CONNECTICUT VOICES FOR CHILDREN

Covering Connecticut's Children: How Policy Changes Affect HUSKY Program Enrollment

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After a successful start, Connecticut's health insurance program for low-income children and families, the HUSKY Program, has undergone significant policy and procedural changes that have led to precipitous drops in enrollment. Most of these changes were intended to save the state money during a budget crisis, but have proved costly in the long run. At the same time, Connecticut's families were experiencing their own economic difficulties and the need for health care coverage increased. While some of these policies have been repealed or reversed, much remains to be done in order to achieve the goal of ensuring that all Connecticut children have access to health care.

Health Insurance Is Important for Children and Their Families

Children need health care to support optimal growth and development from infancy through adolescence. National data show that health insurance coverage for children is strongly associated with access to care.[1] Children with health insurance are more likely to have a usual source for care, more likely to have had health care in the past year, and less likely to have gone without needed care. National data show that children are more likely to be insured when their parents are also eligible for coverage and the health care they need. [2]

Many Connecticut Children are Uninsured

In Connecticut, an estimated 68,000 children under 18 (8.2%) were uninsured for the entire year in 2005.[3] An additional number were uninsured for part of the year or underinsured for costly health care needs. A survey of Connecticut households revealed a decline in employer-sponsored health insurance coverage between 2001 and 2004 that was largely offset by increased coverage in the HUSKY Program.[4] In fact, were it not for the HUSKY Program, the overall number of uninsured would have increased rather than remaining steady in recent years. Since uninsured children are more likely to be living in low-income families, ***most uninsured children in Connecticut are eligible but not enrolled in the HUSKY Program.***

Connecticut's HUSKY Program Provides Health Care Coverage for Many Families

The HUSKY Program is the central feature of Connecticut's health care safety net for children. Affordable coverage in the HUSKY Program is available to nearly all families with uninsured children. The HUSKY Program currently provides health insurance coverage for about 202,000 children and 87,000 parents in HUSKY A (Medicaid managed care) and an additional 16,000 children in HUSKY B (State Children's Health Insurance Program).[5] For nearly 1 of every 4 children in Connecticut, the HUSKY Program provides preventive care (timely, comprehensive well-child care and dental care) and treatment for acute and chronic illnesses and injuries.[6]

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The HUSKY benefit package is tailored to meet the health care needs of children in low-income families who are more likely than children in higher income families to have special health care needs. The positive impact of coverage is readily apparent: after just 6 months of coverage, significantly more newly enrolled children have primary care providers, fewer children rely on emergency rooms for routine care, and more children have had check-ups and dental care than in the 6 months prior to enrollment.[7] HUSKY A also covers more than one in four births in Connecticut, ensuring that mothers and babies have access to prenatal care and well-baby care during the first year of life.

Family Coverage in Medicaid is Not Expensive

Children and their parents make up 75 percent of persons with Medicaid coverage in Connecticut but account for just 23 percent of all the state's Medicaid expenditures.[8] The average annual cost for coverage in HUSKY A is about $2,400 in HUSKY A and about $1,900 in HUSKY B, compared with about $5,000 for coverage in the state employee health insurance program.[9] Furthermore, Connecticut receives 50 cents in federal matching funds for every dollar spent on HUSKY A and 65 cents for every dollar spent on HUSKY B. Most importantly, children and families have access to the primary and preventive care that can reduce more costly use of emergency care and preventable hospitalizations.

HUSKY Program Enrollment Has Declined Sharply

At its peak in June 2005, the HUSKY Program covered over 325,000 children and parents, up from 221,000 at its inception in July 1998. After steady growth since 1998, HUSKY Program enrollment dropped precipitously in July 2005 and again in July 2006 (see Figure 1). Following a series of significant policy changes that affected eligibility, application procedures, and cost sharing, enrollment dropped by 10,000 in July 2005 and an additional 15,000 in July 2006. Most of the enrollment decline was among children under 19 in HUSKY A, down by 20,000 in just 13 months. These dramatic, unprecedented drops in enrollment can be attributed to a variety of factors, including changes and confusion about eligibility and cost-sharing, increased application complexity, and elimination of most community-based outreach and application assistance.

