me. It's for my kids. But I sent this in. I mean what are they doing? Why didn't they call me back if they needed something else? I know I should follow-up and I'm going to, but . . .

RB:

My thinking would be, as a parent, that in this time (the waiting/process period), your children don't have any health insurance.

PE:

Yeah! (emphasis added). I mean it's running a little long now. Because like I said I'm hoping that it's like Medicaid where they'll pay like the last three months of bills.

RB:

How old are your children again?

PE:

Eight, four, three and two.

RB:

Okay.

PE:

And, so I'm hoping they'll go back. So that the last couple of times that I go to the doctor will be covered. If I get this. But I need to hurry up and see if I'm qualified.

RB:

I have a meeting to talk to a policy analyst with CHIP. If it's okay with you, I'd like to mention that I know someone who's having a delay in the application process and maybe she can put you in contact with someone that can speed it up. I don't know. I mean I've got two ladies that I'm supposed to talk. One of them is from CHIP and the other one is from one of the foundations that is researching CHIP coverage and enrollment. That agency is also trying to find out people's attitudes and experiences with CHIP. So, I don't know, Trish. To me it sounds like because it's such a new program, and I'm sure this is probably the biggest reason . . . because it's so new, it still has a lot of glitches in

it. And it'll take a little while before they can streamline it and the fact that Texas didn't start using it until just last May of 2000, it probably really didn't take off until school started in September of 2000 and then maybe a little bit more this year. Uh, I don't know. Because you do see more and more advertisements for Children's Health Insurance. Either through the Insure-A-Kid program or the TexCare Partnership. You've seen the commercials on television. They say that they're doing something through the schools. I don't know if they're sending something to the parents or not.

PE:

They sent this. (Patricia shows me a one page brochure).

RB:

Home from school. The little brochure on TexCare Partnership. Okay.

PE:

{ Cannot hear her response on the tape } I didn't qualify for that.

RB:

You see that's different. Insure-A-Kid.

PE:

It's because I could qualify for Medicaid. That's why when I did this one (she shows me the TexCare Partnership application) I knew that I had to wait.

RB:

That's interesting because I was understanding that Insure-A-Kid and the TexCare Partnership were just outreach programs to bring parents into the CHIP coverage. So that would it seem like the requirements would be the same. I mean if you did Insure-A-Kid. I haven't seen their brochure. But this brochure states that {both talking at the same time, cannot hear tape}. It would seem like Insure-A-Kid would be the same thing . . . trying to get you in to get the CHIP coverage for the kids.

PE:

I don't know, but that's what I'm going to do. I've been trying to do it all week. And I haven't had a chance to call really. But I'm going to check on it and see what they say. I'll let you know.

RB:

Yes, please do.

PE:

I'm trying go get off assistance so I'm trying to get on this CHIP, which is not really looked at as the same thing as Medicaid. As assistance where you have to go to the DHS office and all that. I'm trying to get out of this. I'm trying to pull myself out of being dependent on the system for support. I'm trying to just wean off of it.

RB:

Well, that opens up another . . . just for comment here . . . Because you know you hear a lot people . . . See, people who've never had to get assistance, don't really understand. I mean I hear comments made like you know we're supporting them; our tax dollars support them.

PE:

I know.

RB:

Or why are these moms having all these kids? Here I go having to feed another mouth.

END OF INTERVIEW