CONNECTICUT VOICES FOR CHILDREN

Trends in New Enrollment in the HUSKY Program: 2006-2007

July 2008

On September 7, 2006, Governor Rell announced over $1 million in new funding for community- and school-based outreach and for public information to increase the number of children and families enrolled in the HUSKY program.[1] These new outreach programs were implemented in mid-to-late 2007. These new efforts build upon a long history of outreach in Connecticut by both public and private organizations to increase enrollment of low-income, uninsured children and their parents/caregivers in the HUSKY program. Concurrent with increased outreach, Connecticut expanded income eligibility for parents from 150 to 185 percent of the federal poverty level, bringing parents' income eligibility in alignment with their children's eligibility.[2] By covering low-income parents, Connecticut adopted a proven strategy for increasing enrollment of uninsured children.[3]

Monitoring outcomes of outreach initiatives is essential to evaluating whether these projects achieve their long-term objective.[4] Examining trends in total enrollment alone does not capture the true impact of outreach because of the historical instability of Medicaid coverage, or "churning."[5] Examination of trend in new enrollment—that is, counting persons who have not been enrolled for some specified period of time—provides a far better picture of the effectiveness of HUSKY outreach.

Purpose

To identify trends in new enrollment among children and adults in the HUSKY A program (Medicaid managed care) and children in the HUSKY B program (SCHIP).

This report is the first report issued by Connecticut Voices for Children describing new enrollment in the HUSKY Program.[6] Newly enrolled children and adults are those who were not enrolled at any time in the 12 months before they first appear in the HUSKY enrollment database.[7]

FINDINGS

Net increase in enrollment: Between January 1, 2006 and December 31, 2007, HUSKY program enrollment overall increased modestly by 11,355 individuals. This increase was driven by a nearly 9 percent increase in the number of adults in HUSKY A (from 90,070 to 98,075) over the two-year period. The total enrollment of HUSKY A children increased by one percent over the two-year period (from 211,991 to 214,044). HUSKY B enrollment increased by nearly 9 percent overall, though the increased number of children in the program was relatively small (16,460, up from 15,163 two years earlier).

Number of new enrollees: In the 24-month period, there were 141,291 newly enrolled individuals in the HUSKY Program**.** Nearly 95 percent of the newly enrolled were in HUSKY A, including 79,542 (56.3%) children and 54,062 (38.3%) adults. About 5 percent were children in HUSKY B children (7,687) (Table 1). The average number of newly enrolled children per month was about 3,300 for HUSKY A and just over 300 for HUSKY B. There were an average of 2,300 new adult enrollees in HUSKY A each month over the two-year period.

Table 1. Total number of new enrollees in the HUSKY Program by six-month intervals, 2006-2007

	Jan-Jun 2006	Jul-Dec 2006	Jan-Jun 2007	Jul-Dec 2007	Total
All HUSKY	32,049	34,251	35,039	39,952	141,291
HUSKY A:	30,491	32,353	32,778	37,982	133,604
Children	17,792	19,889	20,006	21,855	79,542
Adults	12,699	12,464	12,772	16,127	54,062
HUSKY B children	1,558	1,898	2,261	1,970	7,687

In HUSKY A, the number of new enrollees per month increased overall among both children and adults (Figure 1).[8] After the income eligibility level for adults increased in July 2007, the number of newly

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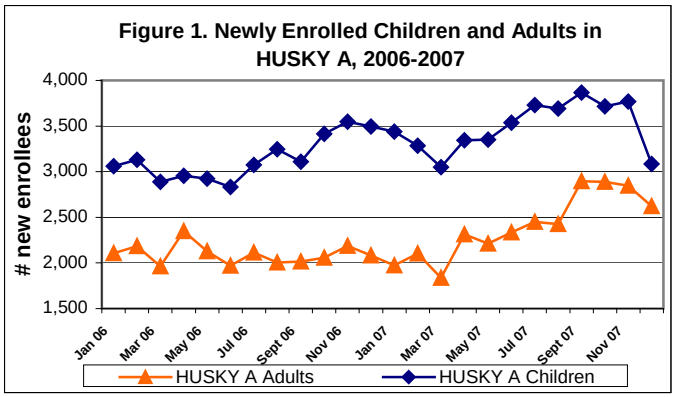
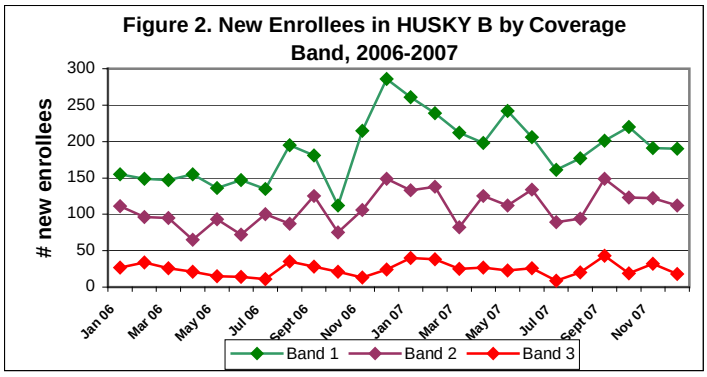


enrolled adults increased by about 30 percent over the previous 6-month period. The increased number of children in HUSKY A paralleled the increase in adult enrollment.

