

Insuring the Uninsured: Reducing the Barriers to Public Insurance

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Health insurance is one of the essential enabling resources to gain access to medical care and ultimately increase health status. Over 11 million or one quarter of the nation's uninsured individuals are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP), but are not enrolled. Interviews with 368 individuals from 1999 through 2003 identify eight primary barriers to enrollment in public insurance. These include: economic aspects of qualifying, lack of knowledge, benefit design of public programs, poor experiences and stigma, complexity and literacy, immigration status, poor customer service, and fear of fraud. These results suggest policy options alone are unlikely to result in reaching eligible uninsured individuals unless knowledge and instrumental support are offered to them about insurance. Key Words: Access to Health Care, Barriers to Insurance, Medicaid, SCHIP, Underinsured, and Uninsured

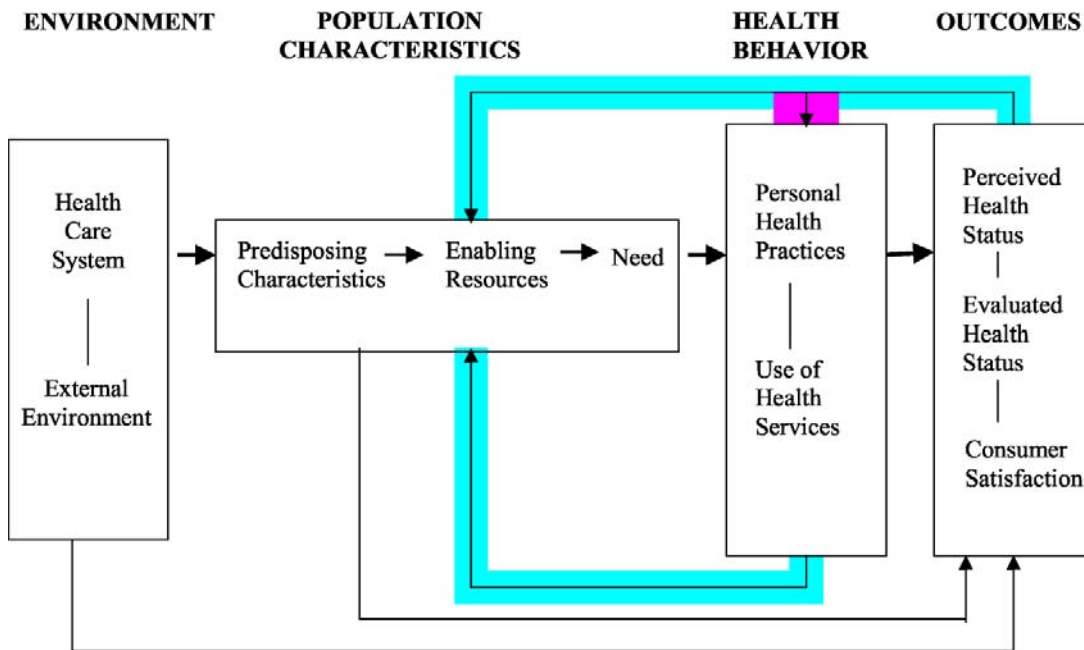
Introduction

The positive effect of health insurance on health status is well documented, with the uninsured consistently having worse health than insured individuals. Specifically, compared to the insured population, the uninsured are more likely to have cancer diagnosed at a late stage (Kaiser Family Foundation, 2004), have a 25% greater risk of premature death (Hadley, 2003), and are less likely to fill a prescription, see a specialist, or go for follow-up tests (Commonwealth Fund, 2001). Lack of insurance is responsible for 21% of medical-related bankruptcies, and medical care expenses accounts for 20 to 50 percent of all individual bankruptcies (Dranove & Millenson, 2006; Himmelstein, Warren, Thorne, & Woolhandler, 2005). Public health insurance is effective; a study using the 2001 California Health Interview Survey identified that poor people with Medicaid, who are likely to be a sicker population than the overall community, were more likely to take medications than those with private insurance (Rice, Lavarreda, Ponce, & Brown, 2005). In Tennessee, the fiscally at-risk public health insurance program known as TennCare is credited with decreasing the immunization gap involving enrollees and non-enrollees as well as African Americans and Caucasians (Kirschke et al., 2004). Further, Medicaid is associated with timely initiation of prenatal care in a study of Hispanic women in California (Kropp, Montgomery, Hill, Ruiz, & Maldonado, 2005). Health insurance contributes to better health status and aids in reducing ethnic/racial health disparities.

