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Center for Children and Families

Maintaining Coverage for Children: Retention Strategies

Summary

Efforts to decrease the number of uninsured children in America often focus on increasing enrollment in Medicaid and the Children's Health Insurance Program (CHIP). With over six million uninsured children eligible for these programs, outreach and enrollment activities can indeed be one of the most effective strategies for covering uninsured children.[1] Yet equally important is making sure those children, once enrolled, do not unnecessarily lose their coverage and join the ranks of the uninsured.

Paying attention to the problem of keeping children enrolled within public insurance programs, chiefly Medicaid and CHIP, makes sense for two reasons:

1. Ongoing health insurance coverage is effective because it helps to ensure appropriate preventive, primary, and condition-based care,[2] which ultimately can improve health outcomes. Research shows that even brief gaps in health coverage cause people to skip or delay care,[3] while uninterrupted coverage can reduce avoidable hospitalizations for children by 25 percent.[4]

2. In addition to the health benefits of continual care, stable coverage reduces administrative costs associated with unnecessary re-processing applications and resolving billing issues.[5]

Although states have had some success in ensuring children remain enrolled, there are still specific strategies that can be utilized to ensure children are not unnecessarily falling off coverage and again joining the ranks of the uninsured.

Background

Some of the children dropping out of public coverage do so because they are no longer eligible for that coverage or they move to private coverage. However, children also inappropriately lose coverage for procedural, rather than eligibility-related, reasons. The evidence from the states is that this problem is substantial. One warning sign that children are losing coverage unnecessarily is the number of disenrolled children who then subsequently reenroll in the program within a short period of time (often called churning). A previous report from the Center on Children and Families for The Commonwealth Foundation showed the extent of children losing coverage and churning in states[6]:

- In Rhode Island, one of four Medicaid children had a gap in coverage over a 12-month period. In addition, about 60 percent of these enrollees returned to the program within the year.
- In Virginia, over an 18-month period beginning in March 2004, about one-third of

the children enrolled in Medicaid or CHIP lost their coverage at some point.

- In Washington in a three-month period in 2004, more than one-third (36 percent) of children whose Medicaid coverage was terminated were reenrolled after a gap in their coverage.

States report that there are a number of reasons children and families do not retain their coverage, including:

- **Administrative barriers.** Renewal procedures can be confusing for families and/or create hardships. They may require time off from work (e.g., for a face-to-face interview with a case worker), completion of complicated forms, and submission of documents that are not readily available. In addition, some families may lose coverage during the year due to paperwork errors (e.g., they do not receive a bill for premium payments or paperwork is lost).[7]

- **Changes in family circumstances.** Low-income families often experience changes in their circumstances such as shifts in their employment status and family composition. Sometimes these changes affect their eligibility. More often, however, families assume – incorrectly – that they have become ineligible for Medicaid or CHIP, and then do not seek renewal.[8]

- **Costs.** Premiums are a leading cause of disenrollment from public health insurance.[9] Many parents do not realize children can be barred from coverage for an extended time if they miss their payments.[10]

However, improving the rate in which children enrolled in Medicaid and CHIP retain coverage (called the "retention rate") can have a high payout.

- In California, for example, a study of Medicaid (Medi-Cal in California) enrollees in 2003 showed that over 600,000 enrolled children had been disenrolled from the program within a three-year period, only to be later re-enrolled. It cost California over $120 million to re-process these eligible Medi-Cal children.[11]

- After requiring renewal every six months rather than annually, and adding new verification steps, the cost of administering the Children's Medical Program in Washington State increased by more than $5 million annually.[12]

Legislative Authority

Since the inceptions of Medicaid (in 1965) and CHIP (in 1997), states have had the flexibility to adopt administrative and outreach practices that can improve retention rates. Specific administrative strategies allowed, and, in some instances, required, under Medicaid and CHIP include: guaranteeing a full year of coverage (12-month continuous eligibility), simplified renewal procedures (such as no renewal interview), implementing Express Lane at renewal, and coordinating coverage between Medicaid and CHIP.[13] When conducting Medicaid renewals, federal law also specifically requires states to base the review "to the maximum extent possible" on information already known to the

