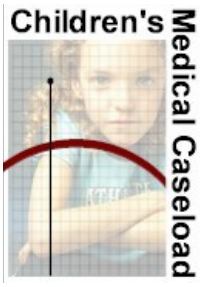


Understanding the Children's Medical Caseload Decline: Part II

WHAT THE SURVEY FINDINGS TELL US

Research conducted by:

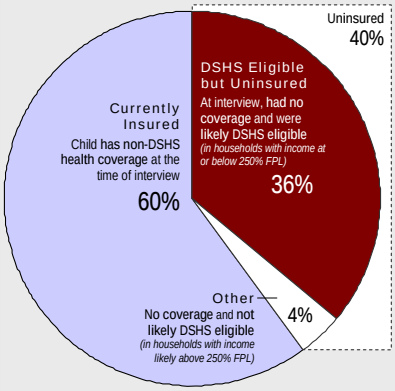
DSHS RDA and Office of Financial Management
David Mancuso, Ph.D.
Barbara Felver, M.E.S., M.P.A.
Vicki Wilson, Ph.D.
Jenny Hamilton, M.S.G.

Medical Eligibility Quality Control
Linda Curtis
Vickie Jackson
Beva Myhre
Susan Rielly

This is the second of two reports exploring why the Children's Medical caseload declined following a series of eligibility policy changes implemented by the Department of Social and Health Services in April 2003. The new policies were implemented under the direction of the legislature and included new signature and income verification requirements, a 6-month eligibility review cycle, and termination of 12-month continuous eligibility.[1] Part I of this study examined administrative data and found a net decline of 39,085 children on the Children's Medical caseload following the eligibility policy changes. Most of the loss of coverage was attributable to increased exits, as opposed to few newer entries or increased cycling on and off the caseload. This report uses client survey data to better understand why children left the Children's Medical program.

FIGURE 1

Most "leavers" have non-DSHS coverage, but most uninsured "leavers" remain DSHS-eligible



What We Found

- ***Do children leaving the Children's Medical caseload have non-DSHS medical coverage? If not, are they still eligible for DSHS coverage?*** Most "leavers" (60 percent) had other coverage at the time of the interview, but almost all uninsured "leavers" were still eligible for DSHS coverage (Figure 1).
- ***Why did the DSHS eligible but uninsured children leave? And do they plan to return?*** Most parents say DSHS made the decision, and about half cite administrative-related reasons. Almost all parents say they plan to reapply for Medicaid.
- ***Do the DSHS eligible but uninsured differ from the kids who exited to other medical coverage?*** They are poorer, more likely to use the emergency room, less likely to have physician or clinic visits, and more likely to be Hispanic.
- ***What might have been the consequences of maintaining 12-month continuous eligibility?*** The 36 percent of "leavers" who were DSHS eligible but lost coverage and were uninsured would likely have remained on Medicaid for another 6 months. The 32 percent of leavers who were "ineligible" would likely have continued on Medicaid for another 6 months.
- ***Are there opportunities to identify more children on Medicaid with private coverage?*** Many "leavers" who remained DSHS eligible had other coverage when interviewed. Enhanced efforts to coordinate benefits or buy into employer-provided coverage may be warranted.

[1] The Governor has since issued an administrative order restoring the 12-month continuous eligibility policy. The return to a 12-month review cycle was effective in May 2005 and implementation of continuous eligibility is scheduled for July 2005.

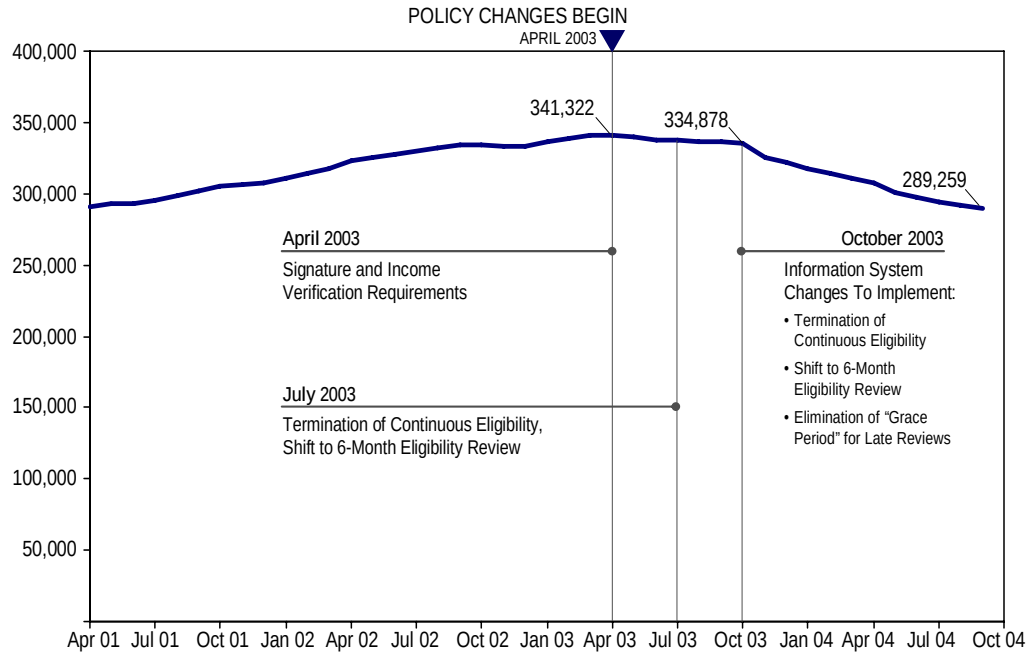
Background

The Children's Medical program[2] provides Medicaid coverage to children under age 19 in households with income at or below 200 percent of the Federal Poverty Level (FPL).[3] In 2003, the Department of Social and Health Services (DSHS) implemented a series of eligibility policy changes affecting the Children's Medical caseload, including:

- **Signature requirements** – Beginning in April 2003 applicants were required to sign their Medicaid application document. Previously, signature requirements had been suspended.
- **Income verification** – Beginning in April 2003, applicants were required to provide verification of household income and Community Service Office (CSO) staff were directed to use information sources such as Employment Security Department earnings data to verify income. Previously, applicants could declare income without providing documentation.
- **Termination of continuous eligibility and adoption of a 6-month eligibility review (ER) cycle** – In July 2003, a change in state law directed DSHS to terminate 12-month continuous eligibility and adopt a 6-month review cycle for the Children's Medical, SCHIP, and Medical-only Family Medical programs. Previously, children would remain eligible for coverage for a 12-month period, even if their family's income changed.

Following these policy changes, the Children's Medical caseload fell from a peak of 341,322 cases in April 2003 to 289,259 cases in September 2004, a "gross decline" of 52,063 cases in 18 months (Figure 2). After accounting for increased transfers to other types of DSHS medical coverage, the Children's Medical caseload experienced a **net decline of 39,085 children** in the 18-month period.

FIGURE 2
Children's Medical caseload declines after policy changes
SOURCE: OFM Eligibility File



[2] For the purposes of this study, the Children's Medical program is defined to include Medicaid Management Information System (MMIS) program-match combinations H-C, H-M, H-Q, H-S, and H-T. Other DSHS medical programs for children that are discussed in this report include the Family Medical program which covers families with children under the age of 19 whose income and resources are below Temporary Assistance to Needy Families (TANF) limits, and the State Children's Health Insurance Program (SCHIP) which covers children in households with income above 200 percent but at or below 250 percent of FPL.