This paper set out to identify the barriers to enrolling eligible individuals in public insurance, specifically Medicaid (called Medi-Cal in California) and the State Children's Health Insurance Program (SCHIP-called Healthy Families in California, Child Health Plus in New York, PeachCare in Georgia and CHIP in Ohio). Approximately 5.3 million adults nationwide are estimated to be eligible for Medicaid (Davidoff, Yemane, & Adams, 2003) based upon the 2002 National Survey of American Families. Most low-income uninsured adults who were eligible for public coverage were poor and many considered themselves to be in fair or poor health. Further, 6.2 million children are estimated to be eligible for Medicaid or SCHIP (Kaiser Commission on Medicaid and the Uninsured, 2005). A large segment of the 45 million uninsured individuals are eligible for public insurance programs: Identifying and eliminating the barriers is imperative if progress is to be made in improving access.

Using the evolving theoretical model proposed by Andersen (1995), illustrated in Figure 1, environmental factors, population characteristics, and health behaviors affect perceived and evaluated health status as well as consumer satisfaction. Environmental factors include the external environment such as the general economy and level of stress and health care system characteristics such as accessibility, availability, and acceptability of medical care services. Population characteristics are classified into three categories: predisposing characteristics, enabling resources, and need. Predisposing characteristics include age, gender, ethnicity, education, occupation, immigration status, social networks, culture, and health beliefs. Enabling resources include availability of health personnel, health insurance, transportation, and acceptable waiting times. The category called "need" includes "perceived need" for services by the individual based upon their physical/mental health issues and "evaluated need" by a health professional based upon diagnostic acumen. Health behaviors include personal health practices such as nutrition and adherence to medical regimens as well as general medical utilization measured by outpatient visits, inpatient days, diagnostic tests, etc. These environmental factors, population characteristics, and health behaviors are determinants of perceived and evaluated health status as well as satisfaction with services received by the consumer or patient.

Figure 1: Determinants of health status and consumer satisfaction (Adapted from Andersen, 1995).



In this paper, a specific aspect of “enabling resources” is examined, in particular health insurance, and explicitly the barriers to enrolling in public health insurance programs. With one quarter of the uninsured eligible, but not yet enrolled in public programs, it is important to outline and describe the barriers so that operational and policy changes can be made. On a more sinister side, if the goal is to reduce or cap enrollment in public insurance programs, ignoring or ensuring the existence of these barriers would likely lead to that objective.

Studies using quantitative methods have identified barriers to enrollment in public health insurance as poor English language proficiency (Feinberg, Swartz, Zaslavsky, Gardner, & Walker, 2002), lack of discussion by health providers (Davidoff & Garrett, 2001), child born outside of the United States (Manos et al., 2001), complex enrollment forms (Ross & Hill, 2003), poor customer service (Saunders, 2005), decreased provider Medicaid reimbursement, and one child families (Sommers, 2005). Surprisingly, intensive marketing was found to be ineffective in enrolling eligible individuals (Kincheloe, 2004).

Requesting less burdensome information for the application process makes a positive difference in enrollment and retention. Specifically, removal of asset tests, implementation of presumptive eligibility, and self-declaration of income were found to be important in maintaining and expanding public insurance programs (Kronebusch & Elbel, 2004). Asset tests have been burdensome to applicants, as they are forced to prove that they have little or no savings, a non-luxury car, and no personal items such as jewelry or silverware that could be used to pay for medical services covered by public insurance. Verifying income by pay stubs or a balance sheet, if self employed, have been barriers to completing applications. Without asset tests and income verification,

automatic eligibility is assumed and patients receive medical services at the point-of-service instead of waiting for an insurance application to be approved. By permitting presumptive eligibility, the opportunity to reduce the number of eligible but not yet enrolled individuals is not missed.

