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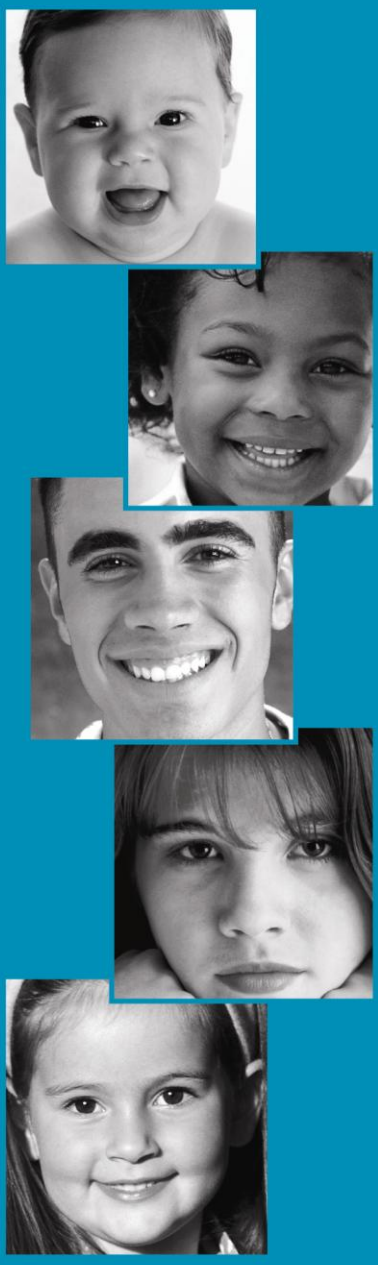

HUSKY Program Enrollment Dynamics:
Coverage Continuity, Gaps in Coverage and Retention

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April 2010

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KEY FINDINGS

In spite of great improvements in children's health insurance coverage rates since the implementation of programs and policies such as Children's Health Insurance Program (CHIP), many Medicaid- and CHIP-eligible children and families remain uninsured. The extent of this problem is largely dependent on two factors: how successful a state is at enrolling eligible children and families who are uninsured (take-up), and how well a state keeps eligible children and families enrolled (retention). Frequently, state efforts to tackle the problem of uninsurance are framed in terms of take-up while the importance of retention is often underestimated and overlooked. Connecticut has been identified as a state that has a problem with retention of Medicaid- and CHIP-eligible children. The scope of the problem is evident in the results of this study of enrollment dynamics in Connecticut's HUSKY Program. The study shows that among these newly enrolled children and adults:

- **Many new enrollees experienced gaps or lost HUSKY coverage in the first year.** Despite having just been determined eligible, about one of every four new enrollees lost coverage in the first year, a disruption that undoubtedly affected access to needed care. Some of those who lost coverage re-enrolled within six months, suggesting that they may have been eligible during the gap in coverage.

- **Many HUSKY enrollees experienced gaps or lost HUSKY coverage at renewal.** Almost one in five who managed to stay enrolled for a year lost coverage at the time of they were to renew their coverage. This problem was particularly acute for children in HUSKY B (45% with a gap or loss of coverage). By 18 months after enrolling in the program, fully half the new enrollees had experienced a gap or lost coverage altogether. Many of those who lost coverage were probably eligible all along since a large proportion returned to the program in six months or less.

- **Retention rates varied across district offices.** If policies and procedures for eligibility determination and renewal are not applied uniformly by workers in the district offices and enrollment broker, coverage continuity and retention may be affected by administrative errors and delays.

In order to reduce the number of uninsured children and families, Connecticut must take steps to keep eligible individuals enrolled. The results of this study suggest an urgent need for addressing the factors that contribute to loss of coverage, especially at the time of renewal. The Children's Health Insurance Program Reauthorization Act of 2009 provides Connecticut with opportunities and fiscal incentives to increase enrollment in Medicaid and CHIP by adopting policies that reduce administrative barriers to getting and keeping coverage.

INTRODUCTION

In spite of great improvements in children's health insurance coverage rates since the implementation of programs and policies such as Children's Health Insurance Program (CHIP), many Medicaid- and CHIP-eligible children and families throughout the country remain uninsured.[1, 2] From state to state, the extent of this problem is largely dependent on two factors: how successful a state is at enrolling eligible children and families who are uninsured and how well a state keeps eligible children and families enrolled. Frequently, state efforts to tackle the problem of uninsurance are framed in terms of program take-up, while the importance of retention is often underestimated and overlooked.

Connecticut has been identified as a state that has a particular problem with retention of Medicaid- or CHIP-eligible children, a portrayal that is supported by analyses of census data comparing states and analyses of HUSKY enrollment records.[3, 4, 5] If the Medicaid and CHIP programs in Connecticut retained all eligible children, it has been estimated that the number of uninsured children in the state would fall by over 40 percent.[6] In addition, poor retention results in "churning," the harmful and costly tendency for Medicaid and CHIP beneficiaries to go off and back on coverage, sometimes repeatedly. Poor retention can be related to a variety of factors, including complex eligibility rules, complicated application and renewal procedures, and enrollee confusion about enrollment and renewal requirements. Administrative procedures may enhance or detract from retention in the program. A family's ability to overcome the administrative barriers may relate in part to the extent of their need for ongoing care.

To date, a handful of studies and reports have examined Medicaid retention and coverage gaps in Connecticut, but none have closely examined short-term disenrollment dynamics or how retention and continuity variables vary along programmatic and sociodemographic lines. This report provides the most detailed account yet of enrollment dynamics in Connecticut's Medicaid and CHIP programs. The results of this study are useful for understanding the scope of retention problems and for developing policy solutions and interventions aimed at keeping eligible children and families enrolled and therefore avoiding coverage gaps.

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[1] Hudson JL, Selden TM. Children's eligibility and coverage: Recent trends and a look ahead. Health Affairs 2007; w618-629 (published online 16 August 2007; 10.1377/hlthaff.26.5.w618).

[2] Selden TM, Hudson JL, Banthin JS. Tracking changes in eligibility and coverage among children, 1996-2002. Health Affairs 2004; 23(5): 39-50.

[3] Over 2006 and 2007, 141,000 new enrollees entered HUSKY A and B, while the net increase in enrollment was only 11,355. See: Connecticut Voices for Children. Trends in enrollment in the HUSKY Program: 2006-2007 (published online July 2007 at www.ctkidslink.org.

[4] Children's Health Council. HUSKY retention: Helping families keep health coverage. Hartford, CT: Children's Health Council, 2001 November. Available upon request from Connecticut Voices for Children (www.ctkidslink.org).

[5] Sommers B. Why millions of children eligible for Medicaid and SCHIP are uninsured: Poor retention versus poor take-up. Health Affairs 2007; 26(5): w560-w567 (published online 26 July 2007; 10.1377/hlthaff.26.5.2560).

[6] Sommers B. Why millions of children eligible for Medicaid and SCHIP are uninsured: Poor retention versus poor take-up. Health Affairs 2007; 26(5): w560-w567 (published online 26 July 2007; 10.1377/hlthaff.26.5.2560).

Connecticut's HUSKY Program

In Connecticut, most children and parents in low-income families are eligible for health insurance coverage in the Healthcare for UninSured Kids and Youth (HUSKY) Program. HUSKY A is a Medicaid managed care program with statewide mandatory enrollment for children and parents or other caretaker relatives with family income less than 185 percent of the federal poverty level (FPL).[7] Depending on family income, pregnant women are also eligible for coverage in HUSKY A.[8] HUSKY B is Connecticut's CHIP managed care coverage for uninsured children whose family income is 185% FPL and over. There are three levels of cost sharing in HUSKY B: Band 1 for children in families with income from 185% to under 235% FPL, with minimal copayments for some services and no premiums; Band 2 for children in families with income from 235% to under 300% FPL, with minimal copayments and subsidized premiums; and Band 3 for children in families with income 300% FPL or greater, with minimal copayments and unsubsidized premiums. Families who apply for coverage in the HUSKY Program report their income without the need for documentary proof at the time of application; instead, administrative verification of income is part of the eligibility determination process. Eligibility for HUSKY A and HUSKY B is typically reviewed every 12 months when an application for renewal is required and more often if the Department of Social Services or its agent is notified of a change in personal circumstances (household composition or income, for example) that affects eligibility for either program. The Department of Social Services administers both programs. Caseworkers in the Department's regional and district offices make eligibility determinations for HUSKY A.[9] The Department contracts with ACS, Inc. (recently acquired by Hewlett Packard) to act as an enrollment broker for processing HUSKY applications, making HUSKY B eligibility determinations and renewals, enrolling HUSKY A and B members in managed care plans, and collecting premiums for children in HUSKY B Bands 2 and 3.

Changes in family income or size may affect eligibility for HUSKY A or B. If a family with increased earned income or increased child support goes over income for HUSKY A, the family is automatically eligible for continuing Medicaid coverage for one year (Transitional Medical Assistance); no application for this coverage is necessary. If families remain over-income, children are referred to HUSKY B for eligibility determination and uninterrupted coverage rather than placed on Medicaid "spend-down." HUSKY B children in families that report a drop in household income may qualify for HUSKY A (Medicaid).