A recent change in federal law may contribute to a further decline in enrollment. As of July 1, 2006, US citizens who are eligible for Medicaid coverage must prove citizenship and identity when they apply for or renew coverage. While this new requirement does not change who is eligible for services, the additional documentary evidence needed and the logistical challenges of presenting it with the application are expected to be problematic for a significant number of low-income children and parents. This new requirement may also cause confusion for legal immigrants whose application procedures and documentary requirements have not changed.

HUSKY Program Policy Changes Created Confusion and Affected Enrollment

During Connecticut's economic downturn (2000–2003), state budget pressures on the program increased. At the same time, Connecticut's families experienced their own budget problems and the need for coverage increased.

In addition to the recent federal requirement to show proof of citizenship and identity at the time of application, the following policy and procedural changes enacted in Connecticut in the past five years have had a significant effect on application procedures and have contributed to confusion about the program:

- **Continuous eligibility**: Connecticut ***extended*** children's coverage for the balance of 12 months even if family income fluctuated while the child was enrolled (July 1998). Connecticut ***eliminated*** continuous eligibility (April 2003), reversing earlier efforts to reduce "churning" in program enrollment and to ensure continuous access to care.

- **Parent coverage:** Connecticut ***raised*** the income eligibility level for parents in families with income up to 150% of the Federal Poverty Level (FPL) (January 2001), then ***eliminated*** coverage for those in households over 100% FPL (July 2003), then ***raised*** the income eligibility level back to 150% FPL (July 2005). These policy changes have undermined efforts to increase the number of children with health insurance by offering coverage to entire families. Even after restoring coverage for some families, the income eligibility level for parents is not aligned with the income eligibility level for their children.

- **Cost-sharing:** HUSKY B premiums were ***raised*** (February 2004); when many families failed to pay the announced increase, the premiums were ***lowered*** (June 2004). HUSKY B premiums were ***raised again*** (July 2005), and ***lowered again*** prior to implementation of premium increases (November 2005). Both times premiums were raised, thousands of children would have lost coverage had the change not been repealed.

- **Coverage for legal immigrants in the US less than 5 year:** Connecticut ***extended*** coverage for legal immigrants in the US less than five years with state funds (July 1997), then ***eliminated*** the coverage (July 2003), then ***restored*** it (July 2004). These policy changes have undermined efforts to overcome misconceptions about public benefits and fear in legal immigrant families that need coverage for their children.

- **Paper proof of income:** Connecticut ***simplified*** the application process by allowing self-declaration of income with electronic verification (July 2001), then ***reversed*** this policy (July 2005), then ***restored*** self-declaration of income (July 2006). These policy reversals have created confusion among applicants and increased the administrative burden for the depleted Department of Social Services' staff.

- **Transitional medical assistance:** Since welfare reform, Connecticut ***offered*** Transitional Medical Assistance (TMA) for 24 months following loss of Medicaid coverage due to fluctuations in earnings. TMA coverage was initially denied for parents affected by the income eligibility cut, then ***extended*** under court order. TMA was ***cut back*** to 12 months for all TMA recipients (July 2005, with greatest effect on enrollment July 2006). These policy changes and court orders have contributed to confusion about eligibility in families whose Medicaid coverage is affected when their earnings increase.

- **Community-based outreach and application assistance:** State funds ***supported*** HUSKY outreach and application assistance (July 1998), then were ***cut back*** during the state's budget crisis (2001-2003). This program change reduced community-based outreach and application assistance just as the need for coverage and the need for explanation of rapidly changing program rules increased. Recently, the Governor has released state funds for resumption of HUSKY outreach and application assistance, but the level of funding is not back to previous levels nor assured going forward.

Connecticut Can Cover All Its Uninsured Children

Connecticut is close to achieving universal health care coverage for children. Just one in twelve children in the state are uninsured and most of them are eligible for health care coverage in the HUSKY Program.[10]

Connecticut is making progress toward ensuring health care coverage for children. In the 2006 session for example, the Connecticut General Assembly removed a significant administrative barrier to enrollment by simplifying income verification.[11] In addition, Connecticut became ***the first state in the nation*** to codify in its own statutes the full scope of health care required for children on Medicaid. [12] There are additional steps Connecticut can take to reduce the number of uninsured children.

