CONNECTICUT VOICES FOR CHILDREN

Keep It Simple:
Reduce Gaps in Children's Health Coverage

May 2007

Gaps in health coverage are costly to Connecticut. Gaps in health insurance coverage for Connecticut residents increase health care costs, as uninsured residents rely on hospitals and safety net providers for care.[1] When large numbers of children cycle on and off the HUSKY health insurance program it drives up the administrative costs of running HUSKY and undermines efforts to provide quality pediatric health care. Children who experience gaps in insurance may also delay or forego care.

Continuous eligibility can reduce gaps in children's health care. Continuous eligibility (CE) can address the "churning" that is common in HUSKY, as families cycle on and off the program due to temporary changes in their income. It allows children a year of *continuous* eligibility for up to one year after enrollment or renewal, regardless of fluctuations in family income or changes in family structure.

Low-income families experience more changes in family structure, mobility, and wage fluctuations than do those with higher incomes. For example, if a parent worked extra hours during the holiday rush, her child might become over-income for HUSKY A for a month or two. Without CE, the family would have to switch the child's coverage to HUSKY B, and then back to HUSKY A. Such transitions often result in gaps in coverage. Recent studies have found that such needless gaps are more common and are growing longer:

- A national study found that 40% of those who spent any time in Medicaid/SCHIP left but then re-enrolled in one of these programs. [2]
- In New York, 66% of the children who lost coverage for Medicaid/SCHIP returned within 12 months. Less than 10% remained ineligible because of income or family structure changes.[3]

To combat this churning, 27 states have adopted continuous eligibility in Medicaid, SCHIP, or both programs.[4] In 2006, the State of Washington reinstated CE in Medicaid and SCHIP after those programs experienced a large decline in enrollment due to the loss of CE.

There is evidence that CE, when combined with notices to families encouraging them to renew their children's coverage[5], helped more eligible children to *stay enrolled* in HUSKY:

- Between 2001 and 2003, enrollment in HUSKY A increased by 15%.[6]
- During this time, an average of over 6,500 children who would otherwise have lost coverage were kept enrolled in the CE coverage group each month.
- A Connecticut Office of Health Care Access survey found that children were less likely than adults to experience fluctuations in health care coverage during the time when CE was in effect.[7]

The elimination of CE in 2003 resulted in over 7,000 children losing their HUSKY coverage.[8]

Continuous eligibility should be restored as it saves state dollars. Maintaining continuous HUSKY coverage for families is cost-effective.

- Research shows that the monthly cost of providing health care drops as individuals are enrolled for longer periods.[9]
- A national study found that 12-month continuous eligibility could *lower* state administrative costs by reducing the staff effort needed to process applications. Reinstating CE for children could reduce such costs between two and twelve percent.[10]
- Children without continuity of care are more likely to visit the emergency room and be hospitalized, costing the state more money. One

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study found that these risks were higher for children on Medicaid.[11]

Continuous eligibility reduces provider costs and improves care. Interruptions in coverage are costly for managed care organizations and providers struggling to maintain eligibility records.

- Recent studies of pediatric and dental providers have found that provider participation in HUSKY/Medicaid decreases as paperwork concerns increase.
- Almost a quarter of Connecticut pediatricians cited concerns with paperwork in HUSKY.[12]
- The Connecticut Hospital Association estimated that the loss of CE and self-declaration of income could cost member hospitals $2.8 million.[13]

Continuous eligibility prevents interruptions in children's health care. Children with continuous coverage are more than four times as likely to have a primary care provider (PCP) as children who go on and off Medicaid. Furthermore, having both continuous coverage and a PCP significantly improves treatment for ear infections.[14]

Reinstating continuous eligibility: a cost-effective strategy. Currently, the state legislature is considering a variety of bills that would bring added stability to the HUSKY program. Several bills propose restoring continuous eligibility. The legislature's Office of Fiscal Analysis has estimated the cost of reinstating this simplification strategy as $2.8 million, with half the cost reimbursed by the federal government.[15]

Reinstating CE could decrease administrative costs, increase provider satisfaction, and prevent interruptions in children's health care. Current gaps in HUSKY are unnecessarily increasing administrative costs and eligible children remain without the health services they need.

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[1] J. Hadley and J. Holahan. "How much medical care do the uninsured use, and who pays for it?" *Health Affairs*. 12 February 2003.

[2] Medicaid funds HUSKY A (for low-income children, pregnant women, and parents) and SCHIP funds HUSKY B (for uninsured children whose family income disqualifies them from HUSKY A) in Connecticut.

[3] M. Birnbaum and D. Holahan, "Renewing Coverage in New York's Child Health Plus B program: Retention Rates and Enrollee Experiences." New York: United Hospital Fund, 200; and K. Lipson et al, "Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs", Pub. No. 656. New York: Commonwealth Fund, August 2003.

[4] The Kaiser Commission on Medicaid and the Uninsured, July 2006 "Renewal: Selected Simplified Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs", available at www.cbpp.org/shsh/tables.htm (Table 7) See also, D. Cohen Ross, L. Cox, C. Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006", Kaiser Commission on Medicaid and the Uninsured, January 2007.

[5] The Department of Social Services (DSS) originally implemented continuous eligibility (CE) in July 1998. In May 2001, DSS began to notify families two months before the end their children's CE periods that their children's coverage would end and inviting them to complete a new application. See "HUSKY Retention: Helping Families Keep Health Coverage", Children's Health Council, Nov. 2001 available at http://www.ctkidslink.org/pub_detail_19.html

[6] "HUSKY A Enrollment: More Children are Keeping Health Coverage", Jan. 2003, Children's Health Council, available at http://www.ctkidslink.org/pub_detail_9.html

[7] Connecticut Office of Health Care Access. "Stability of Health Care Coverage: A Look at the Intermittently Insured." March 2003.

[8] CT Department of Social Services HUSKY Enrollment files.

[9] See note 3.

[10] C. Irvin, D. Peikes, C. Trenholm et al. 2001. "Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children." Cambridge, Mass.: Mathematica Policy Research, Inc.

[11] D. Christakis, L. Mell et al. "Association of Lower Continuity of Care with Greater Risk of Emergency Department Used and Hospitalization in Children," *Pediatrics*, 103: 3, March 2001.

[12] S. Berman, J. Dolins, S. Tang and B. Yudkowsky. "Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients." *Pediatrics* 110:2. August 2002.

[13] Stephen A. Frayne. Testimony before a joint meeting of the Appropriations, Human Services, and Public Health Committees. February 20, 2004. Note: In July 2006, the legislature reinstated "self-declaration of income" which allows families to write down their income on the application without providing paper proof of wages. DSS then verifies the wage information electronically.

[14] S. Berman, J. Bondy et al. "The Influence of Having an Assigned Medicaid Primary Care Physician on Utilization of Otitis Media-related Services," *Pediatrics* 104:5, November 1999.

[15] See, for example, fiscal note attached to Senate Bill 1 (File No. 551) (Section 7), *An Act Concerning the HealthFirst Connecticut Initiative*, which estimates the cost at $2.8 million and also notes that 50% of this cost would be reimbursed by the federal government under Medicaid, available at http://www.cga.ct.gov/2007/FN/2007SB-00001-R000472-FN.htm