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Theodore R. Kulongoski, Governor

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DHS
Oregon Department of Human Services

September 25, 2008

The Honorable Peter Courtney, Co-Chair
The Honorable Jeff Merkley, Co-Chair
State Emergency Board
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Re: DHS Policy Note on Eligibility Duration and Re-enrollment Policies for State Children's Health Insurance Program and Poverty Level Medical for Children

Dear Co-Chairpersons:

NATURE OF REPORT

The attached report (including Appendix) is submitted in response to the adoption of the following policy note request:

> The Department of Human Services is directed to report to the Emergency Board by September 30, 2008 on eligibility duration and re-enrollment policies for the state's Children's Health Insurance Program and the Medicaid Poverty Level Medical program for children. The report should include an assessment of the impacts of re-enrollment policies on health status, program caseloads, administrative costs and the 2009-11 biennial costs from extending the eligibility period of the Medicaid Poverty Level Medical program for children from six months to 12 months.

REPORT SUMMARY

Each time parents have to recertify their children on Medicaid about 50 – 60 percent fail to do so. Yet, the majority of these children are still eligible. In a study of five states with varying enrollment practices, Oregon was the only state without 12-month enrollment, and Oregon had the least stable coverage

for children on Medicaid. Children who lack health care coverage receive fewer routine health services such as immunizations, dental and vision care. They are more likely to receive more expensive forms of care, such as emergency room visits.

The department's administrative costs would decrease with the implementation of a 12-month certification period for children in the Poverty Level Medical program. Caseload would increase, resulting in program costs of approximately $8.9 million in general funds ($24 million total funds) in the 2009-11 biennium. However, it could cost more to provide care for children who have a gap in coverage than it would to keep them covered. One state reported increased cost to the community of over $2,000 per disenrolled child.

In June 2006 the department implemented a 12-month certification period for children in the State Children's Health Insurance Program.

ACTION REQUESTED

The department requests Emergency Board acceptance of the attached report.

LEGISLATION AFFECTED

The attached report responds to a Policy Note in Senate Bill 5556.

Sincerely,

Jim Scherzinger
Deputy Director of Finance

CC: Representative Tina Kotek
John Britton, Legislative Fiscal Office
Sheila Baker, Legislative Fiscal Office
Blake Johnson, Department of Administrative Services
Jim Edge, DMAP Assistant Director, DHS

DHS
Oregon Department of Human Services

September 2008

Policy Note

Oregon HEALTH PLAN

Eligibility Duration and Re-enrollment Policies
State Children's Health Insurance Program
Poverty Level Medical Children

The Department of Human Services was directed to report on eligibility duration and re-enrollment policies for the State Children's Health Insurance Program (SCHIP) and the Poverty Level Medical (PLM) Medicaid program for children. This report includes actual and proposed eligibility policy impact for SCHIP and PLM.

The report looks at policy impact of health status, program caseloads, administrative costs and biennial costs from extending the enrollment duration from six months to twelve months for PLM covered children.

Duration and Re-enrollment Policy Impact Assessment

Health Status

According to the August 2008 Oregon Health Policy and Research Policy Brief most states have turned to a 12-month re-enrollment period so children will not experience an unnecessary and costly break in health benefits. As of July 2006, 44 states had adopted a 12-month re-enrollment period, compared with PLM's six-month re-enrollment requirements.

Most Oregon children who lose coverage are eligible to re-enroll. Each time families are required to re-enroll their children, 50 to 60 percent fail to complete the re-enrollment requirements yet many of these children enroll again within the next year. A 2007 study[1] of five states with varying re-enrollment practices showed that Oregon, the one state without 12-month enrollment, had the least stable coverage for children receiving medical assistance.

Numerous studies have shown that disruptions in insurance coverage for children lead to poorer care quality. Children with gaps in coverage are less likely to maintain a relationship with a primary care provider, and they also have unmet healthcare needs such as minor ailments developing into chronic conditions.