Medicaid agency. This means that a state should use information it has collected from other programs, such as food stamps, to assess ongoing Medicaid eligibility to ensure families are not required to submit information already available to a state.[14]

The implementation of CHIP, and the consequent interest in improving child health coverage rates, led to an increase in states efforts to put some of these practices into play. For example, a decade ago, most states required families to renew Medicaid more than once a year —sometimes as often as every few months. As of January 2009, 44 states and Washington, D.C. allow renewal annually, and 18 states guarantee a full year of coverage regardless of changes in family circumstances.[15]

Another important federal development was the discussion of retention strategies during the 2007 debate on reauthorization of the CHIP program. While the program was ultimately extended with few changes, there was wide support for improving retention and data collection efforts. Specifically, CHIP legislation included financing incentives to encourage states to increase child health enrollment rates, including by strengthening retention efforts. CHIP reauthorization, which will occur again in 2009, offers an opportunity for Congress to implement similar measures.

Strategies

When developing retention strategies, it is important to acknowledge that there is a decade of work in states that has yielded much information about how to improve retention rates. In fact, most successful retention practices are within a state's discretion and in use somewhere; some of these are detailed below.

1. Establish a Routine and Standardized Measurement and Retention Goal

All states collect enrollment data, but not all collect data that provide a clear picture of enrollment dynamics. At a minimum, it is important to know how many people are entering and exiting a program each month. Other vital measures include renewal rates and the reasons for case closings at the point of renewal.

In addition, administrative data do not always capture families' perceptions of the reasons for the renewal failure. For example, a state may find a high number of children are disenrolled because on non-payment of premium. There are many reasons why a family may not pay a premium, including that the family found coverage someplace else and did not pay as a way of disenrolling from the program. However, nonpayment could also be due to a family not being able to afford the premium or not receiving a notice in time. Family surveys can help complete this picture.

Once the data are better understood, establishing a retention goal can help guide strategies. In fact, states that do not routinely measure and track their drop-off and renewal rates have been shown to have greater instability in their coverage.[16] While some children lose coverage for unavoidable reasons, states can focus on preventing children from losing coverage for avoidable or procedural reasons. It is possible and realistic to set high standards; for example, through a number of simplification measures, Louisiana has

been able to decrease its procedural closure rate to less than 2 percent among children in its Medicaid program.

2. Make it Easier for Families to Enroll and Stay in the Program

Adopt 12-month continuous eligibility or lengthen the renewal period. To promote continuity of coverage and care, states have the option under Medicaid and CHIP to enroll children for periods of up to 12 months. This continuous eligibility period allows a child to remain enrolled regardless of changes in income. If continuous eligibility is not possible in a state, another option is to implement a 12-month renewal period – in which a family renews yearly, instead of on a more frequent basis. However, if their income or circumstances change in the midst of their enrollment period, they must report that to the state. (See Snapshot: 12-month Continuous Eligibility for more information.)

Simplify the renewal process. There are a number of measures a state can take to ensure that the renewal process is fair, accurate, and family-friendly. As much as possible, the goal should be to minimize any unnecessary burden on families seeking to maintain their children's health insurance. This approach can include:

- **Complying with federal rules that require states to establish *ex parte* procedures at renewal**. The most effective approach is for a state to conduct *ex parte* reviews of the information already available prior to sending the renewal form to families, limiting what must be requested from families.
- **If applicable, creating a simple and single renewal form for both Medicaid and a separate CHIP program**. The form should not require unnecessary or duplicative information. One way to simplify the form is to pre-populate it with information already on record for the family. That way a family only needs to update information that has changed since enrollment.
- **Eliminating unnecessary documentation**. States have discretion in requiring families to provide documentation of income or other eligibility requirements if the state cannot verify the information through other means. Using this discretion at the point of renewal is a cost-effective and streamlined way to ensure eligible children remain enrolled. At a minimum, a state should eliminate the asset test for families, which requires extensive paperwork. (See Snapshot: Paperless Income Verification for more information.)
- **Implementing Express Lane**. The CHIP law enacted in 2009 allows states to use eligibility findings from other public programs when conducting a redetermination. This could significantly limit the information and/or documentation that families have to provide at renewal.