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[7] Effective July 1, 2007, income eligibility levels for parents and caretaker relatives increased from 150% FPL to 185% FPL, after these new enrollees gained coverage. The policy change would have affected reenrollment after a gap in coverage and renewals.

[8] During the period of time under study, pregnant women were eligible if family income was less than 185% FPL. Effective January 1, 2008, the income eligibility level for pregnant women was increased to 250% FPL. For the purposes of eligibility determinations, pregnant women are counted as two persons.

[9] Legislation enacted in 2007 called for centralization of the eligibility determination process; instead, the Department of Social Services created three regional processing units to handle new applications for HUSKY coverage only (not HUSKY renewals and not applications for HUSKY when the family is requesting other benefits such a food stamps or housing assistance). The regional processing offices began operations in 2008, after the study period.

Statewide, there are currently over 380,000 HUSKY Program enrollees, including nearly 242,000 children under 19 in HUSKY A and about 15,500 children under 19 in HUSKY B.[10] Legal immigrant children, parents, and pregnant women, including those children and pregnant women who have been in the US less than five years, are eligible for coverage.[11] Undocumented immigrants are not eligible for HUSKY Program coverage; however, emergency care, including labor and delivery, is covered fee-for-service. There is no comparable emergency coverage available for children who would otherwise qualify for HUSKY B.

In the HUSKY Program, the eligibility period and the managed care enrollment period may not coincide exactly. The eligibility period begins the month in which the individual was determined eligible, whereas managed care enrollment begins once an individual has selected or been defaulted into a plan. After having been determined eligible for HUSKY A or HUSKY B, families select a managed care plan and are enrolled effective the first of the following month after plan selection (not necessarily in the month following eligibility determination). Prior to selecting a plan, HUSKY A enrollees are covered under fee-for-service Medicaid until they enroll in a plan.[12] In HUSKY B, new enrollees are not covered until they have selected a plan and have been enrolled as of the first day of the following month, even though the period of eligibility begins with the month eligibility was granted. The difference between the eligibility period and the managed care enrollment period may cause confusion about when renewal is due among applicants, providers, and community-based social service providers.

Previous Studies of Retention

Problems with eligibility determination and retention in the HUSKY Program are long-standing. On average, about two out of three ever-enrolled children are continuously enrolled for 12 months at a time, depending on age group and other sociodemographic characteristics of the children.[13] One earlier study of new enrollment and two qualitative studies of the eligibility and renewal processes (described below) shed light on the scope of the problem and its roots in administrative procedures that affect application and renewal processing. In addition, case narratives from calls to the Medicaid agency's helpline contractor reveal how the retention problem affects families and access to care. Other factors that can affect retention (applicant confusion, personal impediments to completing the application) have not been studied systematically in Connecticut.

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[10] HUSKY Program enrollment as of February 1, 2010, as reported to the Connecticut Department of Social Services by its enrollment broker, ACS, Inc.

[11] Coverage for about 4,800 recent legal immigrants who are not children or pregnant women was eliminated by the Connecticut General Assembly, effective December 1, 2009, but reinstated by a state superior court the following month. These eligibility changes took effect long after the study period.

[12] HUSKY A enrollees may be granted up to 90 days retroactive coverage, depending on whether they have outstanding bills for health care. The coverage period dates from the month in which eligibility was determined rather than the beginning of the period of retroactive coverage. For example, a person who was granted eligibility effective January 1 may be covered retroactively for health services received in October, November and December; however, the period of eligiblity will date from January forward.

[13] Based on HUSKY Program utilization monitoring since 1998. See reports posted at www.ctkidslink.org/publications/healthandmentalhealth.

Children's Health Council. In 2001, the Children's Health Council reported on its study of retention in the HUSKY Program.[14] In the three-year study period, the number of new children enrolled in HUSKY A (106,484) plus the number who returned after a gap in enrollment of at least 3 months (46,979) far exceeded the net increase in child enrollment (17,770). This evidence of a serious problem with retention was the basis for recommendations aimed at simplifying renewal in the HUSKY Program.

"Supporting Families." In 2001, the Connecticut Department of Social Services reported on the results of its self-assessment of retention procedures and policies.[15] With funding from The Robert Wood Johnson Foundation under its "Supporting Families After Welfare Reform" initiative, the Department analyzed factors contributing to low Medicaid and SCHIP enrollment rates and implementation of strategies to improve enrollment rates. A team of Department staff and technical advisors under contract to the funder conducted 37 interviews with Department staff, contractors, and stakeholders; 2 client focus groups; 1 focus group with Regional Administrators; a phone survey of disenrolled clients; analyses of enrollment data; and renewal process mapping. The Department identified the following issues that contribute to the retention problem:

- Decentralized organizational structure of the Department;
- Lack of effective communication [with clients];
- Absence of accountability for retention [in the Department at all levels and enrollment broker];
- Confusion about the enrollment broker's role.[16]

The report cited a problem with variation in policy and procedures in the regional offices that result in a "silo effect—each DSS Region and Office runs virtually independently with its own culture, mood, philosophy, and interpretation and application of policy" (p. 10). Inconsistent customer service was identified as a problem, including use by some workers of a "restrictive, welfare-oriented mindset when determining eligibility and interacting with clients" (p.37). The report cited the existence of a perception that "the union environment limits flexibility and adds to bureaucracy" (p. 10).

The self-assessment team also identified other problems related to retention: confusion among clients, especially related to notices and renewal requirements; inability to capture client changes of address and to forward mail; malfunction in automatic sequences ("trickling" and "sprouting") that affect continued eligibility for children who turn 18 and families that are over-income; lack of congruency in reporting by the Department and the enrollment broker; poor communication between regional offices and the Department's

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[14] Children's Health Council. HUSKY retention: helping families keep health coverage. Hartford, CT: Children's Health Council, November 2001. Available upon request from Mary Alice Lee.

[15] State of Connecticut Department of Social Services. HUSKY retention diagnostic: Final report (PowerPoint presentation). Hartford, CT: DSS, August 2, 2001.

[16] Slide 10 of presentation on "HUSKY Retention Diagnostic." Note: Benova, Inc. was the enrollment broker for the HUSKY Program from its inception in 1995. After this report was issued by the Department, Benova was acquired by ACS, Inc., the program's enrollment broker today. The contract for HUSKY Program enrollment broker has not been re-bid in 15 years, notwithstanding a state statute that requires re-bidding after seven years (C.G.S. Sec. 17b-292(h)).

Central Office, the enrollment broker, and the community-based outreach organizations; and lack of consistency in application of policy for determining eligibility for HUSKY A and B.

The "Supporting Families" study team and its technical advisors recommended the following "strategic level" actions: centalize all HUSKY Program intake, maintenance and renewals in the Department's Central Office; implement performance monitoring at all levels of the eligibility determination (Central Office, Regional and District Offices, individual worker); and improve management of the Department's relationship with its enrollment broker. Based on the findings and recommendations, the Department took the following steps to improve retention: adoption of a HUSKY envelope, with the program logo rather than the state seal in the return address location, for use when mailing renewal notices to families with children in the HUSKY Program; after statutory change, implementation of procedures for accepting the applicant's self-declaration of family income, pending electronic verification of income reported to the Department of Labor or other public benefits programs; and use of renewal forms that have been pre-filled with client and household data.[17, 18]

Legislative Program Review and Investigations Committee. In 2004, the Connecticut General Assembly's Legislative Program Review and Investigation Committee (LPRIC) released a comprehensive report on the eligibility determination and renewal processes for the HUSKY Program and other Medicaid coverage groups.[19] LPRIC identified the following problems pertaining to retention in the HUSKY Program:

- Outdated Eligibility Management System (EMS) in need of replacement: EMS is a mainframe system that was developed in the 1980s. At the time of the study, it consisted of 68 databases and 1500 programs, on 336 screens and over 4 million lines of codes. Only state government workers have access to EMS on over 1500 terminals. EMS is not user-friendly and requires "work-arounds" for many aspects of eligibility determination. EMS automatically generates renewal notices. There is no online application for the HUSKY Program.[20]
- Lack of Central Office oversight of the Department's district offices: Processing and application of policies for eligibility determination depend at least in part on which of the nine district offices in three regions process a new application or renewal. The percentages of applications that are denied or overdue vary among

[17] Southern Institute on Children and Families. The Supporting Families Story: the movement toward quality improvement. Columbia SC: Southern Institute, DATE.

[18] In the years since the "Supporting Families" report, the Department has also expanded community-based sites ("qualified entities") for intake of applications for presumptive eligibility in the HUSKY Program; created three regional processing units for handling new HUSKY-only applications (the Department's response to legislation calling for centralization of the eligibility determination process); conducted joint training on Department policies and procedures for regional and district staff with staff of community-based outreach organizations; supported state-funded community-, regional- and state-wide outreach efforts; and actively participated in the "Covering Connecticut Kids and Families" coalition, sponsored by Connecticut Voices for Children with funding from the Connecticut Health Foundation. In recent years, however, the renewal process has been complicated by the new federal requirement that all new (and for a time, renewing) applicants provide proof of citizenship and identity based on original documents.

[19] Legislative Program Review and Investigations Committee. Medicaid eligibility determination process. Hartford, CT: Connecticut General Assembly, December 2004.

