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Beyond Enrollment:
Ensuring Stable Coverage for Children in Medicaid and CHIP

Medicaid and the Children's Health Insurance Program (CHIP) play an important role in ensuring children's access to health care. One-third of all children in the U.S., including half of low-income children, receive coverage under one of these publicly-funded programs.[1] For millions of children, Medicaid and CHIP are the keys to obtaining the regular preventive care and prompt medical treatment so critical to their development.

Federal and state governments invest millions of dollars on Medicaid and CHIP outreach and enrollment, yet turnover remains high. A 2005 analysis found that 12.6 percent of children enrolled in Medicaid and CHIP dropped out within 12 months despite remaining eligible for public insurance and having no alternative source of coverage.[2] Many of these children likely re-enrolled in Medicaid or CHIP at a later date. Unstable insurance coverage, known as "churn," negatively impacts the well-being of children and families while placing financial strain on already limited public insurance budgets. Policymakers can take steps to reduce churn by easing administrative requirements on families and eliminating punitive policies that prevent children from retaining their coverage.

Scope of Churn

Health insurance churn is a pervasive problem for children. According to the Survey of Income and Program Participation, a nationally representative longitudinal survey, 26.6 million children (43.1 percent of the population under 19 years old) were uninsured at least once from 2004 to 2007.[3] Although children were less likely than adults to spend the entire four year period without insurance coverage, a greater percentage of children experienced single or repeated gaps in coverage compared to adults.[4] Even brief coverage gaps are associated with delays in seeking needed health care and a decreased likelihood of having a usual source of care,[5] and the cumulative effects of multiple coverage gaps only compound these problems. Prompt and appropriate medical treatment is especially important during childhood, a time of rapid physical, intellectual, and social development.

Policies that emphasize insurance enrollment while ignoring retention put millions of children at risk of losing their coverage. If every low-income child who began the year with insurance was able to retain coverage for the rest of the year, the number of low-income children without insurance would decrease by two-fifths.[6] Time and money spent enrolling vulnerable children are wasted if those children cannot be retained within the program. Addressing churn in Medicaid and CHIP would make those programs more efficient and greatly improve the lives of children who depend on them.

Contributing Factors

Complicated renewal process

Although changes in families' eligibility status can disrupt children's coverage, the majority of children who lose public insurance coverage do so for reasons other than a change in household income.[7] This includes roughly two million children who left Medicaid or CHIP in 2008 despite continued eligibility.[8] Many of these children fall through the cracks during the renewal process, a time that can be fraught with complications for families. In qualitative studies, some parents of CHIP enrollees reported that they did not understand the renewal process and found the renewal forms to be written at too high a literacy level.[9] Others complained about receiving conflicting information regarding their children's enrollment status from program officials. This confusion has real consequences for enrollees; a review of CHIP administrative files from eight states indicated that nearly one-fourth of renewal applications were denied because families failed to follow administrative procedures.[10] Circumstances common to low-income families--such as frequent moves, unstable employment, limited literacy or English comprehension, and unreliable transportation--may pose further challenges to completing the renewal process.

Premium lock-out periods

Federal regulations allow states to charge a limited amount for children's health insurance premiums, and families at the lowest income levels are exempt from all premiums. In states that charge premiums, children whose families fall behind on payments may be disenrolled from the program until overdue premiums are paid, leaving children uninsured in the interim. As of January 2013, 33 states required some families to pay premiums, and most of these states required children to reapply for the program and repay all outstanding premiums before coverage would resume.[11] To further discourage missing premium payments, 12 states automatically locked children out of their plans for one to six months after a missed payment.[12] Although lock-out periods may seem attractive to cash-strapped states looking to enforce their payment structures, these penalties hit already-vulnerable children who do not necessarily have other options for health care. When Rhode Island imposed lock-out periods for RIte Care (its Medicaid program for low-income children, parents, and pregnant women), the end result was more uninsured children. In 2002, the state implemented a monthly premium for RIte Care families with incomes above 150 percent of the federal poverty line and mandated a four-month lock-out period for those who missed two premium payments in a row. Administrative reports revealed that each month 18 percent of families subject to premiums were locked out of the program for non-payment, and half became uninsured after losing their RIte Care coverage.[13] Seeking to minimize the negative effects of lock-outs, the Centers for Medicare and Medicaid Services (CMS) released a final rule in July 2013 limiting CHIP premium lock-out periods to 90 days.[14] Under the new regulations, children must be permitted to re-enroll as soon as their premiums are paid or at the end of the lock-out period, whichever comes first. While the rule will not eliminate churn caused by lock-out, it attempts to balance states' interest in collecting unpaid premium fees with children's need for consistent coverage and access to care.