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[1] G.L. Fairbrother, H.P. Emerson and L. Partridge, "How Stable Is Medicaid Coverage for Children?" *Health Affairs*, March/April 2007, 26(2): 520-528

Longer enrollment periods would help children receive consistent coverage and make them less likely to be assigned new providers because of coming in-and-out of the system: a process known as churning. Quality of care suffers because a short enrollment period makes it difficult for physicians to monitor their patients effectively and address ongoing health problems.

Families are more likely to experience high out-of-pocket costs and compromised maintenance care during lapses or disruptions in their child's health coverage. Lack of children's health coverage also affects school attendance with health problems contributing to poor performance.

It is more expensive to provide care for children who have a gap in coverage than it is to keep them covered because of delayed preventive care and interrupted ongoing treatments. Children without health coverage, such as a gap due to re-enrollment policies, are more likely to use expensive forms of care while uninsured. The OHPR brief shows how one state experienced an increased cost to the community of $2,121 per child with a 10 percent disenrollment of children.

Longer enrollment periods may also lead to long-term cost savings as health plans have increased incentives to invest in preventive care.

Impact of SCHIP Eligibility and Enrollment Policies

The policy note requests information on the eligibility duration and re-enrollment policies for SCHIP. Until mid-year 2006, children receiving health benefits through SCHIP were enrolled for six months. Thereafter the state allowed SCHIP's enrollment period to extend from six to 12 months. The impact from the 12-month enrollment policy was experienced in December 2006, when more children remained enrolled because of the enrollment duration change.

At the end of the 2005-07 biennium, nearly 5,500 more children received health benefits through SCHIP. While other factors may have contributed to this, the department believes this increase of children receiving health benefits was primarily a result of the change in the enrollment duration.

One method the department used to assess the impact of the lengthened enrollment duration was to determine if more children were receiving continuous health care coverage. The department found that children's coverage increased by about 76,000 months[2] through June 2008. An associated increase in the General Fund budget of $2.3 million is attributed to the additional children maintaining health coverage.

[2] This figure reflects the cumulative increase in months of enrollment from July 2006 through June 2008.

Impact of Extending the Enrollment Period for Children in PLM

The policy note requests information on the impact of lengthening the children's coverage period in the PLM program from six to 12 months. The following topics address the caseload and cost impact.

PLM Caseload

The anticipated average monthly increase of children receiving health benefits through an increased re-enrollment period in the PLM program for the 2009-11 biennium is 7,071 children and 9,608 children for the 2011-13 biennium.

Administrative Cost

The financial impact of the increased enrollment period in PLM is expected to produce a General Fund net savings in administrative costs of $7,023 for the 2009-11 biennium and $199,138 for the 2011-13 biennium. For both biennia, the department requires one full-time employee to provide client services to the increased number of children receiving continuous health benefits. However, this increased cost is offset by savings from not printing and mailing applications at the six-month re-enrollment period. This savings becomes more apparent in the second biennium, where the full impact of the lengthened enrollment period significantly reduces the number of applications printed and mailed.

Program Cost

Maintaining PLM children through a longer enrollment period increases program expenditures for the 2009-11 biennium by approximately $8.9 million in General Funds ($24 million in Total Funds). For the 2011-2013 biennium program expenditures would be $12.1 million in General Funds ($32.6 million in Total Funds). The increased General Fund budget directly provides health care for low-income children who remained enrolled.

Appendix

1. Table highlighting the Department of Medical Assistance Program's health programs available for children listing:
    a. Program name
    b. Program description
    c. Eligibility duration/re-enrollment policy
    d. General income requirements

2. *Office for Oregon Health Policy and Research* (August 2008). Policy Brief: Expanding the Enrollment Period from 6 to 12 Months for Children Under the Age of 19.