[20] LPRIC recommended adoption of an online application for use statewide by July 1, 2006.

the offices. Regional Administrators who run the district offices report directly to the Department of Social Services Commissioner. District office workers are members of a collective bargaining unit.

- Lack of oversight, coordination and integration of enrollment broker function: Despite efforts to streamline application processing and eligibility determination by contracting with an enrollment broker, the Department of Social Services still receives and processes the majority of applications for the HUSKY program. Since 1995, the enrollment broker pre-screens and sorts applications for HUSKY A or B, then sends completed A-eligible applications (by courier) to the Department's Central Office for sorting and distribution (by courier) to the district offices. Since the eligibility criteria used by the enrollment broker are not the same as those used by the Department, it is possible for applications to bounce back to the enrollment broker after re-screening by the Department's workers. Between April 1995 and December 2004, the state's contract with the enrollment broker totalled $34.6 million for the period April 1995 to December 2004. The contract has not been re-bid since its inception in 1995. LPRIC reported that the contract did not contain formal performance standards or sanctions short of contract termination.

Calls to HUSKY Infoline. Finally, another important source of ongoing information about eligibility determination, renewal and inadvertent loss of coverage is HUSKY Infoline. Since 1998, the Department of Social Services has contracted with United Way of Connecticut/2-1-1 for a toll-free call center to assist families in the HUSKY Program who are seeking information, help with eligibility problems, and assistance with care coordination.[21] Until at least 2004, HUSKY Infoline regularly compiled and forwarded case narratives to keep the Department informed about eligibility barriers encountered by families seeking or renewing coverage. More recently, HUSKY Infoline reports to the Department on call volume and other trends, with a high level summary of the leading call reasons (v. case narratives). In a recent semi-annual report to the Department of Social Services, HUSKY Infoline staff reported handling over 9,000 calls a month. The report cited the following types of eligibility barriers: delays in application processing, delays in processing enrollment for newborns, discontinuation of coverage for 18 year olds, lack of coordination and consistency between HUSKY A and B when processing renewals, and unexpected discontinuation of HUSKY coverage.[22] The eligibility barriers encountered by families can result in gaps in insurance coverage that lead to postponing needed care and dealing with out-of-pocket expenses. Case narratives based on calls to the HUSKY Infoline illustrate the problems (see text box).

[21] LPRIC reported that the Department's contract with HUSKY Infline was $720,000 in FY2004. Legislative Program Review and Investigations Committee, p. 13.

[22] Barrett T. CT HUSKY Infoline semi-annual report: July 1, 2008 to December 31, 2008. Issued January 28, 2009. Available from Connecticut Department of Social Services.

Retention Problems:
Some Recent Calls to HUSKY Infoline

A mother and child on family Medicaid were discontinued effective July 1, 2009 because the family was over income for HUSKY A due to a temporary increase in the mother's work hours. When coverage was discontinued, the child was put on Medicaid "spend-down" rather than transitional Medicaid for families with earnings because, according to the worker, the family had already been on transitional medical assistance several years ago.

The parent of an 18 year old who lost coverage at the end of September called HUSKY Infoline in October 2009. After HUSKY Infoline care coordinators made 12 calls to the district office, coverage was reinstated retroactive to October 1.

A parent called about a baby who was eligible for coverage at birth in August 2009. An older sibling was on HUSKY B. The application for baby was sent to the enrollment broker, then referred in mid-September to the Department of Social Services' Regional Processing Unit (RPU) for HUSKY A eligibility determination (due to change in family composition). Meanwhile, HUSKY B coverage for the sibling was terminated for no readily apparent reason in September. The RPU never received the application. The enrollment broker resent the application in early December but again, the RPU did not receive it. The father was very concerned about the gap in coverage and reapplied for both children in December at the Hartford district office. The RPU finally got the application and granted coverage in HUSKY A effective January 1, 2010, but not back to the baby's date of birth. After many calls from HUSKY Infoline care coordinators and a call from the enrollment broker to the RPU supervisor, coverage was granted retroactively for both children.

PURPOSE

In order to better understand the scope of the retention problem and factors that contribute to gaps in coverage, we studied the enrollment experience of children and adults who were new to the HUSKY Program. Specifically, the study was designed to:

- Describe HUSKY Program enrollment dynamics in terms of gaps and loss of coverage;
- Describe variation in HUSKY Program enrollment by region and district office.

METHODS

Study design

We used a retrospective cohort design to describe enrollment dynamics for all children and adults who were newly enrolled in the HUSKY Program in a selected two-year period. Using a longitudinal HUSKY enrollment database created for studying enrollment dynamics, we identified new enrollees and determined the number and percentage who were not continuously enrolled for even one year after enrolling in HUSKY A or B. We also studied disenrollment rates at the time of renewal and subsequent reenrollment rates within the following six months. We examined retention by graphing disenrollment rates by month over the first eighteen months after new enrollment.

Variation by district office within region was described in terms of the net increase in enrollment and number of new enrollees in calendar years 2006 and 2007, compared to the baseline enrollment in that district office on January 1, 2006.

Data

For the purpose of determining eligibility for coverage in the HUSKY Program, the Connecticut Department of Social Services (DSS) and its enrollment broker (ACS, Inc.), gather sociodemographic and income information from each applicant. Once an applicant has been determined eligible and enrolled in a managed care plan, these data are compiled in an enrollment record that is used for administration of the managed care program and for independent performance monitoring. Each enrollment record contains the member's Medicaid ID number, date of birth, gender, race/ethnicity (self-identified), address, primary household language and the type of coverage (depending on family income, either HUSKY A or HUSKY B Band 1, 2 or 3).

Connecticut Voices for Children obtains HUSKY enrollment data from the Department and its agents for ongoing independent performance monitoring. Using these data, we created a longitudinal database with client-level managed care enrollment by month for the period January 2006 through December 2007. For each person enrolled one month or more during the 24 month period, the data show by month whether the person was enrolled or not and in which program (HUSKY A, HUSKY B Band 1, 2, or 3). Changes between HUSKY A and B and between income bands in HUSKY B are readily apparent. Gaps in coverage are evident in the longitudinal file when coverage is not reported for month or more.

For the purposes of this study, we identified a cohort of newly enrolled children and adults who first appeared in the managed care enrollment database between January 2006 and December 2007. Children and adults were considered newly enrolled if they had not been enrolled in Connecticut's HUSKY Program at any time during the 12 months prior to first enrollment in the study window. The focus on new enrollees allows for longitudinal follow-up following a definitive enrollment start date.[23]

For study of regional and district office variation, we used the count of new enrollees for the entire 24-month period. New enrollees were grouped by residence according to the catchment areas that correspond to the district offices. Baseline enrollment (January 1, 2006) by district office and net increase over the 24-month period were determined using enrollment by town that is reported monthly by the Department. The towns served by Department of Social Services district offices are shown in Table 1.

For study of coverage continuity, gaps in coverage, and retention, we focused on the subgroup that was newly enrolled between January 1 and June 1, 2006, and examined their enrollment experience in the 18-months following new enrollment.

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[23] Some new HUSKY A enrollees fail to select a managed care plan for coverage beginning the following month. Their enrollment may be delayed by an additional month for late plan selection or for default into a plan. Those who fail timely selection of a plan will have 10 monthly records corresponding to managed care enrollment. For the purposes of this study, we assumed that HUSKY A enrollees were enrolled in managed care in the month following their eligibility determination.

Measures

The following measures were reported overall and separately for newly enrolled children in HUSKY A, adults in HUSKY A, and children in HUSKY B:

Two-year enrollment trends by district office

- Number of all new enrollees and net increase in enrollment, by residence of enrollee as a "percentage" of enrollment on January 1, 2006, by district office.[24]

Discontinuous enrollment in the first year

- Number and percentage of new enrollees who lost coverage or experienced a gap in coverage during the first 11 months of managed care enrollment.
- Average period of enrollment by age group, program type (HUSKY A or B) and cost-sharing (HUSKY B Bands 1, 2, 3).

Retention

- Percentage of new enrollees who remained enrolled, that is did not disenroll, lose coverage or experience a gap in coverage of 1 month or more, by month, in the 18 months following new enrollment.

These measures are reported by program type (HUSKY A or B Band 1, 2, 3) for children and adults in HUSKY A and for children in HUSKY B, depending on the program type and income band in which they were newly enrolled in January 2006 or, for those who lost coverage, the program type and band in which they were enrolled in the month before having lost coverage. For the purpose of describing enrollment by program type, those children who changed from HUSKY A to B before experiencing a gap in coverage (less than 0.1%) were classified by the program in which they enrolled in the month prior to losing coverage. Among HUSKY B children, coverage continuity, gaps in coverage, disenrollment and retention are reported by income categories (coverage bands 1, 2 and 3) that correspond to levels of cost-sharing (premiums and co-payments). For many enrollees, the period of *managed care enrollment* in the first year begins after plan selection, possibly one or more calendar months after eligibility determination, so we examined the disenrollment rates in the 11th, 12th and 13th months after new enrollment.