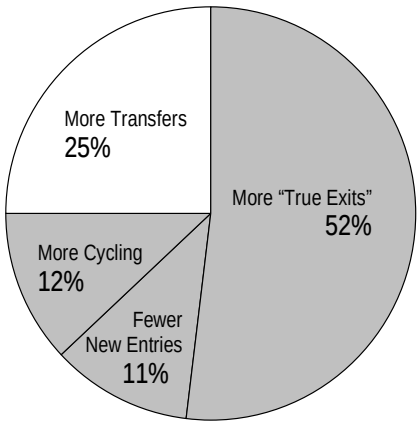
[3] Child care costs, child support payments, and the first $90 of earned income are deducted from gross household income. There are no resource limitations for Children's Medical coverage.

Accounting for the Caseload Decline: Phase I Findings

Among the issues that drive interest in more restrictive eligibility rules for public programs are the potential for cost savings and the appeal of ensuring program integrity. Underlying both issues is the desire to direct limited dollars to people most in need (as defined by eligibility criteria), believing that money spent on *the ineligible* means coverage denied to *the eligible*. At the same time there is concern whether the benefits (cost-savings from lower enrollment, increased program integrity) are worth the costs (loss of coverage for eligible children, costs to implement more restrictive eligibility rules). A key objective of this study is to help assess the benefit-cost tradeoff for the eligibility policy changes affecting the Children's Medical caseload. In particular:

- *Did the new eligibility policy rules create barriers to enrollment that caused eligible children to lose medical coverage?*
- *Did the new rules remove ineligible children who had been able to enroll under the old rules (for example, due to less robust income verification)?*

FIGURE 3
"True exits" account of largest part of caseload decline
SOURCE: OFM Eligibility File



Phase I of this study analyzed administrative data and found that half of the gross decline in coverage (52 percent) was attributable to more "true exits" – that is, more children leaving the caseload and not returning to any type of DSHS medical coverage (Figure 3). Increased exits due to failure to complete an eligibility review (as recorded in administrative data) accounted for 43 percent of the gross decline, while increased verification-related exits accounted for 9 percent.[4] The eligibility policy changes had a more modest dampening effect on the number of children entering the Children's Medical caseload, with fewer new entries accounting for 11 percent of the gross caseload decline. Increased cycling off and on the Children's Medical caseload accounted for 12 percent of the decline. Increased transfers to other types of DSHS medical coverage – primarily to the SCHIP and Family Medical programs – accounted for the other 25 percent of the gross caseload decline.

Increased cycling provides evidence that the new eligibility policies created barriers to continuous enrollment that caused some eligible children to have gaps in medical coverage.[5] The increase in transfers to the higher income SCHIP program, coupled with an increase in verification-related exits, provides evidence that the new rules removed some ineligible children who previously had been able to enroll in the Children's Medical program.

However, the administrative data can only tell us so much. For most children who left Children's Medical coverage, we only know from administrative data that their case was closed because they did not complete their eligibility review. We do not know why the eligibility review was not completed. *Did household income increase? Did the family obtain private coverage? Did the new rules create barriers to enrollment?*

Phase II of the Children's Medical Caseload Evaluation uses survey data to examine these issues from the perspective of parents of children who left the caseload following the eligibility policy changes (and who, by the time of interview, had *not* returned to the caseload). We are particularly interested in whether substantial numbers of these children **continued to be eligible for DSHS coverage**, in their **current health insurance status**, and in parents' views of **why their children left** the program.

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[4] Survey data will cast a different light on the exit reasons recorded in administrative data (see page 8). Many children recorded as leaving due to failure to complete an eligibility review or failure to verify income actually left due to increased earnings or due to the availability of non-DSHS medical coverage.

[5] This inference is supported by the finding discussed below (page 5) that 90 percent of children who left the Children's Medical program and were uninsured at the time of the interview remained eligible for DSHS coverage. Given the high rate of eligibility for DSHS coverage among children who left Medicaid and did not return, it is plausible that most children who left the Children's Medical program and returned (usually after a gap of less than 6 months) remained eligible for DSHS coverage during the coverage gap.

Phase II Objectives: What Will We Learn?

Because Phase I showed that increased "true exits" were the most important source of caseload decline, the Phase II survey focused on children who left the Children's Medical caseload and did not return to any type of DSHS medical coverage. The survey data allow us to answer several key questions about children who left the Children's Medical caseload:

- *Do "leavers" have non-DSHS coverage? If not, are they still eligible for DSHS coverage?*
- *For children who are still DSHS eligible but uninsured, why did they leave? To what degree were administrative issues a factor? And do they plan to return?*
- *Do the DSHS eligible but uninsured differ (health status, demographics) from the kids who exited to other medical coverage?*

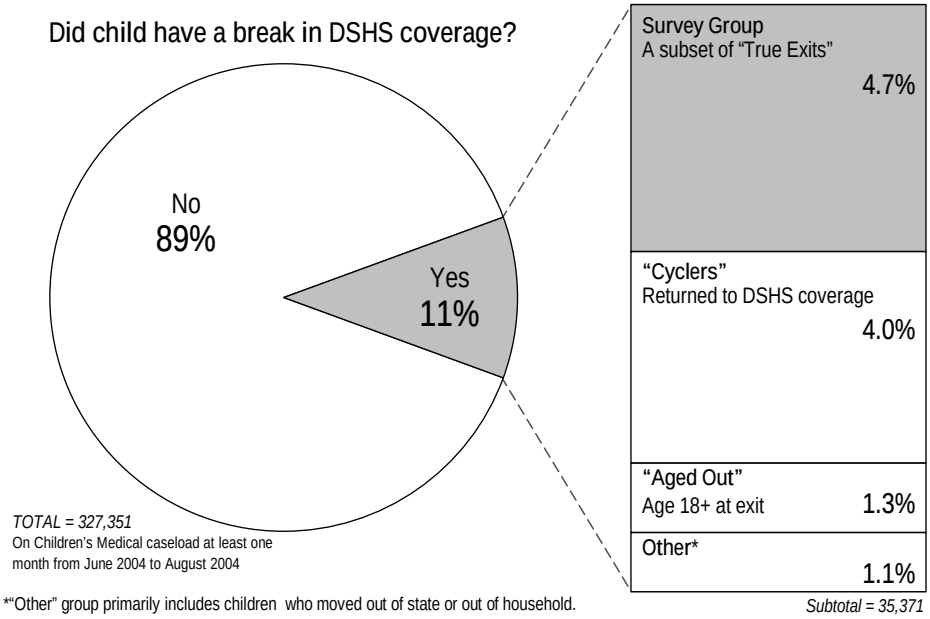
Ultimately, the survey data will help assess the impact of maintaining a 12-month continuous eligibility policy, allowing us to estimate how many eligible children lost coverage and how many "ineligible" children might have continued in coverage under the 12-month rules.

We interviewed parents of 301 children from a random sample who left the Children's Medical caseload in June, July, or August 2004. Our sample **excluded** children who:

- Transferred to other types of DSHS medical coverage,
- Cycled back onto any type of DSHS medical coverage,
- "Aged out"[6] of coverage, or
- Left the state or left the sampled parent's household.