Recommendations

- **Restore funding for community-based outreach and application assistance** in order to reach families who are unaware of or confused about their eligibility for coverage or how to renew. In particular, Connecticut can target outreach to the Hispanic community which faces higher rates of uninsurance than other demographic groups.[13]

- **Align income eligibility for parents and children** in order to increase child enrollment by offering coverage to the entire family.

- **Restore continuous eligibility** so that fluctuations in income, common among low income families, do not jeopardize access to care for their children.

- **Avoid imposing additional cost-sharing on parents or children** that may discourage enrollment or use of essential health services.

- **Cover all pregnant women to 300% FPL** whose babies will be eligible for coverage in HUSKY A or B.

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[1] Simpson L et al. Health care for children and youth in the United States: annual report on patterns of coverage, utilization, quality, and expenditures by income. Ambulatory Pediatrics, 2005; 5(1): 6-44.
[2] Dubay L, Kenney G. Expanding public health insurance to parents: effects on children's coverage under Medicaid. Health Services Research, 2003; 38(5): 1283-1301.
[3] US Census Bureau, Current Population Survey (2006); available at: www.census.gov.
[4] Connecticut Office of Health Care Access. Snapshot: Connecticut's health insurance coverage: results of the Office of Health Care Access 2004 Household Survey. Hartford, CT: OHCA, January 2005.
[5] HUSKY Program enrollment as of October 1, 2006, reported by the Connecticut Department of Social Services. HUSKY A: Children are eligible if living in households with income less than 185% of the federal poverty level (FPL) or $30,710 annually for a family of three; pregnant women are eligible if household income is less than 185% FPL; parents are eligible if household income is less than 150% FPL or $24,900 for a family of three. HUSKY B: Uninsured children are eligible with nominal cost-sharing if living in households with income between 185% and 235% FPL ($30,710 - $39,011 for a family of three) , with subsidized premiums and nominal cost-sharing if living in households with income between 235% and 300% FPL ($39,011 - $49,800), and with state-negotiated, unsubsidized premiums and nominal cost sharing if living in households with income over 300% FPL (over $49,800).
