



Avoid Gaps in Children's Health Coverage: Restore "Continuous Eligibility" in HUSKY

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

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

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

Changes in family income may also result in a child becoming eligible for coverage without the monthly premium or cost sharing that could be unaffordable if the family income goes down. CE doesn't prevent the HUSKY program from reducing the family's premiums or other cost sharing at anytime before the CE period ends, if the family is eligible for such a change.

Recent studies have found that such needless gaps are common among eligible children:

- In New York, 66% of the children who lost coverage for Medicaid/SCHIP returned within 12 months. Less than 10% remained ineligible because of income or family structure changes.²
- A recent national study found that among uninsured children who were eligible for public coverage in 2006, at least 42 percent had been enrolled in Medicaid or SCHIP the year before.³

To combat this churning, 29 states have adopted continuous eligibility in Medicaid, SCHIP, or both programs.⁴ In 2006, the State of Washington reinstated CE in Medicaid and SCHIP after those programs experienced a large decline in enrollment due to the loss of CE.⁵

There is evidence that CE in Connecticut, when combined with notices to families encouraging them to renew their children's coverage,⁶ helped more eligible children to *stay enrolled* in HUSKY:

- Between 2001 and 2003, enrollment in HUSKY A increased by 15%.⁷
- During this time, a monthly average of over 6,500 children who would otherwise have lost coverage at least temporarily stayed enrolled due to CE.
- A survey by Connecticut Office of Health Care Access found that children were less likely than adults to experience fluctuations in health care coverage during the time when CE was in effect.⁸

The elimination of CE in 2003 resulted in over 7,000 children losing their HUSKY coverage.⁹

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

- Research shows that the monthly cost of providing health care drops as individuals are enrolled for longer periods.¹⁰

- A national study found that 12-month continuous eligibility could *lower* state administrative costs due to a reduction in the staff effort needed to process applications. CE for children could reduce such costs by 2-12%.¹¹
- Children without continuity of care are more likely to visit the emergency room and be hospitalized, costing the state more money. One study found that these risks were higher for children on Medicaid.¹²

Continuous eligibility reduces provider costs and improves care.

Interruptions in coverage are costly for managed care organizations and providers who are struggling to maintain eligibility records.

- A recent national study of pediatric providers found that provider participation in Medicaid decreases as paperwork concerns increase.¹³
- Continuous eligibility prevents interruptions in children’s health care. Children with continuous coverage are more than four times as likely to have a primary care provider (PCP) as children who go on and off Medicaid. Furthermore, having both continuous coverage and a PCP significantly improves treatment for ear infections and asthma.^{14 15}

Reinstating continuous eligibility: a cost-effective strategy.

Last year the state legislature and Governor Rell made needed investments in the HUSKY program, including increasing fees paid to providers, and raising the income guidelines for parents and pregnant women. Missing from the final budget was restoration of continuous eligibility. The legislature’s Office of Fiscal Analysis (OFA) has estimated the cost of reinstating this simplification strategy as \$2.8 million, with half the cost reimbursed by the federal government.¹⁶ It is unclear whether OFA’s estimate took into account savings associated with decreased administrative costs or with better health outcomes due to children obtaining timely and needed care.

In sum, reinstating CE could decrease administrative costs, increase provider satisfaction, and prevent interruptions in children’s health care.

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

² M. Birnbaum and D. Holahan, “Renewing Coverage in New York’s Child Health Plus B program: Retention Rates and Enrollee Experiences.” New York: United Hospital Fund, 200;

and K. Lipson et al, “Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York’s Public Health Insurance Programs”, Pub. No. 656. New York: Commonwealth Fund, August 2003. Medicaid funds HUSKY A (for low-income children, pregnant women, and parents) and SCHIP funds HUSKY B (for uninsured children whose family income exceeds the limit for HUSKY A) in Connecticut.

³ B. Sommers, “Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention Versus Poor Take-Up,” *Health Affairs*, 2007, 26(5): w560-w567.

⁴ Tennessee and Texas are the latest states to adopt CE. See, D. Cohen Ross, A. Horn, C. Marks, “Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008,” Table 7, page 44, Kaiser Commission on Medicaid and the Uninsured, January 2008, available at www.kff.org/medicaid/7740.cfm.

⁵ Communication with Donna Cohen Ross, Center on Budget and Policy Priorities, April 2007; See also, fn. 4 above.

⁶ The Department of Social Services (DSS) originally implemented continuous eligibility (CE) in July 1998. In May 2001, DSS began to notify families two months before the end their children’s CE periods that their children’s coverage would end and inviting them to complete a new application. See “HUSKY Retention: Helping Families Keep Health Coverage”, Children’s Health Council, Nov. 2001 available at http://www.ctkidslink.org/pub_detail_19.html

⁷ “HUSKY A Enrollment: More Children are Keeping Health Coverage”, Jan. 2003, Children’s Health Council, available at http://www.ctkidslink.org/pub_detail_9.html

⁸ Connecticut Office of Health Care Access. “Stability of Health Care Coverage: A Look at the Intermittently Insured.” March 2003.

⁹ CT Department of Social Services HUSKY Enrollment files.

¹⁰ See note 3.

¹¹ C. Irvin, D. Peikes, C. Trenholm et al. 2001. “Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children.” Cambridge, Mass.: Mathematica Policy Research, Inc.

¹² D. Christakis, L. Mell et al. “Association of Lower Continuity of Care with Greater Risk of Emergency Department Used and Hospitalization in Children,” *Pediatrics*, 103: 3, March 2001.

¹³ S. Berman, J. Dolins, S. Tang and B. Yudkowsky. “Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients.” *Pediatrics* 110:2: 239-248, August 2002.

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

¹⁵ J. Halterman, M. Guillermo, L. Shone, and P. Szilagyi. “The Impact of Health Insurance Gaps on Access to Care Among Children with Asthma in the United States.” *Ambulatory Pediatrics* 8: 1:43-49, January-February 2008.

¹⁶ See, for example, fiscal note attached to Senate Bill 1 (File No. 551) (Section 7), *An Act Concerning the HealthFirst Connecticut Initiative*, which estimates the cost at \$2.8 million and also notes that 50% of this cost would be reimbursed by the federal government under Medicaid, available at <http://www.cga.ct.gov/2007/FN/2007SB-00001-R000472-FN.htm>