Data collection was conducted by the Medical Assistance Administration Medicaid Eligibility Quality Control unit from January to April 2005. Interviews were completed six to ten months after exit from DSHS coverage. Survey findings reflect the circumstances of children leaving the Children's Medical caseload and not returning to DSHS coverage. **These findings do not reflect the experiences of children who stayed on or returned to the caseload.** It is also important to note that survey findings cannot distinguish between children who left Medicaid specifically due to the eligibility policy changes and children who would have left Medicaid even if the changes had not occurred. More detail about survey methods is provided in the technical note on page 14.

FIGURE 4
Survey focuses on "true exits"
SOURCE: OFM Eligibility File, Children's Medical Leavers Survey estimates



*"Other" group primarily includes children who moved out of state or out of household.

[6] We excluded from the sample all children who were age 18+ at the time of exit.

Most "Leavers" Have Non-DSHS Coverage, but Most Uninsured "Leavers" Remain Eligible for DSHS Coverage

When we asked parents about their child's current health insurance status, **60 percent of children were reported to have non-DSHS health insurance at the time of the interview**. It is important to keep in mind that this finding pertains to children who left DSHS coverage, not children who are currently enrolled in Medicaid. In addition, we do not have information about the *quality* of non-DSHS coverage for the currently insured. The vast majority of this coverage – 87 percent – was reported to be employer or union provided insurance. An additional 6 percent of children were covered by private self-paid plans, 5 percent were covered by a military plan, and 2 percent were covered by other types of plans.

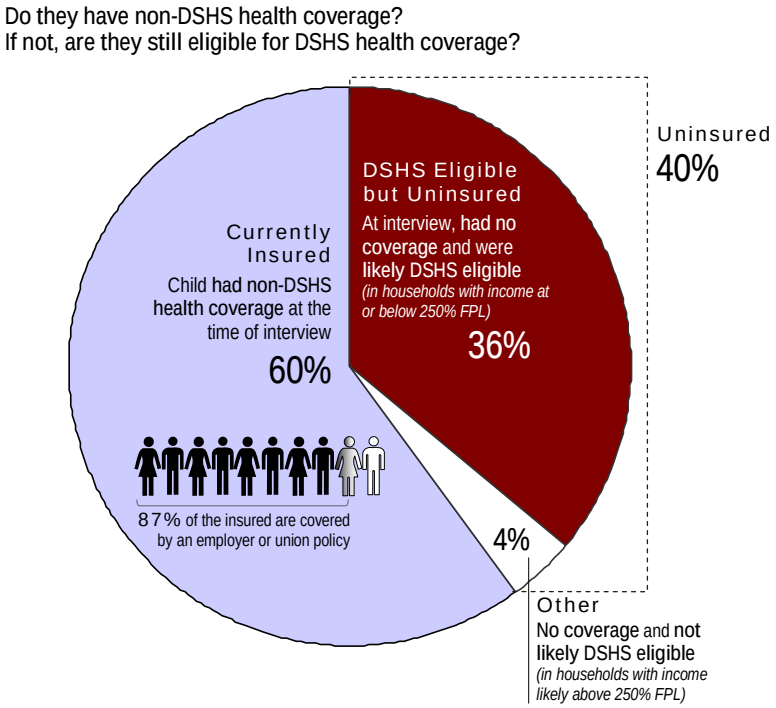
Of the Children's Medical "leavers," 40 percent were uninsured at the time of the interview. **Almost all children who were uninsured at the time of the interview were likely eligible for DSHS coverage.**[7] Specifically, 90 percent of uninsured children were estimated to be eligible for DSHS medical coverage, with 77 percent estimated to be eligible for Medicaid (at or below 200 percent FPL) and 13 percent estimated to be eligible for SCHIP (above 200 percent FPL but at or below 250 percent FPL).

The next set of exhibits compares the circumstances of **DSHS eligible but uninsured** children with the circumstances of children who were **currently insured** at the time of the interview.

FIGURE 5

What happened to the children who left DSHS coverage?

SOURCE: Children's Medical Leavers Survey



[7] Survey respondents were asked about their household size and gross monthly household income. Households with income at or below 250 percent FPL were determined to be likely DSHS eligible. That is, we defined DSHS-eligibility to include eligibility for *either* the Children's Medical (up to 200 percent FPL) program or the SCHIP (200-250 percent FPL) program. This determination is approximate and does not take into account earned income or child care cost disregards or the presence of potentially disqualifying non-DSHS coverage among children who might otherwise qualify for SCHIP. We are more likely to understate (rather than overstate) the proportion of children who are DSHS-eligible. In addition, 9 percent of respondents did not answer the household income question. As shown in Figure 13, there is a strong correlation between household income and the likelihood that a child had non-DSHS health coverage at interview. Children whose parents did not respond to the household income question had higher rates of current non-DSHS coverage (88 percent) than children whose parents reported household income above 250 percent of FPL (84 percent). Based on this finding, we assessed children whose parents did not report income as not likely to be eligible for DSHS medical coverage.

Most DSHS Eligible but Uninsured "Leavers" Say It Was Not Their Decision to Leave Medicaid

Why did your child leave Medicaid? Parents of DSHS eligible but uninsured children reported very different reasons for leaving Medicaid, compared to parents of children with health coverage at the time of the interview. We first asked parents whether it was their decision to leave Medicaid, or whether DSHS made that decision (Figure 6). Most parents of children who were likely DSHS eligible but uninsured when interviewed reported that DSHS made the decision (85 percent), while most parents of children with insurance when interviewed reported it was their decision to leave Medicaid (62 percent).

We then asked parents about the underlying reason why their child left Medicaid (Figure 7). We identified a set of responses that raise potential concerns about the additional administrative burden imposed by the eligibility policy changes, including:

- I didn't complete the eligibility review.
- I didn't or couldn't verify income.
- I reapplied, but never heard back from DSHS.
- It was too much hassle to reapply.

About half (48 percent) of parents of DSHS eligible but uninsured children cited a reason of potential concern – the most common reason being "I didn't complete the eligibility review." Few of these parents cited increased earnings (14 percent) or access to non-DSHS medical coverage (4 percent) as the underlying reason for leaving Medicaid. In contrast, most parents of children with health insurance when interviewed reported they left Medicaid either because they had other medical coverage (43 percent) or because the family had increased earned income (26 percent).

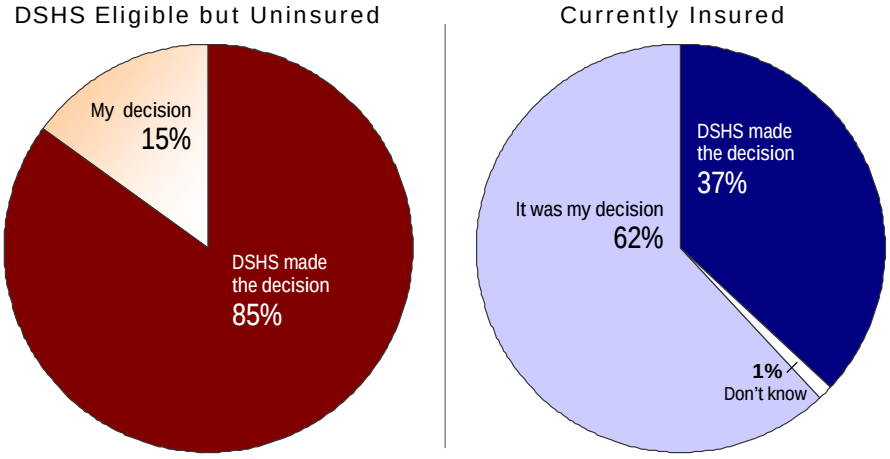
Do you plan to reapply for Medicaid? Most parents of DSHS eligible but uninsured children (88 percent) reported they planned to reapply or had already started to reapply for Medicaid (Figure 8). As expected, fewer parents of insured "leavers" (24 percent) reported they planned to reapply. However, a large proportion of these parents (59 percent) indicated they might reapply in the future if circumstances warranted.