[6] Four managed care plans (BlueCare Family Plan, Community Health Network, Health Net, and Preferred One) contract with the Department of Social Services to provide this care through their networks of primary care physicians and specialists, hospitals, community-based clinics, and dentists. Since January 2006, behavioral health care is provided through the Behavioral Health Partnership – a joint effort of the Connecticut Departments of Social Services and Children and Families. The Behavioral Health Partnership is operated by an administrative services organization, currently Value Options.
[7] Connecticut Voices for Children. Racial/ethnic disparities in health and health care among children enrolled in HUSKY A: a longitudinal survey. New Haven, CT: CT Voices, June 2004. Report based on longitudinal survey of families with newly enrolled children, conducted in 2002-2003 by the Children's Health Council, an entity established by the Connecticut General Assembly, which provided oversight of the HUSKY program from 1995 to 2003.
[8] 2006 analysis of data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Available from www.statehealthfacts.org. The balance of the enrollees (25%) and expenditures (77%) are for coverage of the elderly, blind and disabled.
[9] Information from Connecticut Department of Social Services and Connecticut State Comptroller's Office, November 2006. HUSKY A capitation rates average $199.65 per month; HUSKY B capitation rates average $154.55 per month. The annual premium cost per covered person in the state employees health benefits program is $4,655 for medical and $335 for dental coverage.
[10] US Census Bureau. Table HI10. Number and percent of children under 19 at or below 200% of poverty by heath insurance coverage and state: 2005. Available at www.census.gov.
[11] Income verification simplified: Applicants are allowed to declare their income, under penalty of law, with electronic verification and further follow-up by Department of Social Services staff if necessary.
[12] Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services were codified in Public Act 06-196.
[13] Connecticut Office of Health Care Access. Snapshot: Connecticut's health insurance coverage. Hartford, CT: OHCA, 2005. Available at: http://www.ct.gov/ohca/lib/ohca/publications/snapshotfinal.pdf.
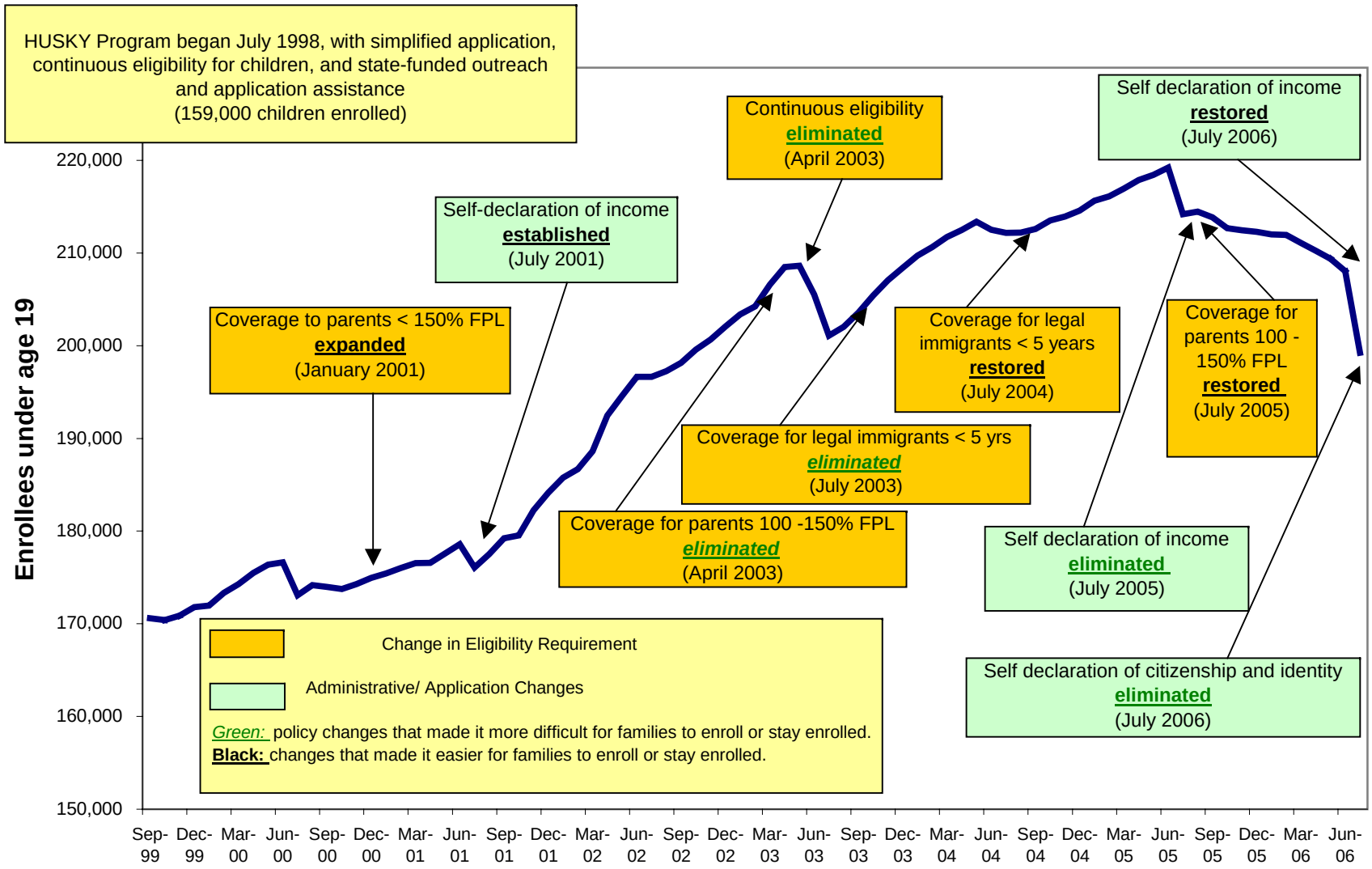
Figure 1. Effect of Policy Changes on Children's Enrollment in HUSKY A