The number of new enrollees in HUSKY B did not increase appreciably over 2006-2007 (Figure 2). Overall, there was a slight increase in the number of new enrollees in coverage Band 1, most noticeably in late 2006 to early 2007, and little to no meaningful increase in new enrollees in coverage Bands 2 or 3.[9]



Limitations of the data: On November 16, 2007, Governor Rell directed the Commissioner of the Department of Social Services to discharge the responsibilities of all four HUSKY A managed care contractors because of compliance problems with public accountability standards under the Freedom of Information Act.[10] This program change appears to have affected HUSKY A enrollment data quality in December 2007.[11] The drop in numbers of new enrollees that is evident in December 2007 in HUSKY A was driven almost entirely by a sizeable drop (53%) in the number of records for newly enrolled infants under 3 months in the HUSKY A enrollment database.[12] During this same period, the number of records for newly enrolled adults in HUSKY A also decreased, though to a lesser extent. In contrast, the number of records for newly enrolled children 2 to 18 declined just 2 percent, while the number of records for newly enrolled children in HUSKY B remained steady. Therefore, it is possible that the actual number of newly enrolled children and adults in HUSKY A increased in December 2007, continuing the trend observed in the preceding months.

DISCUSSION

Many of the nation's uninsured children qualify for coverage in the Medicaid or State Children's Health Insurance Program (SCHIP).[13] Experience in Connecticut and elsewhere has shown that families want to insure their children but are either unaware that they are eligible or find the application process and program requirements daunting. Since creation of SCHIP (HUSKY B in Connecticut), efforts to reach these families, provide them with application assistance, and simplify the administrative procedures for getting and keeping coverage have resulted in a significant decline in the number of uninsured children in low income families nationwide.[14] Community-based outreach and application assistance, combined with simplification of application procedures, have proven effective in getting children enrolled.[15] Certainly Connecticut's experience in recent and past years has shown this to be true.[16] However, in Connecticut, as in other states, the majority of uninsured children are eligible for Medicaid (HUSKY A).[17]

The results of this study show a great difference between net enrollment increase (11,355) and the number of new enrollees (141,291) for the 2-year period 2006-2007. This finding suggests that retention is a problem in the HUSKY Program. Some enrollment turnover is to be expected when family income increases or children turn 19, move out of state, or obtain other coverage. However, there is evidence that retention is a long-standing problem in Connecticut, as in other states.[18] Results of a recent study showed that over 40 percent of eligible-but-uninsured children nationwide had been covered by Medicaid or SCHIP in the previous year; this rate was up significantly from just over 25 percent in 2001.[19] In this report, Connecticut was identified as a state with poor retention, rather than poor take-up, based on the percentage of eligible-but-uninsured children

who had dropped out of Medicaid or SCHIP in the previous year. Our findings and this national study point to retention as a problem warranting increased efforts on the part of policy makers, state agencies and community-based outreach providers.

CONCLUSIONS

- **In 2006-2007, the net increase in HUSKY program enrollment was relatively modest in relation to the amount of statewide attention and resources focused on problems of the uninsured and the need for outreach.**
- **The number of new HUSKY A enrollees far exceeded the net increase in enrollment and increased steadily in HUSKY A over the two-year period.**
- **Expansion of income eligibility for parents led to increased enrollment among adults and children.**
- **The large difference between the net enrollment increase and the number of new enrollees indicates that there are ongoing problems with retention of eligible children in the program.**
- **The effect of new state-funded outreach programs, separate and apart from the effect of expanding parent eligibility, cannot be determined at this time.**

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[1] HUSKY A (Medicaid managed care) provides coverage to children at or below 185% of the federal poverty level and adult parent/caregivers up to 150% FPL. HUSKY B, the non-entitlement State Child Health Insurance Program (SCHIP) program, provides health coverage to children within 3 income bands that require some co-pays and premiums (186-300% FPL) or full premium payment (>300% FPL). Both programs are administered by the Department of Social Services. Enrollment is either program utilizes the same application that is processed centrally.

[2] Parents' increase in income eligibility was effective 7/1/07.