Given the ability of parents of DSHS eligible but uninsured children to obtain "retroactive" Medicaid coverage if a significant medical event were to occur, the fact that many of these parents plan to reapply for Medicaid may temper our view of the impact of loss of coverage for these children. We return to this issue when we look at use of emergency room and physician or clinic care on page 9.

FIGURE 6

Was it your decision to leave Medicaid?

SOURCE: Children's Medical Leavers Survey

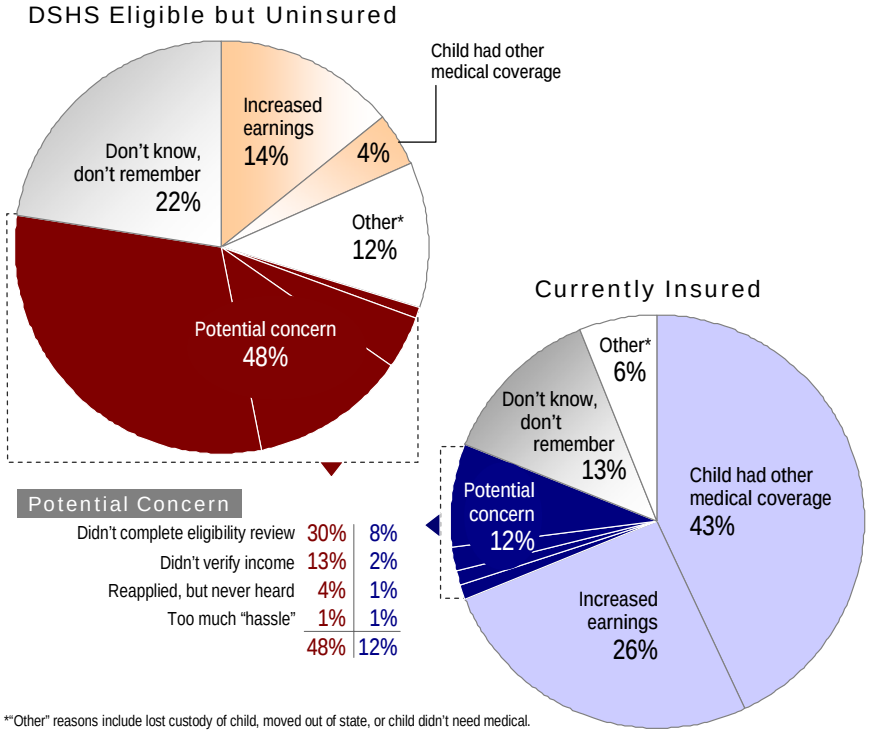


Most Insured "Leavers" Cite Availability of Other Coverage or Increased Earnings as Reason for Exit

FIGURE 7

Why did your child leave Medicaid?

SOURCE: Children's Medical Leavers Survey



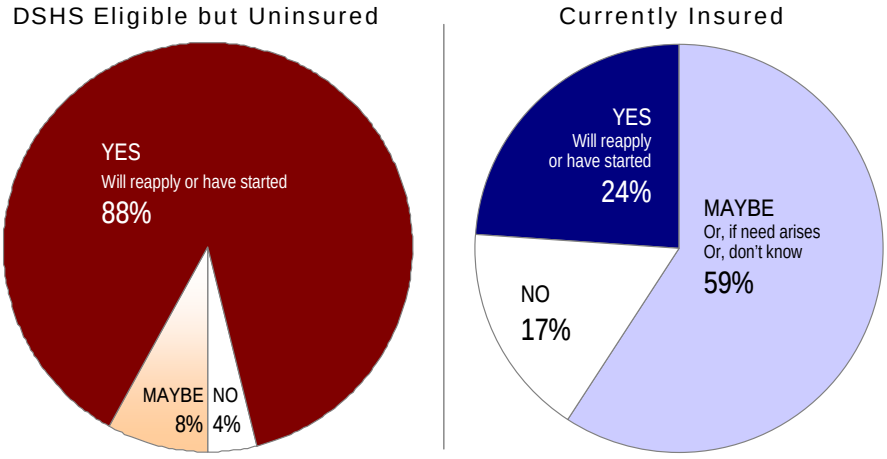
*"Other" reasons include lost custody of child, moved out of state, or child didn't need medical.

Most DSHS Eligible but Uninsured "Leavers" Say They Plan To Reapply for Medicaid

FIGURE 8

Do you plan to reapply for Medicaid?

SOURCE: Children's Medical Leavers Survey



Comparison of Survey and Administrative Exit Reasons

We were interested in parents' views of why their children left the Children's Medical program (Figure 7), and we were concerned about the degree to which administrative data may create mistaken impressions of those reasons. For example, administrative data show that the increase in exits that occurred following the eligibility policy changes was exclusively due to an increase in exits related to income verification or an incomplete eligibility review, perhaps creating an impression that administrative barriers were the prime driver of increased exits.

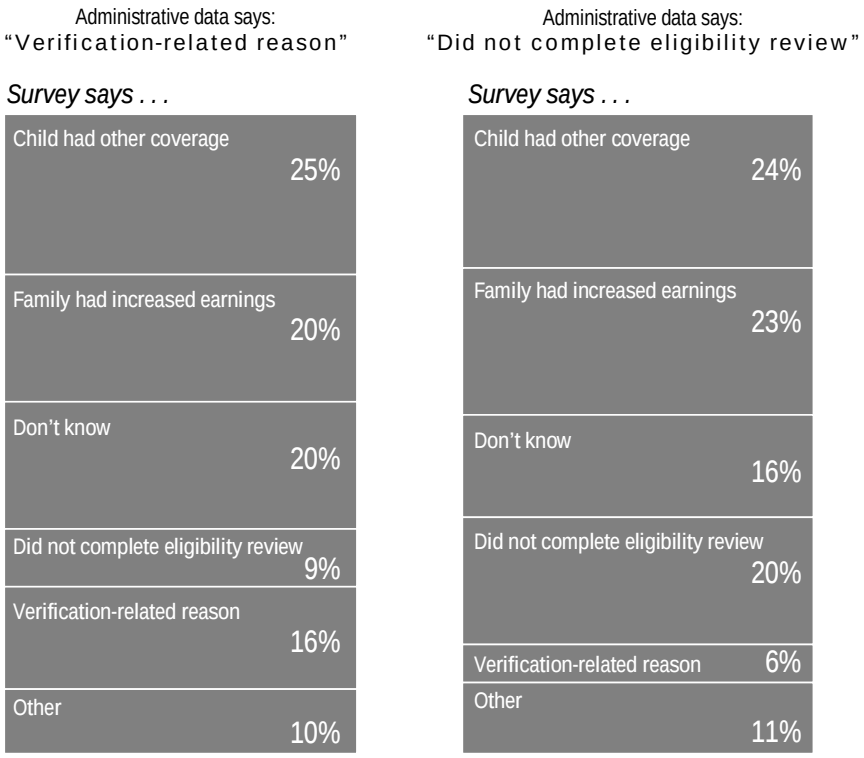
However, a comparison of administrative and self-reported reasons for exit (Figure 9) tells a different story. That is, for children whose administrative exit reason was recorded as "did not complete eligibility review," nearly one-half left for reasons completely unrelated to the eligibility policy changes – because of increased earnings (23 percent) or the availability of other coverage (24 percent). The story is similar for children whose administrative exit reason was recorded as "verification related" – 25 percent of these parents said they left Medicaid because their child had other coverage and another 20 percent said they left due to increased earnings.