With all of these studies elucidating barriers, what is the utility of another research paper explaining the obvious? This paper provides more depth about the meanings of those barriers, identified in the foregoing quantitative studies, using the words of the affected individuals. It also suggests other barriers that are affecting enrollment. By using qualitative inquiry, a reader may sense the feelings, perceptions, and lived experiences of people who need medical care and lack the financial means to obtain it. Qualitative research goes beyond a singular numeric dimension of quantitative estimates, to explore specific aspects of research participants' lives. Sensing the human side of not gaining access to health care provides more compelling evidence of the need for changes in the American health system.

Methods

This paper is comprised of results from three unique studies conducted in California in 1999, 2001, and 2003 (Saunders, 2003, 2004; Saunders & Rinehart, 1999), each using purposive sampling strategies with large sample sizes, incentives for participation, and qualitative inquiry. Similar to qualitative methods such as ethnography or participant observation, the use of focus groups and interviews allow for exploration and discovery of context and depth, facilitating the interpretation of complex phenomena (Fontana & Frey, 1994; Morse, 1994). Furthermore, the use of open-ended questioning techniques, beginning with a standard protocol, lets the participants tell their story with very little sense of researcher intrusion. In fact, focus groups and interviews often are lively, collaborative, and quite spontaneous.

Data collection was conducted by the author, doctoral level colleagues as well as graduate and undergraduate students, using a semi-structured set of four to seven questions, with encouragement to probe deeper in order to gain further understanding of the participants' experience. Everyone involved in data collection had, at one time or another, experienced being uninsured and empathized with the circumstances of the study participants. This shared characteristic of being without health insurance helped to build trust between researchers and study participants.

Table 1 summarizes aspects of each study in terms of data source, location, research questions, and focus population. Interviews with all research participants were audio-taped, transcribed, checked for accuracy, and content-analyzed using N 4 software (QSR International, 1997). Although questions varied for each of the three studies, the dominant theme of each was to understand the barriers to enrollment in insurance programs.

Table 1

General Research Questions and Characteristics of 1999, 2001, and 2003 Studies

	Data Source	Location	Research Questions	Focus
1999	16 focus groups -12 English -4 Spanish	Counties of San Bernardino and Riverside, CA	1. Barriers to program implementation 2. Viewpoints 3. Strategies to enhance enrollment	Non-urban
2001	150 interviews -50 Filipino (Tagalog/Ilocano) -50 Spanish -50 Vietnamese	Counties of Los Angeles and Orange, CA	1. Barriers to program implementation 2. Viewpoints on health quality, traditional healers, informal network, expected communication 3. Strategies to enhance enrollment	Immigrant
2003	150 interviews -workers from entertainment, food service, retail, and other	Counties of Los Angeles and Orange, CA	1. How care received and paid. Application to private/public insurance 2. Health policy opinions	Employed

The first study in 1999 was comprised of 16 focus groups with parents of uninsured children living in non-urban areas, with 12 groups conducted in English and 4 in Spanish. To qualify for the group, participants had to be a parent of an uninsured child living in a pre-selected area of San Bernardino and Riverside Counties, California. Towns were pre-selected based upon low ratios of enrolled to uninsured populations. Participants in the focus groups were recruited from ads, schools, churches, face-to-face encounters, and flier distribution. Transportation and child care were provided to encourage involvement. The 16 groups had 68 participants and generated 750 pages of text.