Analytic approach

In order to describe variation in retention by district office, new enrollees were grouped by town of residence within the corresponding catchment area for the district office. Since district offices vary in size, the number of new enrollees for each district office was compared to the baseline enrollment in that office (truly a ratio, but expressed as a "percentage" for ease of communicating the findings). Likewise, the net increase in each

[24] This measure is really a ratio, not a percentage, as the new enrollees are not a subset of the baseline enrollment; however, for ease of reporting, the measure is called "percentage."

district office was compared to the baseline enrollment for that office (and expressed as a "percentage). The measures were plotted and a linear trend line was fitted to the data points. District offices with new enrollment and net enrollment percentages above the line were characterized as doing better than the offices below in terms of retention.

Retention is reported in terms of the cumulative percentage of enrollees who remained continuously enrolled, that is did not experience a gap in coverage or loss of coverage in any month during the first 19 months after new enrollment.[25] This measure of retention was calculated without adjustment for any other personal or programmatic factors that may have contributed to continuity of coverage, gaps in coverage, or loss of coverage.

RESULTS

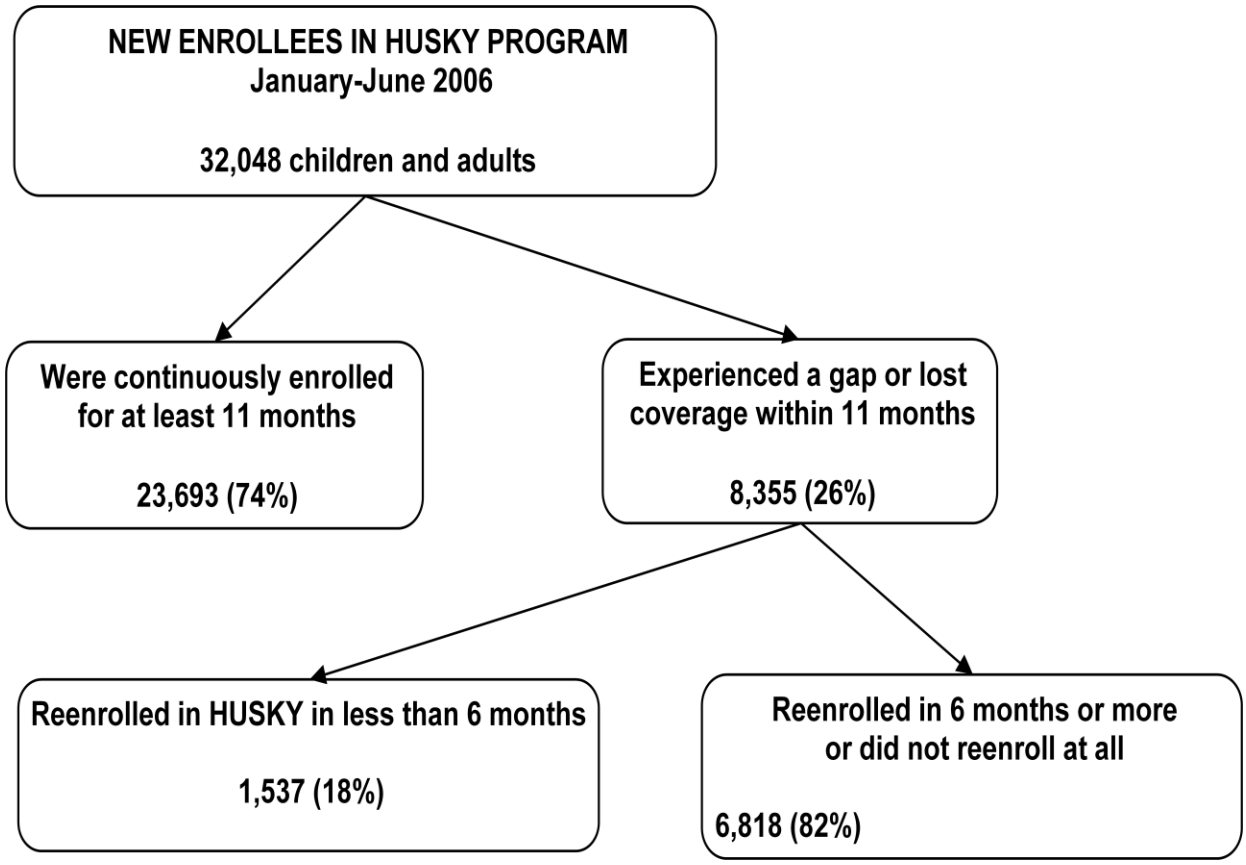
Discontinuous Enrollment in the First Year

Between January and June 2006,there were 32,048 adults and children who were newly enrolled in the HUSKY Program. Their sociodemographic and enrollment characteristics are shown in Table 2. HUSKY A accounts for nearly all of these new enrollees (95.2%), mainly children under 19 (58.4% of new enrollees) a large portion of which were children under 2 (47.8%). About 40 percent of all new enrollees identified themselves as White, while 27 percent self-identified as Hispanic and 17 percent as African American. In HUSKY B, new enrollees were more evenly distributed by age and more likely than new enrollees in HUSKY A to be White . Differences in the proportion of enrollees that were female are almost entirely in HUSKY A and are likely mothers of newly enrolled children who also obtained coverage.

In the first year of enrollment, many new enrollees (8,355 or 26%) experienced a gap in coverage or dropped out of the program all together (Figure 1). Overall, one in four new enrollees experienced discontinuous coverage (Figure 1), including 18 percent of children and 36 percent of adults who were newly enrolled in HUSKY A and 35 percent of children in HUSKY B (Table 3). The rate of continuous enrollment in the first year varied considerably by age group. Children under two were least likely to lose coverage and if they did, most likely to regain coverage in less than 6 months. Adolescents and adults were most likely to lose coverage in the first year and least likely to regain coverage. The rate of continuous enrollment in the first year also varied by program type (HUSKY A or B) and cost-sharing (HUSKY B premium band). The average period of enrollment was 10.1 months for children in HUSKY A, 8.9 months for adults in HUSKY A, and 9.3 months for children in HUSKY B. For children in HUSKY B, the average period of enrollment in the first year after new enrollment varied by family income band (10.3 months for children in Band 1, 8.5 months in Band 2, and 6.8 months in Band 3). Among children in HUSKY B Band 1, the percentage of children with continuous coverage decreased as cost-sharing increased, from 78 percent of children in Band 1 to 53 percent of children in Band 2 and 35 percent of children in Band 3.

[25] For example, a person who experienced a gap in the third month but returned to the program in the fifth month would not contribute to the retention rate after the third month.

Figure 1. Disenrollment and Reenrollment in the First Year of Coverage



Eighteen percent of those who lost coverage regained coverage in HUSKY in six months or less, including just over half who regained coverage in three months or less (Table 3). Among those that lost and regained coverage within 6 months (18.4%), the median length of the coverage gap was 2 months. Most of those who lost coverage did not reenroll within six months (81.6%).

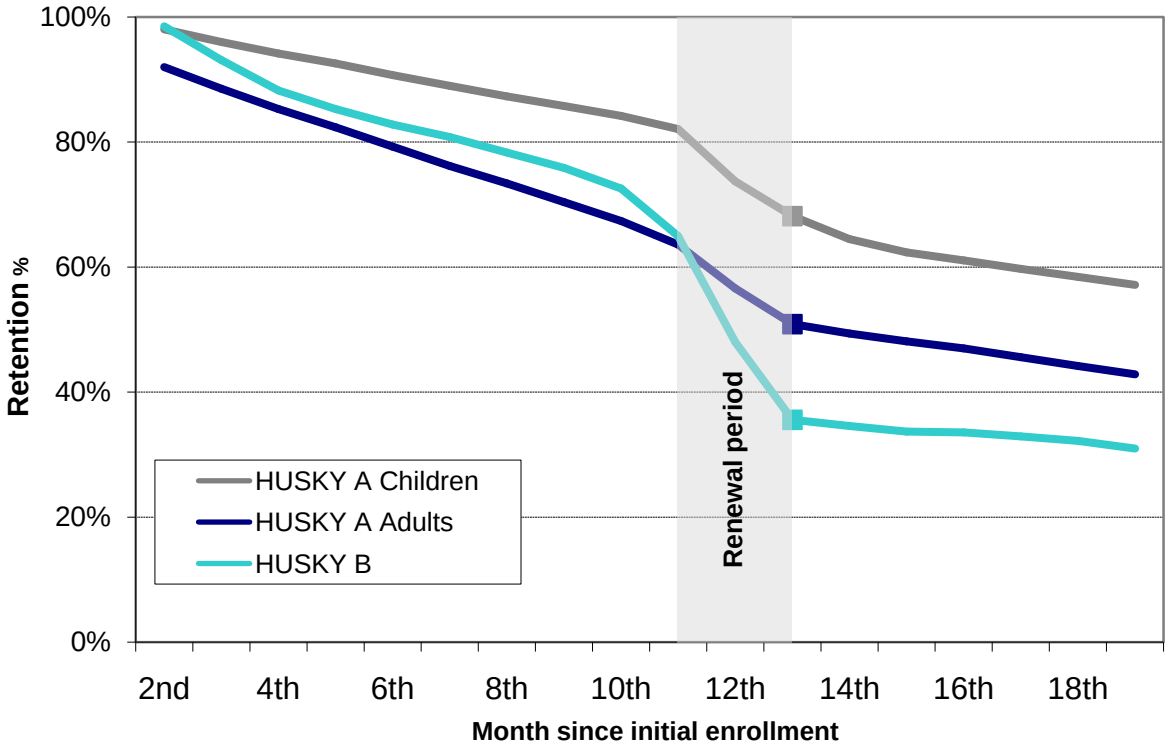
Children in HUSKY B had a disenrollment rate in the first year (34.8%) that was almost twice as high as the disenrollment rate among HUSKY A children (18.0%). Reenrollment was also much higher among HUSKY B children, over 37 percent of whom were reenrolled within 6 months, compared with about 25 percent among HUSKY A children. This finding indicates a higher rate of "churning" among HUSKY B children. In fact, the rate of disenrollment in HUSKY B increased as families' cost for coverage increased. Reenrollment rates within 6 months were similar for all three bands of HUSKY B coverage, all within a 35 percent to 40 percent range.