We raise this issue not to argue pro or con the impact that the administrative changes may have had for maintaining enrollment for eligible children; rather as simply a caution not to "over interpret" the administrative reasons for exit. Refinements to the process of recording reasons for exit may help to better identify children's exit reasons in administrative data.

FIGURE 9

How do self-reported reasons for exit compare to reasons recorded in administrative data?

SOURCE: ACES Exit Reason and Children's Medical Leavers Survey



A Look at Health Status and Use of Medical Services

To facilitate comparisons between Children's Medical "leavers" and children staying on Medicaid, our survey included items from the Consumer Assessment of Health Plans Survey (CAHPS) regarding health conditions, emergency room use, and physician or clinic visits.[8] The CAHPS surveyed children continuously enrolled in Medicaid ("stayers") and was fielded in 2004. We found Children's Medical "leavers" to be less likely than CAHPS "stayers" to have a persistent medical, behavioral, or other health condition lasting three months or more (Figure 10). Only 8 percent of currently insured "leavers" and 12 percent of DSHS eligible but uninsured "leavers" were reported to have a persistent health condition, compared to 24 percent of CAHPS "stayers."

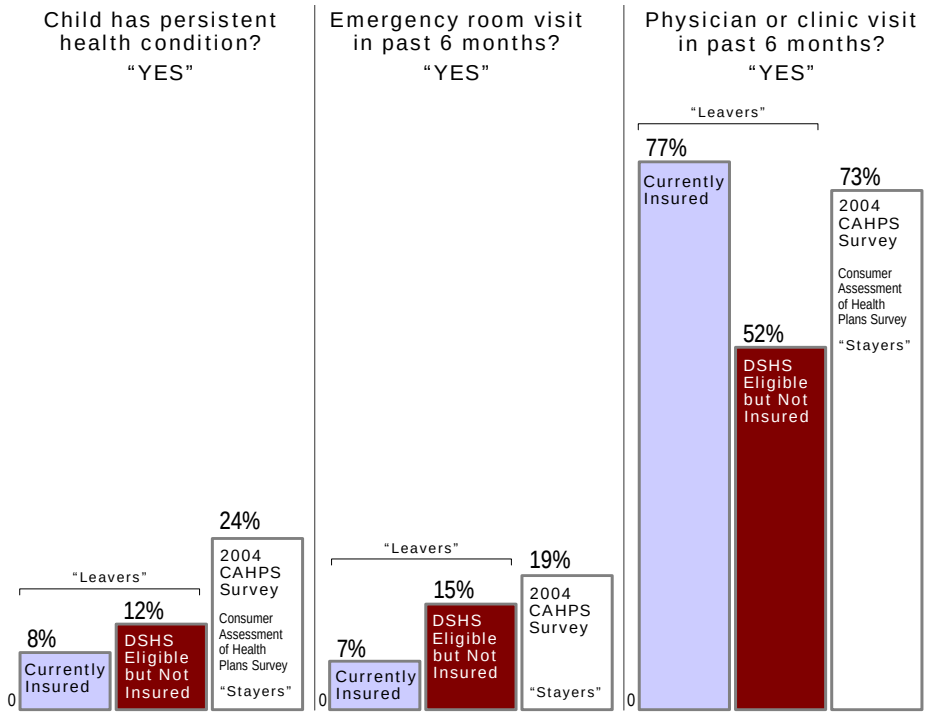
A likely consequence of the relatively low prevalence of persistent health conditions among our "leavers" is a low rate of emergency room use, compared to CAHPS "stayers." Among "leavers," 7 percent of the currently insured and 15 percent of the DSHS eligible but uninsured had an emergency room visit in the previous six months, compared to 19 percent of CAHPS "stayers."

Earlier we noted that a high proportion (88 percent) of parents of DSHS eligible but uninsured children planned to return to Medicaid, and raised the question of how concerned we should be about lack of current coverage for these children who could be covered (retroactively if necessary) by Medicaid if a significant medical event should occur. However, survey data on emergency room visits and physician or clinic visits suggest reason for concern. DSHS eligible but uninsured "leavers" were less likely than currently insured "leavers" to have had a physician or clinic visit in the previous six months (52 percent vs. 77 percent), but were twice as likely to use the emergency room in that period (15 percent vs. 7 percent). Although merely suggestive, these findings are consistent with the notion that DSHS eligible but uninsured "leavers" may not be getting the routine care they need, which could result in more potentially avoidable emergency room visits for these children.

FIGURE 10

"Leavers" less likely than "stayers" to have a persistent health condition or use the emergency room

SOURCE: Children's Medical Leavers Survey



[8] Our survey also included a CAHPS item asking the parent to assess their child's health status. Similar proportions of Children's Medical "leavers" and CAHPS "stayers" were reported to be in very good or excellent health (about 80 percent of children in each group). See the Technical Note on page 16 for more about the CAHPS survey.

Demographic Differences

Among children leaving the Children's Medical caseload, Hispanic children were overrepresented in the DSHS eligible but uninsured group. Specifically, 24 percent of the DSHS eligible but uninsured children were Hispanic, compared to only 11 percent of "leavers" who had coverage at the time of the interview (Figure 11).

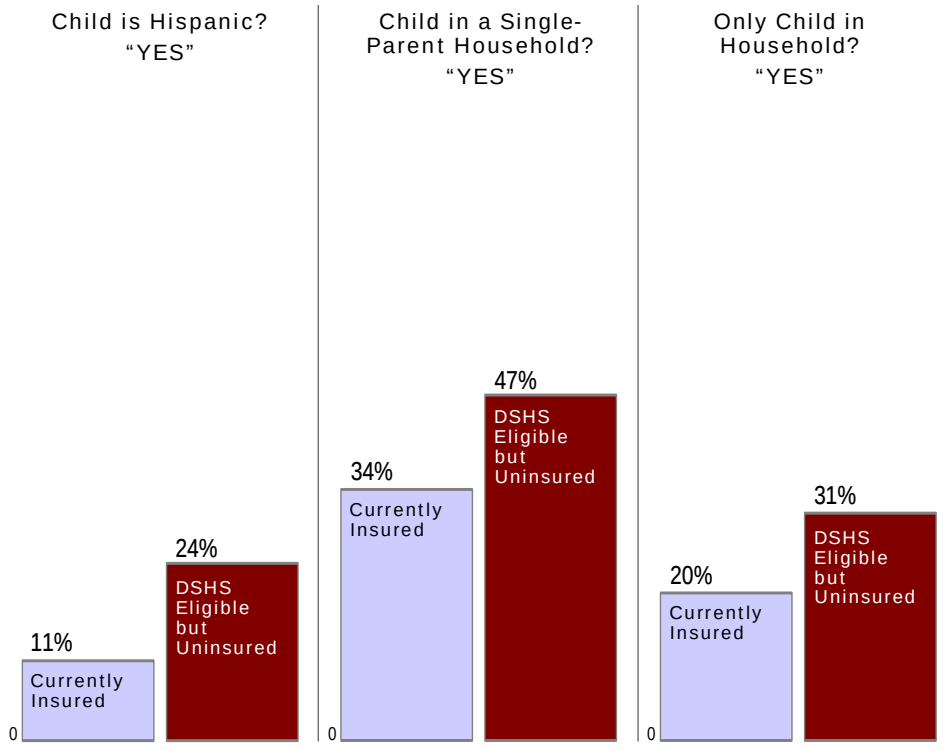
It is interesting to compare this result to the Phase I finding that children leaving Medicaid following the eligibility policy changes were *less likely* to be Hispanic than children staying on the Children's Medical caseload.[9] In other words, Hispanic children were less likely to leave the Children's Medical caseload following the eligibility policy changes, but the Hispanic children who did leave that caseload were disproportionately likely to end up uninsured.