The second study in 2001 of Filipino, Latino, and Vietnamese immigrants was comprised of 150 interviews, with 50 research participants in each ethnic group. To qualify for the interview, participants had to meet the income and household size criteria to be eligible for public insurance, but not the immigration status criteria (i.e., a number of our participants were in the United States as undocumented persons). Interviews were conducted in their language (Tagalog/Ilocano, Spanish, or Vietnamese), audio-taped, transcribed, and checked for accurate translation by two native speakers. Participants were recruited from community clinics in the California counties of Los Angeles and Orange, who were seeking medical care at the time of the research encounter. The 150 interviews produced 2,040 pages of text.

The third study in 2003 of workers without health insurance was comprised of 150 interviews, with full- or part-time workers without insurance. Interviews were conducted in mutually convenient locations with a bulk of the workers in the entertainment industry, food service, or retail clerks. To qualify, participants had to lack health insurance and be employed. Participants were recruited from ads in newspapers, magazines, and the worldwide web, not necessarily a population in need of medical care.

All three studies had varied struggles in undertaking the research. For the 1999 study, in rural California, recruiting research participants was our greatest challenge because of the breadth of the geographic area with over 6,000 miles logged by the research team and the diversity of geographic areas in mountain and desert communities. In the 2001 immigrant study, the greatest difficulty was ensuring accurate transcription of the audio-taped interviews from Spanish, Vietnamese, Tagalog, or Ilocano into colloquial English. For the 2003 working uninsured study, the greatest difficulty was analyzing the lengthy texts in a timely manner with over 3,200 pages derived from this project.

Analytic Approach

Qualitative inquiry is the analytic method of choice when trying to describe concerns and perceptions of persons using their own words (Sandelowski, 2000). In qualitative content analysis “there is an emphasis on allowing categories to emerge out of data and on recognizing the significance for understanding the meaning of the context in which an item being analyzed appeared” (Bryman, 2004). The researcher systematically applies codes, which are derived from the data and expanded to include all of the varied content in the transcripts. After coding, the transcripts are further “cleaned” to aid in readability. From there, quotes are interwoven to build a theory of evidence using qualitative description methodology (Kohlbacher, 2006). The “essence of content analysis is identifying *substantive* [original emphasis] statements that really “say something” (Gillham, 2000).

Results

Barriers to Enrolling in Public Insurance

Eight barriers to enrolling in public insurance were identified in the three studies including economic aspects, lack of knowledge, benefit design of public insurance, poor experiences and stigma, complexity and literacy, immigration status, poor customer service, and fear of fraud. Similarities and differences regarding enrollment barriers are present in the three studies, with each one adding different ideas for problematic areas. All of the studies discussed poor experiences and stigma associated with public programs as well as the complexity of filling out enrollment forms. Both the 1999 and 2003 study participants expected that they would lose time from work in attempting to correctly fill out the forms and provide the proper paperwork. Further, the 1999 and 2003 studies discussed the economic aspects of qualifying, specifically exceeding income guidelines. The 1999 study went further to include the difficulties of seasonal and temporary workers and the exclusion of step-children in determination of household size and eligibility for coverage. The 2001 study elucidated the lack of knowledge associated with the programs,

although the names of the programs were familiar to participants, the framework was confusing. In 2003, the uninsured workers bemoaned the design of public programs that linked lack of health insurance associated with the need for income support. Immigration issues and poor customer service were omnipresent for 1999 and 2001 participants. Fear or expectation of fraud in collecting insurance premiums was part of the 2001 findings. These issues will be discussed further with illustrative quotes providing contextual meaning to the theme of each barrier.

Economic aspects

Individuals experienced frustration in earning slightly higher income than the guidelines, and not receiving health insurance from their employer. A parent in the 1999 focus group expressed her frustrations.

I have a 16 ½ year old daughter. My husband is disabled and I have Healthy Families, but expect to lose it [in] October because, as I read the guidelines, I'm \$25 over this year. My income varies because I work for the school. At this point, I have two 3 ½ hour jobs that have no benefits.

Another 1999 focus group participant had heard of the program, but her acquaintances, who inquired about it, were unable to enroll due to the strict income guidelines. She said, "There is a program that they speak of on the radio, that says you only pay \$27, but it seems that many people who have gone didn't qualify—either they earn too little or too much."