Oregon's Children's Medical Assistance Programs

August 2008

Program	Description	Enrollment Rules	Income Limit by Federal Poverty Level (FPL) Asset Limit
CHIP Children's Health Insurance Program	Uninsured children not eligible for Medicaid	Application every 12 months	Up to 185% FPL $10,000
FHIAP Family Health Insurance Assistance Program	Private health insurance premium subsidy	Application every 12 months	Up to 185% FPL $10,000
PLM Poverty Level Medical Children	Health benefits for low income children	Application every 6 months	Age 5 or less: up to 133% FPL Age 6-18: up to 100% FPL No resource limit
Medical Foster Care/ Substitute Care	Foster care, substitute care or adoption assisted children	Eligible while in foster care	Up to 46% FPL (child's income only) $2,000
TANF Temporary Assistance to Needy Families	Method for placing family in OHP program when a dependent child is deprived of parental support because of a parent's death, continued absence, unemployment or incapacity	Regularly scheduled reviews, not to exceed 12 months, or when client reports changes Enrollment length is unlimited When client no longer meets program requirement, enrollment ends	Up to 46% FPL, depending on family size $2,500 ($10,000 when enrolled in JOBS)
CAWEM Citizen/Alien-Waived Emergency Medical	Non-citizen limited-emergency medical services and labor/delivery service	Client is placed in Medicaid program for which they qualify except for citizenship or immigration status	Age 5 or less: up to 133% FPL Age 6-18: up to 100% FPL Pregnant (age 19 or less): up to 185% FPL Program's resource limit

Office for Oregon Health
Policy and Research

Policy Brief:

Expanding the Enrollment Period from 6 to 12 Months for Children Under the Age of 19

August 2008

POLICY BRIEF: EXPANDING THE ENROLLMENT PERIOD FROM 6 TO 12 MONTHS FOR CHILDREN UNDER THE AGE OF 19

Introduction

Once states have made the initial decision to offer health coverage to certain populations, the next challenge is to enroll participants. Once participants are enrolled, it can be an even greater challenge to keep them from losing coverage unnecessarily. To maximize the enrollment of children in Medicaid and the State Children's Health Insurance Program (SCHIP), states have implemented a number of different strategies. Some states have simplified their application procedures, or they provide direct assistance to eligible families during the application process. Other states have expanded outreach efforts to eligible populations. And most, but not all, states have turned to a 12-month renewal period so that applicants only have to reenroll once a year. As of July 2006, 44 states had adopted a 12-month renewal period, and a handful of states allowed 12-month continuous eligibility, regardless of changes in income or family situation.[1]

This policy brief provides an overview of why Oregon may want to consider establishing a minimum enrollment and re-enrollment period of 12 months for children under the age of 19 who receive state medical assistance. Research indicates that this policy may improve children's access to health care as well as potentially lower costs for the state.

Most Children Who Lose Coverage Are Still Eligible

Many children who have health insurance lose it over the course of the year. This is especially true for low-income children. One recent study showed that among children on Medicaid, about one-fifth of those who had coverage at the beginning of the year had lost it 12 months later.[2] Studies also repeatedly show that each time parents have to recertify their children, roughly 50 to 60 percent of those children do not remain enrolled, yet many of those children end up on the Medicaid and SCHIP rolls again in less than a year.[3] In one state, of children who failed to recertify, two-thirds came back onto the program within the next 12 months; only ten percent of those who failed to recertify had become ineligible because of changes in income or family composition.[4] By extending enrollment to 12 months, states eliminate what many see as an unnecessary hurdle to keeping eligible children covered.

Continuity of Care

Numerous studies have shown that disruptions in insurance coverage for children lead to poorer quality care. A 2007 study of five states with varying enrollment practices showed that the one state without 12-month enrollment – Oregon – had the least stable coverage for children in Medicaid.[5] Expanding the enrollment period to 12 months would help mitigate that problem.

Children with gaps in coverage are less likely to have relationships with primary care providers and are also more likely to have unmet health care needs.[6] Quality of care suffers because short tenure makes it difficult for physicians to monitor their patients effectively and to address any ongoing health problems.[7] In addition, these disruptions can lead to high out-of-pocket costs for families who need care while not enrolled.[8] A longer enrollment period would help these children receive quality coverage for a longer period of time and make them less likely churn on and off of coverage unnecessarily.