DSHS eligible but uninsured "leavers" were also more likely than insured "leavers" (47 percent vs. 34 percent) to reside in a single-parent household (Figure 11). This probably reflects the greater likelihood that two-parent households will have access to employer-provided health insurance. DSHS eligible but uninsured "leavers" were also more likely to be an only child (31 percent vs. 20 percent).

FIGURE 11

DSHS eligible but uninsured "leavers" are more likely to be Hispanic, from single parent households, or an only child

SOURCE: Children's Medical Leavers Survey



[9] To see this, compare the Hispanic proportion of the "Leavers After" and "Stayers After" columns in Table 1 of the Phase I report.

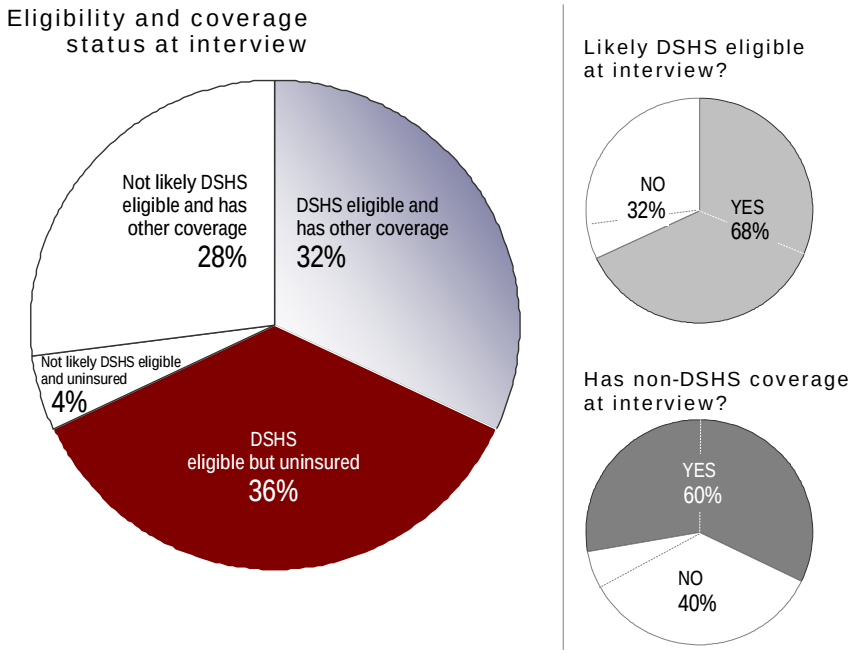
Policy Implications: Eligibility and Coverage Trade-offs

Findings from the survey help shed light on the trade-offs that decision makers face in setting program policy direction. Using Figure 12 we examined these trade-offs from the perspectives of eligibility[10] and coverage.

Eligibility – *How wide to cast the net?* There is a trade-off between serving *only* children for whom the program is intended (in which case some eligible children may be excluded) and serving *all* children for whom the program is intended (in which case some ineligible children may be included). Our survey results put some numbers to this trade-off, given that these are all children who left the program and yet under the "rules" of 12-month continuous eligibility could have stayed, generally for an additional six months. Taken *solely* from the perspective of eligibility, the trade-off between serving *"only versus all"* boils down to this question: *If 12-month continuous coverage were in place, would it have been worth covering up to 32 percent ineligible children to ensure that the 68 percent eligible children remained enrolled?* To make the trade-off more challenging, consider that 4 of the 32 percentage points of ineligible children would also become uninsured if they lost their public coverage. And to raise the ante even more, consider that most children who *left but were still likely to be eligible* were *uninsured* at interview.

Coverage – *Balancing the private side?* A second trade-off raised by the findings in Figure 12 relates to the unexpectedly high proportion of children who had other coverage, primarily employer/union based. This trade-off comes in the form of *"opportunity gained versus opportunity lost"* to capitalize on other sources of coverage. Again, under the rules of 12-month continuous coverage all of these "exited" children could likely have stayed in the program beyond the time they left. At risk, under less frequent (i.e., 12-month) compared to more frequent (i.e., 6-month) reviews, is the opportunity to identify children with employer-based coverage and to make use of that information.[11] Again, our survey puts some numbers to this potential opportunity.

FIGURE 12
Two of three "leavers" were likely DSHS-eligible
SOURCE: Children's Medical Leavers Survey



[10] Our approach to estimating eligibility is described in footnote 7.

[11] Experience indicates that parents are more likely to engage in "passive disenrollment" rather than "active disenrollment." If parents obtain other coverage for their children they simply quit using the public coverage and when recertification comes around they do not respond. (If most children were enrolled in fee-for-service, rather than managed care, the cost implication of this would be much less. However, under managed care the state continues to pay a monthly premium for the child whether or not services are used.)

Policy Implications: More on Eligibility and Coverage

Ineligible children with private coverage. First, Figure 12 shows that in the presence of 6-month reviews, 32 percent of the surveyed group left the program and likely were not eligible. *However,* seven out of eight of these "exited" children had other coverage (primarily employer/union based) at the time their parents were interviewed and *thus were not at risk of being uninsured* if their DSHS coverage were discontinued.[12]

Eligible children with private coverage. For those children who continue to be eligible for medical assistance, there also may be an opportunity to capitalize on the existence of other coverage – *close to half of the children who remained DSHS eligible also had other coverage*. Six-month reviews present an opportunity to identify the "covered" children sooner rather than later and open the door to earlier coordination of benefits and/or the possibility of "buying the child into" employer-based coverage.[13] The Medical Assistance Administration (MAA) currently does significant work in the area of coordinating benefits and is piloting an "employer buy-in" initiative which, if cost-effective, covers the premium needed to enroll a child in employer coverage. Survey results provide support for both efforts to continue and be enhanced where they are cost effective.