Many of our research participants were involved in seasonal or temporary employment (farming, construction, tourism, etc.), which often required a minimum number of service hours before qualifying for employer-based health insurance. One man from the 1999 study, whose daughter had a chronic illness explained,

We workers in the lemon fields are going to have insurance until December. The work only lasts 4 to 5 months and with the insurance that we have, we must work 80 hours per month prior to getting covered. During September of this year, due to the humidity, we couldn't work. In October, we had to work 80 hours just so that we can have insurance in December. Since work is over in January, we will no longer be covered.

When work was slow, participants were unable to afford coverage in the private market, but still made too much money to qualify for public insurance. A 2003 contributor recounted her inability to qualify for public programs, despite losing a job.

I don't qualify for Medi-Cal because I was an aerospace engineer. I got permanently eliminated. I'm only 49 and I don't qualify 'cause I don't have children and am not 65, but when I go to work, they take the taxes out of my paycheck.

Another issue related to economic aspects was the definition of family, and parents wondered why state-sponsored programs did not keep up with the current times. Parents with stepchildren deserved help as one 1999 participant said.

Nowhere in their application does it say stepchildren are not eligible. I mailed it in for seven children, out of seven they would cover one. They're my children—even if they have a different last name—I pay all their other bills.

Knowledge of public insurance programs

Lack of knowledge was a predominant stumbling block in the immigrant studies due to the language barriers and the absence of a public insurance program in their native land. Filipino, Latino, and Vietnamese participants in the 2001 study noted, "I don't know the mechanics—Medi-Cal, Medicare, Medicaid. I just saw the pamphlet in the waiting room at the clinic. I don't have any other knowledge about them." "Well, it's like I've heard about those, but the truth is that I don't really know about it." "I'm not at the age to qualify [for Medi-Cal]; I have to be 65 years."

Design of public insurance programs

Many in the 2003 study of the working uninsured had heard of public programs and had inquired about them in the past, especially when medical care was necessary. They only needed medical coverage, but the county programs required that they apply for the gamut of welfare benefits. Comments from 2003 participants describe this situation. "When you tell'em that you want to go for Medi-Cal, they always ask you, do you want General Relief and food stamps? No, I just want the Medi-Cal."

You couldn't just get Medicaid, you had to apply for the whole thing. It's really a shame. You had to apply for the food stamps, and the money—I didn't want that, I just wanted medical care, you know?

Poor experiences and stigma of public programs

Participants in the 1999 focus groups and 2003 interviews had quite a bit of experience in applying for public insurance programs. A parent from the 1999 focus groups remarked,

Stop asking so many really stupid questions and start treating us like citizens! Even though my daughter is in need of help, does not mean that she is any less of a person than somebody who has a million dollars!

Workers from the 2003 study described their perceptions of applying for public insurance. "The welfare office is one of the most depressing places. Most of the people there are so suspicious; I feel like a second class citizen." "I would never recommend going there because people will treat you like absolute garbage."

Further, 1999 and 2003 contributors spoke of stigma associated with public programs.

Oh, you have this great insurance! We're gonna be extra nice to you, and sanitize everything for you, and this and that. But, if you have regular Medi-Cal, if we take you an hour late, it really doesn't matter, it's just Medi-Cal that's paying for it.

I have very good years and very bad years. The way an artist works is that you go into a studio every day and work. You hope that there will be some income that arrives, but you go in there every day and work. You work for yourself. Because that is what you do. Period. Now, you know, I'm not going to an office for food stamps.

Others spoke of the piecemeal or categorical coverage of public programs and assumed that they would apply for Medi-Cal and Healthy Families. In fact, Healthy Families, despite its name, covered only children in 2005, despite approval of a federal waiver in 2000 to include parents. One 2001 Latina mother expressed, "My two daughters are in the Healthy Families program, but I don't qualify since I'm an adult."

A 1999 participant vociferously stated, "The State of California is lying to me again. They call it Healthy Families, but it doesn't include parents...call it what it is—Healthy Kids!"