Retention at Time of Renewal

At the time for renewal, many HUSKY Program enrollees lost coverage. Among the 23,693 new enrollees who managed to stay enrolled for the first year, 19 percent lost coverage at or around the time of renewal. One in four of those who lost coverage in the renewal period reenrolled within six months of losing coverage (Tables 4, 5).

Renewal appears to have triggered a drop in retention decline for all programs, but was markedly worse for children in HUSKY B (Figure 2). While retention declined by 17 percent over the renewal period among HUSKY A children and 20 percent among HUSKY A adults, retention declined by about 55 percent among HUSKY B children. By the thirteenth month, 32% of children and 49% of parents in HUSKY A and 64% of children in HUSKY B had experienced a gap or lost coverage. Almost half (47.9%) of those in HUSKY B who lost coverage during the renewal period were reenrolled within six months (Table 4).

Figure 2. Retention by HUSKY Program and Age Group

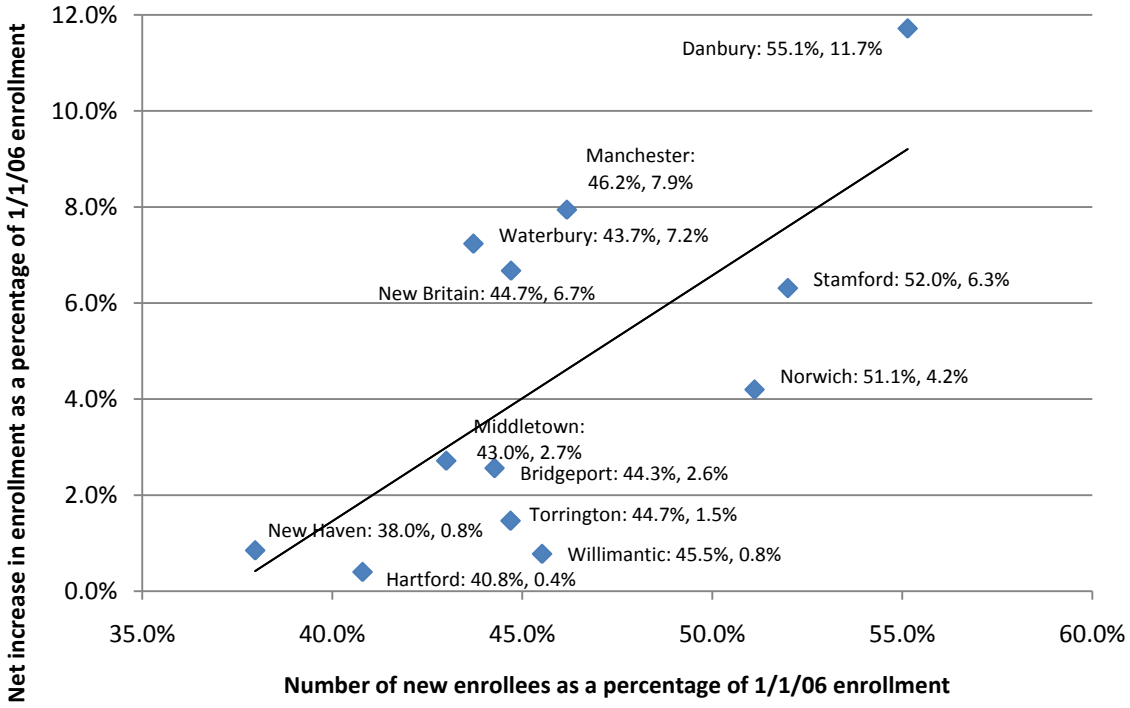


Enrollment by district office

Between January 2006 and December 2007, there were 141,291 adults and children newly enrolled in the HUSKY Program. This total included 79,542 children under 19 in HUSKY A, 54,062 adults 19 and over in HUSKY A, and 7,687 children under 19 in HUSKY A at the time they enrolled. In the same two-year period, the net increase in HUSKY Program enrollment was just 11,355 children and adults. Overall, enrollment in the HUSKY Program grew by 44.5 percent (37.5% for HUSKY A children, 60.0% for HUSKY A adults, and 50.7% for HUSKY B). However, the overall net increase was just 3.6 percent of baseline enrollment (1.0% for HUSKY A children, 8.9% for HUSKY A parents, and 8.6% for HUSKY B children).

Figure 3 shows new enrollment and net enrollment increases compared with baseline enrollment by district office. The relationship between these measures was fitted with a linear trend line. Those offices with enrollment increases (new and net) above the line performed better in terms of this representation of retention than those offices with enrollment increases below the line. Enrollment in the Danbury district office's area grew both in terms of new enrollees and enrollees who managed to stay enrolled in the program (net increase). While enrollment in the New Haven district office's area grew at both in terms of new enrollees and net increase, both measures were less than in all other offices.

Figure 3. HUSKY Enrollment Trends by DSS District Office (January 2006 - December 2007)



DISCUSSION

National research suggests that close to half of all beneficiaries who disenroll from Medicaid remain eligible but become uninsured.[26, 27] If this rate held true for the HUSKY enrollees in this study, about 6,000 of the early 13,000 who disenrolled may have gone on to become uninsured in spite of remaining eligible for the HUSKY program. The results of this study show that discontinuous enrollment, that is "churning" and loss of coverage at the time of renewal, is problematic in the HUSKY Program. Just over 40 percent of children and adults who successfully obtained coverage and enrolled in managed care experienced a gap in coverage or loss of coverage in the first year or at the time of renewal. Parents in HUSKY A lost coverage despite an increase in their income eligibility threshold during the study period.[28] The higher disenrollment rate among children in HUSKY B (64 %) and evidence from the literature that disenrollment increases with increased cost-sharing suggests that affordability may be a factor that affects continuity of coverage for families of these children.

Medicaid discontinuance occurs for a number of reasons. Connecticut Department of Social Services records show that half of all discontinuance in HUSKY A (family Medicaid) is due to a failure to reapply.[29] Consistent with these records, our analysis shows steep increases in disenrollment around the time of renewal. The problem of disenrollment at the renewal period is especially dramatic among HUSKY B children: 46 percent of all disenrollments in the first 13 months occurred around the time of renewal. Aside from failing to renew, disenrollment can occur due to confusion about the need to renew coverage annually, administrative errors, voluntary disenrollment, or loss of eligibility due to fluctuations in income, age, or family status. Variation between district offices and lack of coordination with the enrollment broker may account for some of the problem.

Results from this study and others show that although many Medicaid and CHIP beneficiaries disenroll within the first year after becoming eligible, many re-enroll, providing evidence that high disenrollment rates are not simply due to changes in eligibility status. Among new enrollees in HUSKY who had lost coverage before the time of renewal, 18 percent had returned to the program within six months. Disenrolled children returned at a much higher rate (27%, including 38% of children under age two) than disenrolled adults (12%). These rates are similar to what Sommers reported based on analyses of national data: 28 percent of children who had lost coverage returned to Medicaid within six months and 17 percent of adults returned.[30] Additionally, Sommers found that just over 40 percent of all children and half of all adults who had lost Medicaid coverage were *uninsured* six months after disenrolling. Connecticut's high disenrollment rate is even more worrisome if large numbers of eligible-but-disenrolled children and families become uninsured.

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[26] Sommers BD. From Medicaid to uninsured: Drop-out among children in public insurance programs. Health Services Research 2005; 40 (1): 59-78.
[27] Sommers BD. Loss of health insurance among non-elderly adults in Medicaid. Journal of General Internal Medicine 2008; 24 (1): 1-7.
[28] The income eligibility threshold for parents and relative caregivers increased to 185% of the federal poverty level on July 1, 2007, up from 150% FPL prior to that date.
[29] Connecticut Department of Social Services. Reasons for discontinuance, January 2009 – April 2009. (Obtained from Kevin Loveland, May 2009)
[30] Sommers BD. Loss of health insurance among non-elderly adults in Medicaid. Journal of General Internal Medicine 2008; 24 (1): 1-7.

Low disenrollment and high reenrollment among children younger than two years old may be due to the higher frequency of office visits typical of this age group. Every three to six months, parents of infants and toddlers are reminded of their need for coverage of routine preventive care. Health care settings are often important centers of information dissemination where Medicaid enrollees may receive materials and advice about the enrollment process.[31,32] One study found that children who had more frequent office and outpatient visits were less likely to drop out.[33] Additionally, to ensure reimbursement for care, hospitals and clinics will typically urge or assist uninsured, Medicaid- or CHIP-eligible patients to apply for public insurance. Eligible patients who interact with the health care system are therefore likely to become enrolled and may be less likely to disenroll or remain uninsured. Of all age categories, clinician office visits were the highest among Connecticut's newly enrolled Medicaid and CHIP children under two.[34] More frequent interaction with the health care system may increase awareness of enrollment and reenrollment requirements and explain why disenrollment rates are low and reenrollment rates are high among the youngest children.