Balancing public eligibility and private coverage. In the end, it is important that public program integrity be maintained and that resources are directed to those children most in need. At the same time, one must ask: *Where is the integrity in creating barriers that make it less easy for parents of eligible children to sustain their child's coverage or that contribute to the ranks of uninsured children (at interview, four of 10 children were uninsured, the majority of whom continued to be eligible)?* Given our findings, *perhaps the most reasonable compromise* is to maintain 12-month continuous enrollment while ensuring a robust network for linking to other state and local systems, such as Employment Security, to identify those children who are likely to have other coverage. Once identified, these children can be reviewed for eligibility – if ineligible their enrollment can be ended (without fear of them being uninsured[14]) and if eligible, then opportunities to link public dollars with private coverage, if cost effective, can be explored. MAA should be supported in its continued efforts to improve the linkages it makes with other state and local systems.[15] [16]

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[12] Clearly this statement does not address concerns regarding the quality and continuity of that other coverage, concerns not to be ignored. We are limited by the contents of the survey which asked only about the presence/absence and source of non-DSHS coverage, not about the specifics of the coverage. However, the findings reported in Figure 10 do not suggest that the children who left to private coverage have health coverage that limits access to care. Despite having a lower incidence of persistent health conditions, currently insured "leavers" were somewhat more likely than CAHPS "stayers" to have had a physician or clinic visit in the previous 6 months.

[13] In part, this gets to the issue of continuous versus non-continuous coverage (regardless of whether it's for 6 or 12 months). A requirement to report changes of circumstances that might impact eligibility (i.e., non-continuous eligibility) generally is enormously hard to police and often ineffective. Thus, shorter eligibility periods are sometimes considered in lieu of requiring "change" reporting.

[14] See footnote 12.

[15] This compromise aligns with the Governor's and Legislature's goal to cover all children by 2010 and hopefully would prevent premature additions to the ranks of Washington's uninsured children.

[16] It was not part of our study to look at the cost trade-offs associated with the recertification policy changes. However, we would be remiss in not reminding ourselves that part of the balancing equation involves other costs including, for example, financial costs of eligible but uninsured children on other parts of the system funded by public dollars; costs to the program, working parents, health plans, providers and community outreach programs of disenrolling and re-enrolling children; and, individual and system costs associated with discontinuous care.

Policy Implications: Other Issues

Beyond the implications of Figure 12, there are other policy issues we want to raise. The first concerns the income distribution of children who had non-DSHS coverage at the time of the interview, the second is a reminder of where the survey population of "leavers" fits in the context of the Children's Medical program as a whole, and the third addresses impacts of the eligibility policy changes on program cycling.

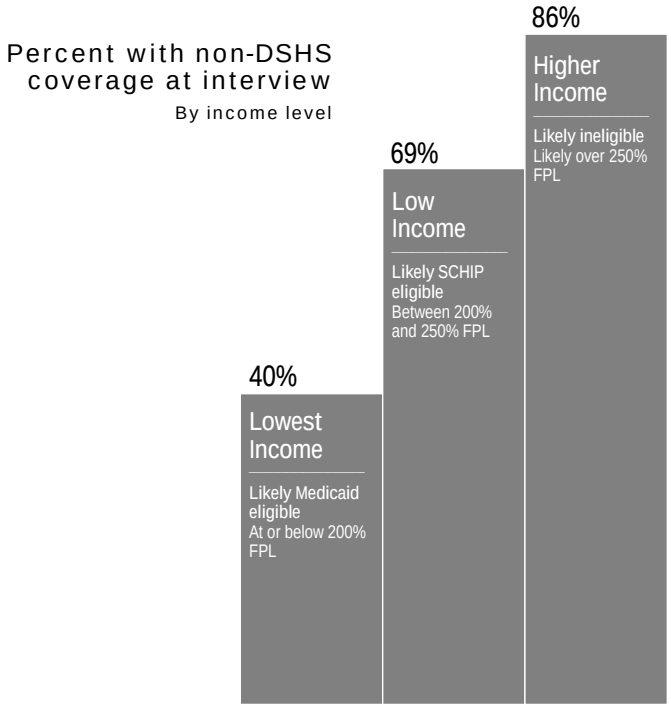
Lowest-income children disproportionately impacted. It is clear from Figure 13 that based on parents' reports of child's coverage status at interview, the lowest income children were much more likely to end up without coverage, either public or private, than were less-poor children, following their exit from the caseload. Specifically, higher income children (over 250 percent federal poverty) were more than twice as likely to have coverage (mostly employer or union based) as were the lowest income children (at or below 200 percent federal poverty). Thus, it appears that the very group for whom our public programs are designed is the group most disadvantaged by the recertification policy changes in that their earlier exit (earlier than if 12-month continuous eligibility were in place) added substantial numbers of them to the uninsured population.

Crowd-out concerns. Although we did not focus on crowd-out per se, Figure 13 provides some support for conventional wisdom. That is, as income eligibility levels for public programs increase the *potential* for public coverage to supplant private coverage rises, simply by virtue of the fact that greater numbers of children at higher income levels have private coverage options. Considered in a vacuum, crowd-out might seem to present a solid argument for lower income eligibility levels. That argument pales somewhat when one considers that many potentially excluded children are likely to end up uninsured. We are not arguing that concerns about crowd-out should be ignored, but perhaps dealt with in ways other than closing the doors on lower income children truly in need of a public coverage option.

FIGURE 13

Poorest "leavers" least likely to have health coverage

SOURCE: Children's Medical Caseload Survey Responses



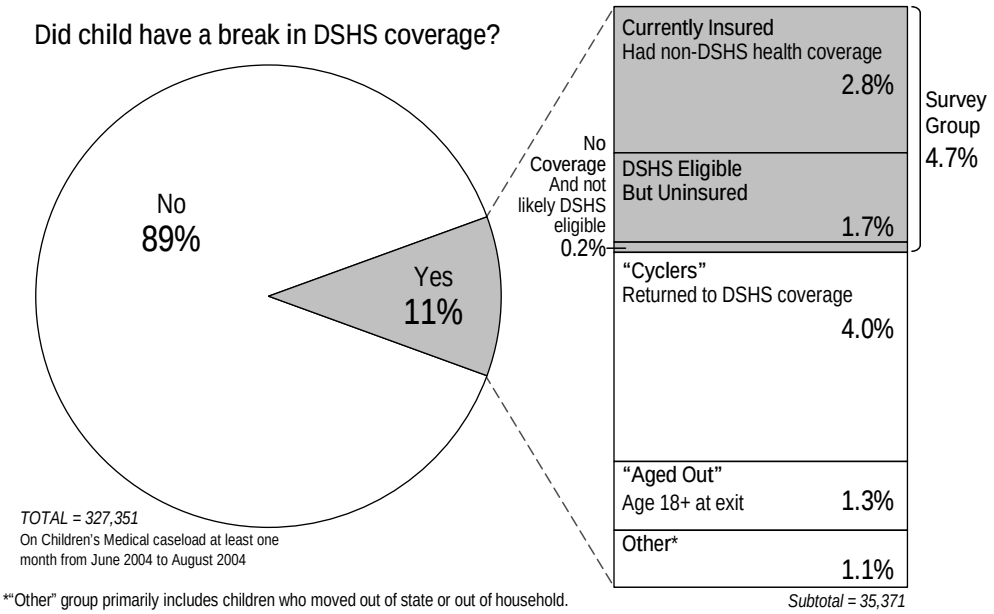
Policy Implications: Other Issues

Study Group in Broader Context. Finally, by design this analysis is about children who left the Children's Medical program following implementation of more stringent eligibility policies. Although we do not want to trivialize the impact of the administrative changes on an eligible child's ability to remain in the program, it is useful to note the small segment of the program represented by the study group, and remind the reader not to stretch the interpretation of results too far.