Complexity and literacy

All participants spoke of the difficulties in filling out forms for public insurance programs. A 1999 interviewee said, "They are so complicated. Some of the language and the way they put it."

Filipino and Latinos in the 2001 study said, "This is unnecessary information about your assets, savings, and checking accounts. Too much, it's like they're going to operate on you (laughs). Like they're diagnosing you for eligibility." "Oh, my head starts to hurt. A lot of forms, a lot of questions like: Where do you live? How many cars do you have? What do you eat?"

Spending time at the welfare office meant time lost from work as these 1999 and 2003 participants expressed. "If I don't work, my family doesn't eat! It's real hard for me to try to take off and play the paperwork game."

It's very difficult because it's a long line of people waiting. I tried to do that once, because I had to go to the hospital to take care of something. I needed to have the plan so that I wouldn't have to pay. And I tried applying there, and there were long lines of people. You just have to sit there for hours before you get your turn to go into see them.

The difficulty in filling out forms was expressed by participants from all three studies in 1999, 2001, and 2003.

You fill out big honkin' forms and it's sometimes the same questions on five different pages. And this feeling, "You want something free?" Okay, we'll finally give it to you, but you're gonna go through hell—you're gonna fill this out and wait!

I just turned to the first page—it's too complicated. I think it's too technical. A lot of people have probably heard these words, but they don't know what they mean or what it relates to or how to answer the question the right way.

Oh, it's just piles and piles of paperwork and so many little loopholes and everything. It seems like a lot. I kept trying to read it and understand. I just didn't understand a lot of it. I mean you almost have to sit down with somebody and have them help you fill out the whole thing. I thought that was what they were going to do, but they don't have anyone available to do that...

The issue of complex terminology was noted by a Vietnamese immigrant in the 2001 study. "Pardon me, for those people who are educated, it won't be difficult. For those who can't read or write, it will be hard."

Immigration status

Legal residents of the United States are eligible for public insurance programs, but many do not enroll for fear that it will affect their immigration status. Undocumented or illegal residents are eligible for public programs in California, depending upon the availability of county programs. These issues were apparent in the 1999 and 2001 studies, but not in the 2003 study, likely because it consisted of entirely a working, English-speaking population. A 1999 study participant recounted her story of her son's hospitalization.

A social worker told me that I could get Medi-Cal. Then one of the nurses from the hospital told me that if I got it, they are going to report you to INS and keep your son in the hospital. For the next five days, I felt such anguish. Perhaps they weren't going to give me back my son. When they did [give him back], all I did was run with him.

In the 2001 study, all three ethnic groups—Filipino, Latino, and Vietnamese—expressed concerns about enrollment affecting their immigration status. "This isn't applicable, because you need your Social Security and your ID. What if you're not legal?" "Getting Medi-Cal causes problems when one goes to get their papers—that's another reason I don't like it." "I'm afraid of it affecting my paperwork—that's why I didn't apply. I also don't know about any programs that could help me."

Poor customer service

Seeing an advertisement and calling for more information is often the first step towards enrollment in programs, particularly for children. Although participants responded to the advised invitation to call to learn more about the program, many participants described the negative experience they had when they responded.

A 1999 participant said, “I was on the phone when I talked to Healthy Families for 45 minutes and on hold for 35 of them!”

Both 1999 and 2001 subjects had curt or dismissive experiences when inquiring about these programs and waiting for information or eligibility determination. “I didn’t really ask her a lot of questions, but she was kind of brief and told me it’s all in the packet. If you have questions, it’s in the packet.”

I was planning on applying for this program—Healthy Families. I called a number of times and was not able to get through. The phone line was so busy. I stopped trying to apply and left it at that.

Fear of fraud

Embedded within this poor customer service and the complexity of paperwork is the fear of fraud. In particular, in the 2001 study, Filipino and Vietnamese study participants said,

It is important to be sure that the insurance company is real and not fake. In the Philippines, there are those kind of insurance—You go to their office and can’t find them because it’s not real. You keep on paying but do not get anything out of it.