[3] Dubay, L Kenney G. Expanding public health insurance to parents: effects on children's coverage under Medicaid. Health Services Research, 2008; 38(5): 1283-1301. Ku L, Broaddus M. Coverage of parents helps children too. Washington, DC: Center on Budget & Policy Priorities, 2006; available at: www.cbpp.org/10/20-06health.htm. Committee on the Consequences of Uninsurance, Institute of Medicine. Health Insurance Is a Family Matter. Washington, DC: National Academy Press, 2002.

[4] Mattaliano L, Lee MA, Langer S. Guidelines for evaluation of HUSKYoutreach programs." New Haven, CT: Connecticut Voices for Children, September 2007. Report available at www.ctkidslink.org.

[5] Fairbrother G, Jain A, Park HL, Massoudi MS, Haidery A, Gray BH. 2004. Churning in Medicaid managed care and its effect on accountability. *J Health Care Poor Underserved* 15(1): 30-41.

[6] Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on trends in new enrollment was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Mary Alice Lee, Ph.D., Karen M. Sautter, M.P.H., and Amanda Learned, B.A. This publication does not express the views of the Department or the State of Connecticut. The views and opinions expressed are those of the authors. This report and reports on other health policy topics are available online at www.ctkidslink.org.

[7] Methods: Using HUSKY Program enrollment data from the Department of Social Services, a longitudinal database of HUSKY A and B enrollment records from January 1, 2005 on was constructed and used to identify children and adults who were newly enrolled in HUSKY A (Medicaid managed care) or HUSKY B (SCHIP) between January 1, 2006 and December 31, 2007 (24 months). Those children and adults who were counted as newly enrolled had not ever been enrolled in the 12 months prior to the first month in which they appear in the enrollment database.

[8] Trend-line for children in HUSKY A: $y = 31.865x + 2915.9$, $R^2 = 0.5381$; trend-line for adults in HUSKY A: $y = 29.66x + 1881.9$, $R^2 = 0.4862$.

[9] Trend-lines for children in HUSKY B by income band: For Band 1, $y = 2.8361x + 152.51$, $R^2 = 0.2167$; for Band 2, $y = 1.5126x + 88.884$, $R^2 = 0.2006$; and for Band 3, $y = 0.0709x + 23.656$, $R^2 = 0.003$.

[10] "Governor Rell Orders Termination of HUSKY Contractors' Managed Care Role over Failure to Accept Public Oversight." Press Release, November 19, 2007. Available at: http://www.ct.gov/GovernorRell/cwp/view.asp?A=2791&Q=399666.

[11] According to staff at Mercer Government Health Services Consulting, the data vendor for the HUSKY Program, some new members may have selected or been assigned to "traditional Medicaid" (non-managed care), in anticipation of the program change, causing inadvertent omission of their records from the enrollment databases provided three times for this analysis.

[12] From one month to the next, the number of records for newly enrolled infants under 3 months in HUSKY A dropped from 1,196 (November 2007) to 556 (December 2007). According to DSS staff, the number of newborns whose eligibility was processed by the Central Processing Unit in December 2007 was 1,193 (consistent with applications for newborns in November 2007 and January 2008), far more than the number of records for newly enrolled children under 3 months that appeared in the data extract provided by DSS' data vendor for this analysis.

[13] Analysis of 2005 Current Population Survey data using July 2004 state eligibility rules by Lisa Dubay Ph.D., reported by the Georgetown University Health Policy Institute's Center for Children and Families in "Making Real Gains for Children: Strategies for reaching more than six million uninsured children eligible for Medicaid and SCHIP," June 2007.

[14] Dubay L, Guyer J, Mann C, Odeh M. Medicaid at the ten-year anniversary of SCHIP: looking back and moving forward. Health Affairs, 2007; 26: 370-381.

[15] Ukaegbu UA, Schwartz S. Seven steps toward state success in covering children continuously. Portland, ME: National Academy for State Health Policy, 2006. Available at: www.nashp.org.

[16] Connecticut Voices for Children. Covering Connecticut's children: how policy changes affect HUSKY Program enrollment. New Haven, CT: Connecticut Voices, November 2006. Available at: www.ctkidslink.org.

[17] US Census Bureau. Number and percent of children under 19 years of age, at or below 200 percent of poverty, by state: three-year averages for 2004, 2005 and 2006. Available at: www.census.gov/hhes/www/hlthins/liuc06.html.

[18] Children's Health Council. HUSKY retention: helping families keep health coverage. Hartford, CT: Children's Health Council, November 2001. Available at: www.ctkidslink.org.

[19] Sommers BD. Why millions of children eligible for Medicaid and SCHIP are uninsured: poor retention versus poor take-up. Health Affairs, 2007: w560-w567.