Connecticut's frequent disenrollment and reenrollment within the first year of coverage is evidence of "churning," a common problem that has negative implications for several healthcare performance measures. Coverage gaps of any length are correlated with discontinuity of care,[35] delays in seeking needed treatment,[36] unmet medical care,[37] and worse patient outcomes.[38] Longer gaps in coverage are associated with worse outcomes than shorter gaps.[39, 40] The churning described in this report undoubtedly interferes with establishing a "medical home" with continuous access to timely, comprehensive care.

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[31] Davidoff AJ, Garrett B. Determinants of public and private insurance enrollment among Medicaid and CHIP-eligible children. Medical Care. 2001; 39(6):523-35.
[32] Feinberg E, et al. Language proficiency and the enrollment of Medicaid and CHIP-eligible children in publicly funded health insurance programs. Maternal Child Health Journal. 2002; 6(1):5-18.
[33] Sommers BD. Protecting low-income children's access to care: Are physician visits associated with reduced patient dropout from Medicaid and the Children's Health Insurance Program? Pediatrics 2006; 118(1): e36-e42 (published online at www.pediatrics.org/cgo/doi/10.1542/peds2005-2685).
[34] Connecticut Voices for Children. Health care for children and adults newly enrolled in HUSKY A (published online August 2008 at www.ctkidslink.org).
[35] Olson LM, Tang SS, Newacheck PW. Children in the United States with discontinuous health insurance coverage. New England Journal of Medicine 2005; 353(4): 382-389.
[36] Cummings JR, Lavarreda SA, Rice T, Brown ER. The effects of varying periods of uninsurance on children's access to health care. Pediatrics 2009; 123(3): e411-e418 (published online March 2009 at www.pediatrics.org/cgo/doi/10.1542/peds.2008-1874).
[37] Halterman, JS, Montes G, Shone LP, Szilagyi PG. The impact of health insurance gaps on access to care among children with asthma in the United States. Ambulatory Pediatrics 2008; 8(1): 43-49.
[38] Weissman JS. Delayed access to health care: risk factors, reasons, and consequences. Annals of Internal Medicine. 1991; 114(4):325-31.
[39] DeVoe JE, Graham A, Krois L, Smith J, Fairbrother GL. "Mind the gap" in children's health insurance coverage: Does the length of a child's coverage gap matter? Ambulatory Pediatrics 2008; 8(2): 129-134.
[40] Cummings JR, et al., The effects of varying periods of uninsurance on children's access to health care. Pediatrics. 123 (2009). Cummings JR, Lavarreda SA, Rice T, Brown ER. The effects of varying periods of uninsurance on children's access to health care. Pediatrics 2009; 123(3): e411-e418 (published online March 2009 at www.pediatrics.org/cgo/doi/10.1542/peds.2008-1874).

Gaps in coverage diminish the gains in continuity of care that many policy makers expect from managed care and medical homes. Connecticut's HUSKY members who experience gaps in coverage are less likely to realize the full benefits of continuous care. Managed care plans derive much of their potential benefits through management of continuous care, which is difficult if not impossible if beneficiaries are not continuously enrolled. Research has also found that coverage gaps are a greater obstacle to accountability in managed care systems due to the widely accepted convention of basing quality assurance measurement on access and utilization by members who are continuously enrolled in their respective plans for 12 months.[41]

Connecticut's experience with HUSKY enrollment is consistent with prior research identifying Connecticut as a poor-retention state. Several factors have been identified as contributors to low retention. First, poor understanding among enrollees of eligibility rules and the renewal process contributes to enrollment and retention problems. One study found several instances of mistaken beliefs—for example, that working families are not eligible for coverage—that can contribute to dropout.[42] Additionally, patient surveys have shown that a lack of knowledge about the renewal requirement is a leading cause of lost coverage.[43] Second, wide variation from state to state in disenrollment, gaps, and retention indicates the relevance of state policies and program structure in keeping eligible Medicaid members insured.[44]

There were several limitations to this study that warrant mention and suggest opportunities for future study. First, we were unable to ascertain the reasons for disenrollment or eligibility of the beneficiary at the time of disenrollment, factors that are important for describing the severity and nature of the problem. This report used reenrollment rates after three and six months as an indicator that individuals continued to be eligible through the coverage gap, though no substitute was available to determine why beneficiaries lost coverage and whether they truly remained eligible for the program. Disenrollment reason codes exist but were not available for this report. Future studies of enrollment dynamics would benefit from the inclusion of record-specific disenrollment reason codes, including aging out of the program, that could be used to better understand Connecticut's retention problem. Second, we were unable to determine the exact date of eligibility and renewal for each record due to the difference between eligibility determination and enrollment in managed care. As a result, we had to assume but could not verify that all disenrollments that occurred during the 11th or the 12th month following new enrollment in managed care were associated with renewal. Third, race/ethnicity is self-reported and often incomplete, as evidenced by the relatively high number of beneficiaries coded as "unknown." The abnormally low rate of disenrollment and high rate of reenrollment among those in the "unknown" category present the possibility of bias (systematic under- or over-estimate of

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[41] Fairbrother G, Jain A, Park HL, Massoudi MS, Haidery A, Gray BH. Churning in Medicaid managed care and its effect on accountability. Journal of Health Care for the Poor and Underserved 2004; 15: 30-41.
[42] Perry M, Paradise J, Enrolling children in Medicaid and SCHIP: Insights from focus groups with low-income parents. Kaiser Commission on Medicaid and the Uninsured. 2007. http://www.kff.org/medicaid/7640.cfm
[43] Perry M, Kannel S, Riley T, and Pernice C. What parents say: why eligible children Lose SCHIP. Portland, Maine: National Academy for State Health Policy: 2001.
http://www.nashp.org/_docdisp_page.cfm?LID=2A789925-5310-11D6-BCF000A0CC558925
[44] Fairbrother GL, Emerson HP, Partridge L. How stable is Medicaid coverage for children? Health Affairs 2007; 26 (2): 520-528.

the disenrollment by racial/ethnic group). Finally, the results of this study may not be representative of enrollment and disenrollment in other states with different income eligiblity thresholds, different outreach and application assistance programs, differnent administrative procedures, and different documentation requirements. Despite these limitations, the results of these analyses shed light on enrollment dynamics that warrant the attention of policy makers and program planners who are committed to reducing the number of uninsured children and families in Connecticut.

Implications for Policy and Practice

Over the past decade, Connecticut has made a considerable investment in children's coverage. CHIPRA provides even more opportunities for taking steps to reduce the number of uninsured children and families. Despite the fact that Connecticut law provides for near universal health insurance coverage for children, an estimated 46,000 children (5.6%) are uninsured.[45] Many of these children are in low income families and are likely eligible for the free or low cost coverage in the HUSKY Program. Undoubtedly, many of their parents also need and would qualify for coverage.

Based on the findings in this and other studies or retention, reducing the number of eligible-but-uninsured children and families will depend in large part on reducing administrative barriers to maintaining coverage, especially at the time of renewal. The following recommendations for Connecticut are based on our experience with the HUSKY Program, recommendations from the "Supporting Families" and LPRIC studies, reports from other states, and CHIPRA options for ensuring that eligible children are covered:

- **Unify and centralize the eligibility determination and renewal processes for HUSKY A and B, and increase accountability for retention at all administrative levels.** Enrollment in HUSKY B is and has always been far smaller than enrollment in HUSKY A. In low income families, income fluctuations that affect eligibility in A or B are common, but children generally remain eligible for one or the other program. The programs have many features in common, including the application, the renewal requirements, and nearly all benefits. Absent proof that maintaining a separate eligibility determination and renewal process is warranted fiscally or otherwise, it makes sense to combine this function to reduce administrative costs, applicant confusion, and administrative errors when household income or composition change. Unifying eligibility determination processes and income counting rules could go a long way towards preventing the all-too-frequent gaps in coverage and loss of coverage at the time of renewal. Moreover, centralization would improve quality and accountability for retention in the HUSKY Program. Retention rates would likely improve with adoption of an online application, development of a sure way to capture changes of address, and implementation of electronic exchanges of data between all entities that process renewals. Under CHIPRA, states with uniform eligibility determinations processes for separate Medicaid and CHIP programs may be entitled to bonus funds from the federal government.

[45] An estimated 46,000 children under 18 (range: 32,000-60,000) were uninsured on average in 2006-07.Two-year average number of children uninsured in 2006-2007. Analysis of data from the 2008 Current Population Survey by Connecticut Voices for Children.