“People from private health care insurance companies keep advertising, but I don’t know if they’re reliable or not.”

Discussion

Simply providing financial access through a new health policy initiative is insufficient to enroll all eligible individuals, even when states expend substantial resources for an outreach campaign (Ross & Cox, 2002). The power of the social network is evidenced here, reflecting the marketing adage of the bad news of strict income guidelines and mounds of paperwork traveling faster than the good news of an available public insurance program. As more people try to get information and are unsuccessful, acquaintances in their social circles are less likely to enroll.

Just providing a pamphlet or information about the program is insufficient to increase enrollment, particularly within the immigrant community. Interviewees spoke of the bureaucracy of contacting agents of the state and the lack of responsiveness to their needs. The prior experiences of some participants tended to color their responses to new programs, and made many of their comments sound cynical and negative. Despite their distaste with how they had been previously treated, many of them were forgiving; if only

the contact person treated them with a sense of dignity. These strong statements reflect the hurtful aspects of the application process and the lack of respect encountered when requesting help. The past difficulties of qualifying for other public programs, particularly Medicaid, left a negative impression with participants of these studies, and were also a factor noted in a national focus group study of SCHIP retention and disenrollment (Kannell, Perry, Riley, & Pernice, 2001). Language and literacy issues are likely to continue as barriers to enrollment unless application assistors are used to facilitate the process. Assisting the applicants with the paperwork is necessary for both English and non-English speaking populations.

Frustration about income guidelines and household size were apparent and being “too rich” to qualify for public programs was a disappointment for study participants. Defining households by birth children and excluding step-children was aggravating, since ensuring all kids are covered enables the parent to bring all their children to the doctor, and not pick and choose which ones are deserving of public medical insurance. For participants born outside of the United States, information about the Department of Justice ruling (US Citizenship and Immigration Services, 2005), which allows aliens applying for lawful permanent resident status to not be considered a “public charge” for using health care benefits, is not being communicated to affected populations. Considering experiences with fraud abroad in native lands and in Los Angeles (Kondo, 2000), with the fraudulent collection of Healthy Families premiums in cash, it is imperative to reassure applicants that the program is genuine to ensure retention. Teaching them about using insurance and medical care as well as assessing transportation and child care barriers is likely to enhance retention.

Policy and legislative solutions are necessary, but ineffective as the exclusive answer to increase enrollment. Elimination of asset tests in several states for Medicaid has resulted in slight increases in enrollment, decreased administrative costs, and improved program efficiency (Kaiser Family Foundation, 2001). Other important simplification strategies used by states include presumptive eligibility, eliminating the face-to-face interview requirement, and using a family renewal form (Ross & Cox, 2000).

In 1999, early in program implementation, schools distributed information to parents about “Insure Kids Now” campaign, which provides a toll-free number and internet access to enrollment materials (Pear, 1999). The Urban Institute found that over 4 million uninsured children were eligible for the federal school lunch program (Kenney, Haley, & Ullman, 1999). Recognizing the link between children who are eligible for the school lunch program and Healthy Families, California passed legislation in 2001 establishing a statewide project to expedite Medi-Cal and Healthy Families enrollment for children who qualify for the federal free school lunch program (Frates & Wulsin, 2001).

Further, California attempted to remedy the concern about not enrolling parents in Healthy Families in December 2000 by submitting a 1115 waiver application to the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), to extend the subsidized insurance program to eligible parents (Managed Risk Medical Insurance Board, 2000). However, by the time the federal government granted approval, the state’s fiscal condition had greatly deteriorated and the waiver has been repeatedly postponed.

Recognizing that undocumented immigrant children are unlikely to ever be eligible for publicly subsidized coverage, a number of California counties have implemented a comprehensive children's health insurance initiative, typically in collaboration with a local managed health care plan launched with foundation support. These counties have articulated a commitment and marshaled resources to ensure that all children who reside in that county, in families with incomes from 250% to 400% of the federal poverty level, obtain health insurance, regardless of their immigration status or their parent's immigration status (Frates, Diringer, & Hogan, 2003; Rivera, 2004).