Potential Cost Savings

All else equal, reducing the number of children enrolled in Medicaid and SCHIP will reduce state expenditures on public health insurance. This cost reduction, however, does not represent a reduction in total state, federal, or societal spending on health care for these children.[9] To begin with, it may cost the state more to provide care for children who have had a gap in coverage than it would have cost to keep them covered. When the children do become insured, they utilize more care because they have delayed getting preventive care or treating ongoing conditions until they gained coverage again.[10]

Another factor is that children are more likely to utilize expensive forms of care while they are uninsured. One study in Arizona showed that a 10 percent disenrollment of children from Medicaid/SCHIP resulted in increased costs to the community of $2,121 for each child disenrolled. Most of these costs are the result of increased emergency department visits and hospitalizations and are borne by both state and federal governments.[11]

In addition, keeping eligible children covered prevents the problems associated with adverse selection, which can raise per capita costs.[12] The parents of children with the most severe health needs will be more likely to ensure that their children do not lose coverage. Parents with healthy kids may be less careful to secure continuous coverage. A recent study in the state of Georgia confirmed that lower-cost enrollees in the state's SCHIP program (PeachCare) are more likely to drop coverage than higher-cost enrollees. The study's authors conclude that focusing state efforts on retaining coverage for children already enrolled in PeachCare is one of the most cost-effective ways to reduce the number of uninsured children in their state.[13]

States also incur unnecessary administrative costs every time they reenroll an eligible child. The fewer transactions required for children to maintain coverage, the lower the administrative burden on both the eligibility office and families. A 2004 study of New York's Medicaid program showed that it cost approximately $280 to enroll a child in Medicaid or SHIP because of administrative costs associated with documentation requirements.[14] One study estimated that implementing a policy of 12-month continuous eligibility for children could save the state 2 to 12 percent of total administrative costs.[15] In addition, short reenrollment periods may lead to additional costs as health plans have reduced incentives to invest in preventive care.[16]

Conclusion

Expanding Oregon's enrollment period from six to twelve months for children receiving state medical assistance offers the opportunity to keep eligible children enrolled in coverage, increase their continuity of care, and save money on administrative costs, if not overall.

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[1] D.C. Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2007).

[2] L. Ku and D.C. Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families,* (New York: Commonwealth Fund, 2002).

[3] G.L. Fairbrother, H.P. Emerson, and L. Partridge, "How Stable Is Medicaid Coverage for Children?" *Health Affairs*, March/April 2007, 26(2): 520-528.

[4] G.L. Fairbrother, H.P. Emerson, and L. Partridge.

[5] G.L. Fairbrother, H.P. Emerson, and L. Partridge.

[6] J.E. DeVoe et al., "'Mind the Gap' in Children's Health Insurance Coverage: Does the Length of a Child's Coverage Gap Matter?" *Ambulatory Pediatrics*, March-April 2008, 8(2): 129-134.

[7] G.L. Fairbrother, H.P. Emerson, and L. Partridge.
[8] A.W. Dick et al., "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review,* Spring 2002; 23(2): 65-88.
[9] M.E. Rimsza, R.J. Butler, and W.G. Johnson, "Impact of Medicaid Disenrollment on Health Care Use and Cost," *Pediatrics,* May 2007, 119(5): e1026-e1032.
[10] [10] L. Ku and D.C. Ross.
[11] M.E. Rimsza, R.J. Butler, and W.G. Johnson.
[12] A.W. Dick et al.
[13] P. Ketsche et al., "Discontinuity of Coverage for Medicaid and S-CHIP Children at a Transitional Birthday," *Health Services Research,* December 2007, 42(6 part 2): 2410-23.
[14] G. Fairbrother et al., "Costs Of Enrolling Children In Medicaid And SCHIP," *Health Affairs,* January/February 2004; 23(1): 237-243.
[15] C. Irvin et al., "Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children" (Cambridge, MA: Mathematica Policy Research, Inc., 2001).
[16] A.W. Dick et al.