- **Restore 12-month continuous eligibility**. Connecticut typically reviews eligibility every 12 months or whenever families notify DSS of changes in household income or family composition. If the changes affect eligibility for HUSKY A or B, children are at risk of losing coverage. With guaranteed 12-month continuous eligibility, children are given the balance of 12-months' coverage even if fluctuating household income or changes in family composition would otherwise result in changing programs or losing coverage. This policy was in effect from July 1998 until April 2003 when it was eliminated as part of state budget cuts enacted during the last economic downturn. As a result of the policy change, about 7,000 children lost coverage in HUSKY A.[46] Given the evidence that many children lose coverage throughout the year, perhaps when eligibility reviews are triggered by redeterminations for other family members, guaranteeing 12-months coverage reduces the risk of losing coverage and disrupting access to needed care.[47] Under CHIPRA, adoption of 12-month continuous eligibility for children in HUSKY A and B would help to make Connecticut eligible for bonus funds from the federal government.

- **Align eligibility and enrollment cycles for family members.** Research suggests that providing health insurance to parents increases coverage for eligible children.[48,49,50] Toward this end, Connecticut expanded coverage for parents by aligning income eligibilityfor parents (185% FPL for HUSKY A), effective July 1, 2007. This action had an immediate, measurable effect on new enrollment of children and their parents.[51] It makes sense to align redetermination cycles for entire families in order to prevent inadvertent loss of coverage when parents come up for renewal.

- **Adopt administrative or "ex parte" renewal.** Given the problems with retention in the HUSKY Program, especially at renewal, reducing administrative barriers to maintaining coverage is key to reducing the number of uninsured children and children with discontinuous coverage. Ex parte renewals are administrative renewals based on agency review of existing data pertaining to eligibility, without requiring families to submit renewal applications. In Louisiana for example, this paperless, automated approach resulted in far higher retention rates, compared to earlier periods when families were required to reapply for coverage and submit supporting

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

[47] Ideally, entire families would be eligible for 12 months of uninterrupted coverage, even if fluctuations in household income occur. However, current law provides only for federal reimbursement of state expenditures on behalf of children with continuous eligibility.

[48] Ku L. Collateral damage: children can lose coverage when their parents lose health insurance. Washington, DC: Center on Budget and Policy Priorities 2007; 1-2 (published online at www.cbpp.org).

[49] DeVoe JE, Krois L, Edlund T, Smith J, Carlson NE. Uninsurance among children whose parents are losing Medicaid coverage: Results for a statewide survey of Oregon families. Health Services Research 2008; 43(1 pt 2): 401-18.

[50] Sommers BD. Insuring children or insuring families: Do parental and sibling coverage lead to improved retention of children in Medicaid? Journal of Health Economics 2006 (published online June 2006; doi:10.1016/j.jhealeco.2006.04.003).

[51] Connecticut Voices for Children. Trends in new enrollment in the HUSKY Program: 2006-2007. New Haven, CT: Connecticut Voices, 2008 July; 1-4. Available at www.ctkidslink.org.

documentation.[52] In Connecticut, eligibility determinations and renewals are made by 12 district offices and three regional processing units in three regions (HUSKY A) and an enrollment broker (HUSKY B) making it imperative that the processes are well-coordinated to ensure seamless coverage for children. Under CHIPRA, states are not only allowed but rewarded for adopting methods for administrative renewals that help to ensure continuing coverage for children who are eligible based on income data held by the state.

ACKNOWLEDGEMENTS

We are grateful to Sharon Langer, JD, Senior Policy Fellow at Connecticut Voices for Children for expert review and technical assistance and to Michael Sullivan, Communications Director, for editorial assistance. Kevin Loveland, formerly Director of Bureau of Assistance Programs; Rose Ciarcia, formerly HUSKY Program Supervisor; and Kristin Dowty, Health Program Associate, at the Connecticut Department of Social Services provided very helpful information we needed for better understanding of the eligibility determination process and managed care enrollment. Amanda Learned, Senior Manager, Business Development, at MAXIMUS, Inc., created the longitudinal data extract for this study and expert advice for analyses. Alana Kroeber, M.P.H (candidate), assisted with analyses of enrollment by district office, in partial fulfillment of requirements for the University of Connecticut School of Public Health. We appreciate review and expert advice from Benjamin Sommers, MD, PhD.

Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on enrollment dynamics 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 and additional funding from the Center on Budget and Policy Priorities. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This publication does not express the views of the Department of Social Services the State of Connecticut. The views and opinions expressed are those of the authors.

[52] Personal communication, Ruth Kennedy, LACHIP Director, May 2009.

Table 1. Department of Social Services Regions and District Offices

Connecticut Department of Social Services
Southern Region

New Haven: Ansonia, Bethany, Branford, Derby, East Haven, Hamden, Milford, New Haven, North Branford, North Haven, Orange, Seymour, Shelton, West Haven, Wallingford, Woodbridge; **Middletown:** Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Guilford, Haddam, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Old Lyme, Old Saybrook, Portland, Westbrook; **Norwich:** Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Ledyard, Lisbon, Montville, New London, North Stonington, Norwich, Preston, Salem, Sprague, Stonington, Voluntown, Waterford

Connecticut Department of Social Services
Northern Region

Hartford: Avon, Bloomfield, Canton, East Granby, Farmington, Granby, Hartford, Newington, Rocky Hill, Simsbury, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks; **Willimantic:** Ashford, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Eastford, Hampton, Killingly, Mansfield, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Willington, Windham, Woodstock; **New Britain:** Berlin, Bristol, Burlington, New Britain, Plainville, Plymouth, Southington; **Manchester:** Andover, Bolton, East Hartford, East Windsor, Ellington, Enfield, Glastonbury, Hebron, Manchester, Marlborough, Somers, South Windsor, Stafford, Tolland, Vernon

Connecticut Department of Social Services
Western Region

Waterbury: Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, Southbury, Waterbury, Watertown, Wolcott; **Bridgeport**: Bridgeport, Easton, Fairfield, Monroe, Norwalk, Stratford, Trumbull, Weston, Westport; **Danbury**: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Sherman; **Torrington**: Barkhamstead, Bethlehem, Canaan, Colebrook, Cornwall, Darien, Goshen, Greenwich, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Roxbury, Salisbury, Sharon, Stamford, Thomaston, Torrington, Warren, Washington, Wilton, Winchester, Woodbury; **Stamford**: Darien, Greenwich, New Canaan, Stamford, Wilton

Note: District Offices are shown in bold, followed by the towns in the district.

Table 2. New Enrollees in HUSKY A, January 2006-December 2007

		Total		HUSKY A		HUSKY B	
		#	%	#	%	#	%
Total		32,048	**100.0%**	30,507	**100.0%**	1,541	**100.0%**
Age	**<2**	8,823	**27.5%**	8,510	**27.9%**	313	**20.3%**
	2-5	2,886	**9.0%**	2,602	**8.5%**	284	**18.4%**
	6-10	3,082	**9.6%**	2,703	**8.9%**	379	**24.6%**
	11-15	2,791	**8.7%**	2,451	**8.0%**	340	**22.1%**
	16-18	1,743	**5.4%**	1,541	**5.1%**	225	**14.6%**
	Adults 19 and over	12,723	**39.7%**	12,700	**41.6%**	-	**0.0%**
	Children under 19	19,325	**60.3%**	17,807	**58.4%**	1,541	**100.0%**
Gender	**Female**	16,632	**51.9%**	15,874	**52.0%**	758	**49.2%**
	Male	12,175	**38.0%**	11,394	**37.3%**	781	**50.7%**
	Unknown	3,241	**10.1%**	3,239	**10.6%**	-	**0.0%**
Race	**Hispanic**	8,601	**26.8%**	8,607	**28.2%**	311	**20.2%**
	Black	5,405	**16.9%**	5,242	**17.2%**	149	**9.7%**
	White	12,950	**40.4%**	11,944	**39.2%**	907	**58.9%**
	Other	1,131	**3.5%**	1,054	**3.5%**	74	**4.8%**
	Unknown	3,961	**12.4%**	3,660	**12.0%**	100	**6.5%**
HUSKY B	**Band 1**	848	**55.0%**			848	**55.0%**
	Band 2	561	**36.4%**			561	**36.4%**
	Band 3	131	**8.5%**			131	**8.5%**

Note: The count and distribution by program (HUSKY A or B Band 1, 2 or 3 are reported according to the program in which they were newly enrolled.