Even with all of these policy changes expanding access and increasing outreach, a quarter of the uninsured remain eligible for public programs. In response to budget constraints of the past several years, 11 states have made it more difficult to enroll and stay enrolled by reversing previously adopted procedural simplifications, perhaps resulting in the recent increase in the number of uninsured (Kaiser Commission on Medicaid and the Uninsured, 2005). Lack of knowledge, literacy, stigma, and perceptions of poor treatment, upon program enrollment or provider visit, remain as barriers. A new program, launching in Orange County, California, in August 2005, will employ "Care Coordinators" to enroll individuals, particularly children, in public programs and follow-up to ensure enrollment, provider appointment, degree of satisfaction with provider, and understanding of re-enrollment procedures with an expected enrollment of 8,000 kids in the first fiscal year (C. Bustamante, personal communication, February 27, 2006). The program plans to go beyond mere enrollment and educate individuals of the importance of insurance and preventive medicine as well as discuss transportation, health plan, and child care options while visiting the doctor.

Limitations of these studies are fourfold. First, focusing exclusively on California limits external validity to other states, although the similarities found throughout the studies illustrate how prevalent these barriers are whether the study participants live in rural areas, have immigrant status, or are working and lack health insurance. Second, audiotapes do not capture all of the idiosyncrasies of the information, which means that gestures, facial expressions, and body language are lost. Researchers kept copious notes to relate these to the transcripts, although it is likely incomplete due to the intensity of fieldwork. Third, despite our best efforts to ensure that transcription and translation were accurate, the 2001 immigrant study may not be translated into the best, colloquial English. Two native speakers reviewed the transcripts to raise the chances of accurate translation, but disagreement is probable if more individuals examined the transcripts. Fourth, these studies were dependent upon the state of the researcher, subject to their feelings and biases. Since the researcher is an instrument for appropriately probing and identifying particular issues, there may be some problems in the 2001 immigrant study since the interviewers were bi-cultural and bi-lingual, but not doctoral trained researchers with extensive knowledge in qualitative methods. Although these limitations of generalizability, inability to document body language, potential for translation problems, and reliance upon the researcher as an instrument are serious, it does not invalidate the findings of these studies. In fact, since most of the barriers were identified throughout the three studies, the results provide a better understanding of the context and nature of issues affecting uninsured populations.

Implications for Future Research

As the paradigm of health care policy and reform shifts to a more market-based approach in the United States, it is important to continue to identify barriers that lead to informational problems for patients and/or consumers of health care. Medicare Part D, which is the new voluntary pharmaceutical plan for beneficiaries of Medicare, illustrates how important it is to reduce barriers in a timely manner. Currently, this legislation is offered to all Medicare eligible patients, but beneficiaries who decide to enroll after May 2006 will be charged a one percent penalty for each month thereafter, so that they do not enroll in the plan. Given the results in this study examining the barriers to enrollment in public insurance, there will be many seniors who will be paying hefty penalties in future enrollment. Continued monitoring is necessary of Medicare Part D and the numerous state programs to ensure that enrollment targets are consistently met and barriers are reduced or easily surmountable by individuals who are eligible, but not yet enrolled.

Conclusion/Lessons Learned

Qualitative inquiry encourages readers to “get under the skin” of the target population. In the words spoken by interviewees, frustration, anxiety, and concern are apparent. These expressed feelings provide greater meaning to the severity of having no way to pay for necessary medical care, and insight into the development of future strategies. Eight primary barriers were identified that affect enrollment in public programs including economic aspects of qualifying, lack of knowledge, benefit design of public programs, poor experiences and stigma, complexity and literacy, immigration status, poor customer service, and fear of fraud. If full enrollment is to be achieved, developing policy and management oriented solutions to lower these barriers is of paramount importance.

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