This group of "leavers" represents *slightly less than 5 percent* of the children enrolled during the 3-month sampling period (June through August 2004). Overall, 89 percent of the enrollment during this 3-month window stayed in the program, i.e., did not experience a gap in coverage. We should not lose sight of the fact that the Children's Medical program serves hundreds of thousands of children on a monthly basis.

Increased Cycling Merits Attention. Last but not least, what research paper can end without a suggestion for further research? There is another group of children that was not the focus of this survey but for whom the administrative changes also have had consequences – the 4 percent of children with a break in coverage who were identified as "cyclers" (Figure 14). These are children who left the program but subsequently returned. By itself, the 4 percent may not seem compelling. However, when combined with two other pieces of information we believe the issue rises to a level meriting concern. First is the finding in Part I of the study that increased cycling in the Children's Medical program accounted for 12 percent of the caseload decline that occurred after the eligibility policy changes. Second, there is the survey finding showing that a substantial portion of parents of DSHS eligible but uninsured children say they have already started the reapplication process for their "exited" child or are likely to do so (Figure 8). Thus, many of our DSHS eligible but uninsured "leavers" may become "cyclers" in the near future. Given the substantial amount of literature on the problems associated with non-continuous access to coverage and care, this is a consequence of the policy changes that warrants a closer look.[17]

FIGURE 14
Study group in broader context
SOURCE: OFM Eligibility File, Children's Medical Leavers Survey estimates



*"Other" group primarily includes children who moved out of state or out of household.

[17] Problems associated with non-continuous access include health and economic impacts on the children and families, as well as added costs to the system (public programs, health plans, providers, community programs) for disenrolling and re-enrolling the same child. See footnote 16.

What do other studies say?

Few studies perfectly share Washington's program context, often differing in one or more important respects. For example, they address dropout at different stages of enrollment (*prior to* versus *at* recertification); focus on different programs (SCHIP versus Medicaid) with varying income eligibility levels that aren't always clear and don't correspond to Washington cut-offs; and examine related but slightly different issues (e.g., benefits of staying in the program versus impact of policy decisions on drop-out). The distinctions are important but not always readily discernable. The following are selected references that speak specifically to disenrollment at recertification (reasons for, predictors of, impacts) and its relationship to more stringent review procedures, especially 12-month continuous eligibility compared to more frequent reviews.

Dick, A.W., R.A. Allison, S.G. Haber, C. Brach, and E. Shenkman. 2002. "Consequences of States' Policies for SCHIP Disenrollment." *Health Care Financing Review* 23 (3): 65-88.

Fairbrother, G. April 2005. *How Much Does Churning in Medi-Cal Cost?* Woodland Hills, CA: The California Endowment.

Gardner, M., T. Lew, and P. Lichiello. 2004. *The Costs of Enrollment Instability in Washington State's Medicaid Program*. Seattle, WA: Health Policy Analysis Program, University of Washington.

Hill, I., and A.W. Lutzky. 2003. *Is There a Hole in the Bucket? Understanding SCHIP Retention.* Assessing the New Federalism. Occasional Paper 67. Washington, DC: The Urban Institute.

Irvin, C., D. Peikes, C. Trenholm, and N. Khan. 2001. *Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children.* Cambridge, MA: Mathematica Policy Research.

Kavoussi, R. and E. Burchfield. May 2004. *Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers.* Seattle, WA: Community Health Network of Washington.

Kronebusch, K., and B. Elbel. 2004. "Simplifying Children's Medicaid and SCHIP." *Health Affairs* 23 (3): 233-246.

Lipson, K., E Fishman, P. Boozang, and D. Bachrach. August 2003. *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs.* New York, NY: The Commonwealth Fund.

Mark-Wilson, P., J. Gallagher, and S.A. Mathis. 2004. *Findings and Recommendations: Focus Group and Interview Study of Washington Medicaid and CHIP Programs.* Washington, D.C.: Health Systems Research, Inc.

O'Brien, E., and C. Mann. 2003. *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*. Washington, DC: Health Policy Institute, Georgetown University.

Phillips, J.A., J.E. Miller, J.C. Cantor, and D. Gaboda. 2004. "Context or Composition: What Explains Variation in SCHIP Disenrollment." *Health Services Research* 39 (4): 865-885.

Riley, T., C. Pernice, S. Kannel, and M. Perry. May 2002. *Technical Report: Why Eligible Children Lose or Leave SCHIP: Findings from a Comprehensive Study of Retention and Disenrollment* Portland, ME: National Academy for State Health Policy.

Sommers, B. D. 2005. "From Medicaid to Uninsured: Drop-Out Among Children in Public Insurance Programs." *Health Services Research* 40 (1): 59-78.

Survey Design

The survey sample frame was developed using the December 2004 Office of Financial Management (OFM) Eligibility File. The sample was selected from children age 17 and under who left the Children's Medical caseload in June, July, or August 2004 and were not observed to return to any type of DSHS medical coverage by December 2004. We excluded children age 18 from the sample frame because most of these children "aged off" the caseload, and most of those who did not age off the caseload would have been age 19 (and therefore ineligible for the Children's Medical program) by the time of the interview. We sampled 800 heads of households of children who met these criteria. Many sampled parents had more than one "study eligible" child, and we randomly sampled a "reference child" for each parent, with a systematic structure to ensure balanced representation by child age and gender.

Data collection was conducted by the MAA Medical Eligibility Quality Control unit. During the "desk audit" phase of data collection, we excluded 196 children from the telephone interview phase who were observed to return to DSHS medical coverage after December 2004 (that is, they returned to DSHS coverage prior to the interview but too late to be excluded from the initial sample frame). We also excluded 87 children who were determined to have left the state. Thirty children were screened out of the telephone interview phase for other reasons (primarily because they left the sampled parent's household).

This left 487 children from the initial sample who screened through to the telephone interview stage. Of these children, 353 had an Automated Client Eligibility System (ACES) exit reason of "ER not complete," 78 had a verification-related exit reason, and 56 had other ACES exit reasons. We completed 301 interviews, for a response rate of 62 percent. Interviews were conducted from January to April 2005, six to ten months after exit from DSHS coverage.

Analysis weights were constructed to account for the number of exiting children associated with the sampled head of household. Weights were also adjusted for non-response using the inverse fitted probability of response (among the 487 children who screened through to the telephone interview stage) from a logistic regression model with the following control variables:

- Child's age, gender, and race/ethnicity;
- Household head's age and gender;
- Administrative reason for exit from ACES; and
- Estimated household income at exit (from the desk audit).

Weighted and unweighted survey estimates were generally very close to each other.

Comparisons with the CAHPS Healthy Options General Child Population

The 2004 CAHPS Healthy Options general child population sample frame included children age 17 and younger who were enrolled in a Medicaid Healthy Options plan from July 1, 2003 through December 31, 2003 with no more than a one-month break in Medicaid coverage during that period. The survey was fielded in 2004. The CAHPS sample frame includes lower income children enrolled in the Family Medical program, in addition to children enrolled in the Children's Medical program.

Additional copies of this fact sheet may be obtained from:

http://www1.dshs.wa.gov/RDA/

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