Low perceived value

For some families, the marginal benefits of coverage may not outweigh the costs of keeping their children enrolled in Medicaid or CHIP. Besides annual enrollment fees or monthly premiums that some families are charged, there are often indirect costs associated with enrolling in and maintaining public insurance. Although the number of states requiring face-to-face interviews to enroll has shrunk in recent years,[15] in the past this onerous requirement forced parents to take

time off work or arrange childcare in order to be interviewed by a case manager. A provision of the Affordable Care Act (ACA) will prevent states from requiring face-to-face interviews of anyone who meets income-based eligibility standards for coverage starting in 2014.[16] Even when enrollment is simplified, limited geographic access to providers accepting Medicaid or CHIP may discourage families from renewing their coverage.[17] Finally, one of the strongest protective factors against disenrollment is having a sibling who is also covered by public insurance,[18] as families glean greater benefit from a given amount of time and effort required to enroll in and maintain coverage. For the same reason, providing public insurance coverage to parents has been linked to increased enrollment and retention among children.[19]

Consequences for Children and Families

Periods of uninsurance undermine children's access to care and leave families exposed to catastrophic medical bills in the event of an emergency. Children with discontinuous coverage are less likely to have a usual source of care or to receive preventive care.[20] These children miss out on the opportunity to build a relationship with a consistent provider who could monitor their health over time and diagnose any chronic conditions that develop. Disruptions in care may occur even after the period of uninsurance is resolved: previous Medicaid or CHIP patients who reenroll after a coverage gap may find that they have been assigned to a new primary care site.[21] This is concerning because continuity of primary care is associated with a lower risk of emergency department visits and hospitalization.[22] For children with chronic conditions such as asthma or diabetes that are easily controlled through regular primary care visits, disruptions in Medicaid coverage are strongly linked to hospitalizations.[23] Medical bills accrued during coverage gaps are likely to be especially burdensome for lower-income families eligible for Medicaid or CHIP.

Consequences for States and Health Plans

Children's insurance churn places financial strain on states and their health plans. There are substantial administrative costs associated with tracking enrollees' eligibility, sending lock-out or termination notices, responding to families' questions about why coverage was terminated, and re-enrolling children who previously lost coverage. Health plan administrators report that unstable enrollment generates significant costs.[24] According to enrollment files for Medi-Cal (California's Medicaid program for low-income children, pregnant women, and people with disabilities), approximately 600,000 children were disenrolled and then re-enrolled from California's public insurance program between 2001 and 2003, generating $120 million in reprocessing costs.[25] Most of the children who regained Medi-Cal coverage did so within a few months, suggesting that their disenrollments occurred for administrative reasons rather than changes in eligibility. Smaller Medicaid managed care organizations with 75,000 members each in Rhode Island and Virginia report spending several hundred thousand dollars annually on "disenrollment and reinstatement tasks related to churning."[26]

Increased administrative costs are not the only churn-related issue faced by health plans. Analysis of Medicaid medical expenditures across the country indicates that average monthly medical costs decrease as individuals are enrolled for more of the year; in other words, the cost to insure a child for a full year is less than twice the cost of six months' coverage.[27] While it is

likely that some unrealized demand for services builds up during periods of uninsurance, this is insufficient to explain all the medical expenditures related to churn. A study of children's Medi-Cal claims compared medical costs paid by the insurer in the six months before and after a disruption in coverage. Even relatively brief three-month coverage gaps were associated with 70 percent higher medical expenditures in the six months after coverage resumed.[28] Reduced access to primary care during gaps may exacerbate known health conditions and delay the diagnosis of new conditions, leading to otherwise preventable medical costs down the line.

Policy Strategies to Reduce Churn

While some degree of insurance instability is inevitable under our current health care system, several policy approaches have been demonstrated to reduce churn among Medicaid and CHIP enrollees. Because so many eligible children lose coverage at the time of renewal, this period presents an obvious target for improvement. One solution is to reduce the frequency of eligibility reviews requiring families to report their financial status. States may certify children for up to 12 months of continuous eligibility which reduces the amount of paperwork families must complete and protects those children whose family income varies throughout the year. (Unsteady employment, including temporary employment and fluctuating work hours, causes some families with low annual income to lose coverage when eligibility is reviewed more frequently.) In January 2013, more than half of states utilized this option for children in Medicaid or CHIP.[29] As an added benefit, extending the length of time between eligibility determinations decreases administrative costs.[30] Some children's health groups have also advocated for continuous eligibility from zero to five years to ensure uninterrupted access to vaccinations and other preventive care during the critical early childhood period, but CMS has yet to make this measure an option for states.

Other strategies include reducing the amount of documentation required for renewal and improving renewal notifications for families. Beginning in 2014, all states must offer online renewals as part of the ACA. They will also be expected to rely on existing financial information collected by other public agencies (e.g. Head Start, SNAP, TANF) to determine eligibility when possible, reducing the documentation that families must provide. Since lock-out periods due to non-payment of premiums contribute significantly to churn, the elimination of these lock-out periods and the elimination of monthly premiums—together or individually— would improve continuity of care and may even save states money in cases where churn-related administrative costs exceed the amount of premiums collected.[31] Finally, increasing Medicaid and CHIP reimbursement rates to providers has been demonstrated to improve retention by improving children's access to care and increasing the marginal benefit of coverage.[32] Previous research indicates that even when other factors remain the same, a $1 increase in physician reimbursement is associated with a 5.8 percent decrease in the number of children dropping out of public insurance.[33] It is likely that a combination of changes to state and federal policies would be most efficacious in combatting churn among children in public insurance programs.

Conclusion

Medicaid and CHIP represent a major investment in the health and well-being of millions of children. As we move closer to the goal of universal, affordable coverage espoused by the ACA,

even more children are expected to enroll, and some who have dropped out will return. In order to capitalize on these gains, policymakers and advocates should take steps now to reduce churn, ensuring that children who enroll stay covered.

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