Table 3. Disenrollment and Reenrollment in the First Year of Coverage

		Lost HUSKY Coverage within 11 Months							
		Disenrolled		Reenrolled within 3 months		Reenrolled within 6 months		Did not reenroll within	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total		8,355	**26.1%**	818	**9.8%**	1,537	**18.4%**	6,818	**81.6%**
Age	**<2**	1,328	**15.1%**	307	**23.1%**	507	**38.2%**	821	**61.8%**
	2-5	664	**23.0%**	72	**10.8%**	132	**19.9%**	532	**80.1%**
	6-10	615	**20.0%**	76	**12.4%**	123	**20.0%**	492	**80.0%**
	11-15	547	**19.6%**	67	**12.2%**	128	**23.4%**	419	**76.6%**
	16-18	558	**32.0%**	55	**9.9%**	106	**19.0%**	452	**81.0%**
	Adults 19 and over	4,643	**36.5%**	241	**5.2%**	541	**11.7%**	4,102	**88.3%**
	Children under 19	3,712	**19.2%**	577	**15.5%**	996	**26.8%**	2,716	**73.2%**
Gender	**Female**	4,875	**29.3%**	421	**8.6%**	843	**17.3%**	4,032	**82.7%**
	Male	3,009	**24.7%**	322	**10.7%**	552	**18.3%**	2,457	**81.7%**
Race/Ethn	**Hispanic**	2,736	**30.7%**	225	**8.2%**	475	**17.4%**	2,261	**82.6%**
	Black	1,435	**26.6%**	155	**10.8%**	260	**18.1%**	1,175	**81.9%**
	White	3,329	**25.9%**	287	**8.6%**	539	**16.2%**	2,790	**83.8%**
	Other	237	**21.0%**	20	**8.4%**	40	**16.9%**	197	**83.1%**
	Unknown	618	**16.4%**	131	**21.2%**	223	**36.1%**	395	**63.9%**
Program	**HUSKY A children**	3,197	**18.0%**	431	**13.5%**	794	**24.9%**	2,403	**75.2%**
	HUSKY A adults	4,622	**36.4%**	241	**5.2%**	541	**11.7%**	4,081	**88.3%**
	HUSKY B children	536	**34.8%**	146	**27.0%**	202	**37.4%**	334	**62.3%**
HUSKY B	**Band 1**	197	**22.3%**	62	**31.5%**	72	**36.6%**	125	**63.5%**
	Band 2	250	**46.8%**	62	**24.8%**	98	**39.2%**	152	**60.8%**
	Band 3	89	**65.0%**	22	**24.7%**	32	**36.0%**	57	**64.0%**

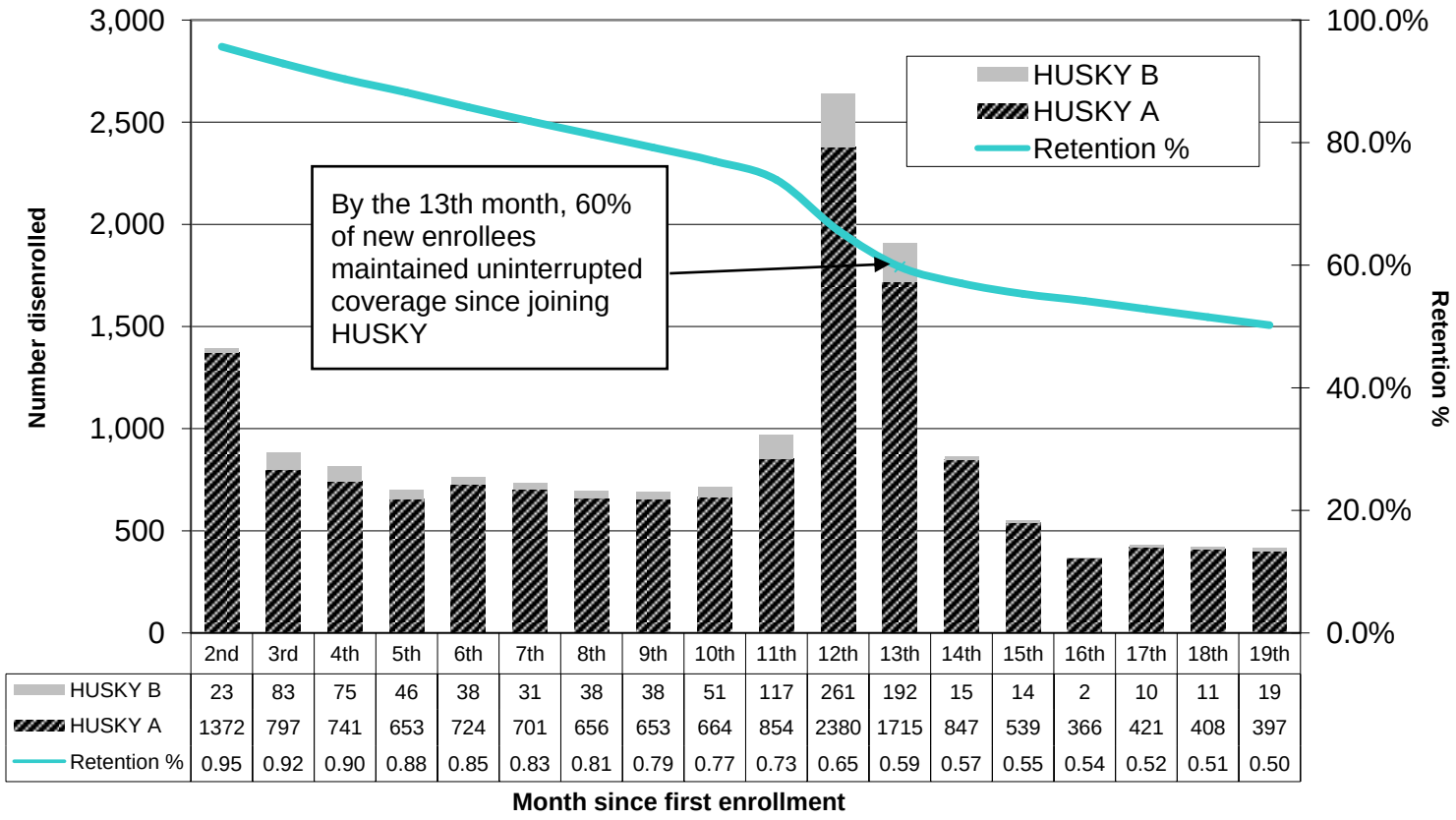
Note: For the purpose of describing disenrollment and re-enrollment by program type (HUSKY A or B Band 1, 2 or 3), those children who changed from HUSKY A to B before experiencing a gap in coverage (less than 0.1%) were classified by the program in child they were enrolled in the month prior to losing coverage

Table 4. Disenrollment and Reenrollment among New Enrollees at Renewal

		Lost HUSKY coverage at renewal (12th or 13th month)							
		Disenrolled		Reenrolled within 3 months		Reenrolled within 6 months		Did not reenroll within 6 months	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total		4,548	**19.2%**	508	**11.2%**	1,140	**25.1%**	3,408	**74.9%**
Age	**<2**	877	**11.7%**	164	**18.7%**	326	**37.2%**	551	**62.8%**
	2-5	537	**24.2%**	79	**14.7%**	148	**27.6%**	389	**72.4%**
	6-10	612	**24.8%**	77	**12.6%**	179	**29.2%**	433	**70.8%**
	11-15	546	**24.3%**	72	**13.2%**	148	**27.1%**	398	**72.9%**
	16-18	360	**30.4%**	39	**10.8%**	84	**23.3%**	276	**76.7%**
	>=19	1,616	**20.0%**	77	**4.8%**	255	**15.8%**	1,361	**84.2%**
	Children (<=18)	2,932	**18.8%**	431	**14.7%**	885	**30.2%**	2,047	**69.8%**
Gender	**Female**	2,453	**20.9%**	278	**11.3%**	645	**26.3%**	1,808	**73.7%**
	Male	2,007	**21.9%**	224	**11.2%**	470	**23.4%**	1,537	**76.6%**
Race/Ethn	**Hispanic**	1,357	**22.0%**	176	**13.0%**	408	**30.1%**	949	**69.9%**
	Black	822	**20.8%**	59	**7.2%**	164	**20.0%**	658	**80.0%**
	White	1,945	**20.4%**	204	**10.5%**	408	**21.0%**	1,537	**79.0%**
	Other	200	**22.5%**	16	**8.0%**	48	**24.0%**	152	**76.0%**
	Unknown	224	**7.1%**	53	**23.7%**	112	**50.0%**	112	**50.0%**
Program	**HUSKY A Children**	2,481	**17.0%**	274	**11.1%**	668	**27.0%**	1,813	**73.1%**
	HUSKY A Adults	1,616	**20.0%**	77	**4.8%**	255	**15.8%**	1,361	**84.2%**
	HUSKY B	451	**45.1%**	157	**34.7%**	217	**47.9%**	234	**51.9%**
HUSKY B	**Band 1**	325	**47.2%**	99	**30.5%**	153	**47.1%**	172	**52.9%**
	Band 2	110	**39.8%**	50	**45.5%**	56	**50.9%**	54	**49.1%**
	Band 3	16	**36.2%**	8	**50.0%**	8	**50.0%**	8	**50.0%**

Note: For the purpose of describing disenrollment and re-enrollment by program type (HUSKY A or B Band 1, 2 or 3), those children who changed from HUSKY A to B before experiencing a gap in coverage (less than 0.1%) were classified by the program in child they were enrolled in the month prior to losing coverage.

Table 5. Retention rate and monthly disenrollment counts



	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th
HUSKY B	23	83	75	46	38	31	38	38	51	117	261	192	15	14	2	10	11	19
HUSKY A	1372	797	741	653	724	701	656	653	664	854	2380	1715	847	539	366	421	408	397
Retention %	0.95	0.92	0.90	0.88	0.85	0.83	0.81	0.79	0.77	0.73	0.65	0.59	0.57	0.55	0.54	0.52	0.51	0.50

Month since first enrollment

Note: The X-axis categories in the figure are relative to each record and therefore do not represent a unique calendar month, e.g., the first bar represents all enrollees who disenrolled in the second month since first enrolling in the HUSKY Program. In a cohort of new enrollees who first enrolled between January and June 2006, the calendar month of the second month of enrollment could be any month between February and July 2006.