Make premiums easier to pay. A number of states have found that non-payment of premiums can be a primary reason families lose CHIP coverage. Requiring families to submit premium payments every month puts them at risk for losing coverage. A state can rectify this by ensuring their premiums are affordable for families and implementing streamlined payment procedures. These payment procedures include allowing for premium grace periods (a minimum 30-day period is required by law) and a range of payment

options and/or mechanisms, like payroll deductions, to facilitate collections.[17]

Conduct outreach and education to families. In addition to administrative simplifications, it is important to ensure that families have the assistance they need to renew coverage. Most outreach focuses on enrolling new participants. Yet misperceptions about on-going eligibility and how to renew are common. Participating families may need regular follow-up to stay enrolled.[18] It is also important to provide accessible, culturally appropriate renewal assistance in the community.

A simple increase in the number of follow-up calls to families can have a significant impact on retention. For example, California's CHIP (Healthy Families) increased its reminder calls to families from three to five and ensured those calls where made at varying times of day and different days in the week, including Saturday. State officials report that these changes, in combination with simplifications to its forms and letters, increased the state's CHIP retention rate by seven percent from 2003 to 2004, with the gains holding steady in subsequent years.

State Examples:

"*Ex parte*" review in Louisiana. In 2000, Louisiana Medicaid staff began to verify eligibility and renew coverage by using a range of external data sources. Beginning with citizenship, household, and residency data, the sources were expanded to include child support and age data, and then information from other public programs such as TANF, Food Stamps, and SSI. These *ex parte* renewals are now utilized for a majority of its Medicaid children, and procedural closures at renewal have dropped to less than 1% statewide. ccf.georgetown.edu/index/postcards-from-ccf-la

Reminders and telephone renewal in Arkansas. To reduce drop-off from unreturned re-enrollment forms, Arkansas outreach workers call families. If they do not reach families directly, a special number is left for them to call. This designated call-back number is answered immediately, and renewal is completed with just five questions (changes in household, income, child care, insurance, and doctor). www.aradvocates.org

Community-based express renewal in Massachusetts. A pilot program in Massachusetts allowed families, whose circumstances had not changed since their last determination and were within 30 to 180 days of their next scheduled renewal, to renew coverage during appointments at community-based health clinics. Completion of a one-page form and a quick certification of family and income status led to renewal for a full 12 months. Initial results showed that 42 percent of the "Express Renewal" applications had coverage extended. Those that did not result in an extension lacked available information on renewal dates and/or did not fit the Express Renewal requirements. Ultimately the statewide implementation of the program could not be supported by the state's existing automated systems, which the state is currently revising.[19]
http://www.hcfama.org

3. Use Linkages and Technology to Streamline the Renewal Process

Implement rolling renewals. Some states coordinate the renewal for insurance programs with other public programs to increase the likelihood that families will successfully renew coverage – a one-stop-shopping approach. For example, a family renewing its Food Stamp benefits can be given the opportunity to simultaneously renew their health coverage even if it is not yet due for renewal. Once done, the family has secured health coverage for another year. These so-called "rolling" renewals are designed to give families a convenient way to renew their insurance even before their next regularly scheduled renewal period. This process has been used in Idaho, Illinois, South Dakota, New York, Washington, and Wisconsin.

Automatically enroll children transferring between Medicaid and a separate CHIP program. A child no longer eligible for Medicaid or a separate CHIP program because of income should have their case automatically reviewed for eligibility in the other program and automatically enrolled when eligible. This goes beyond providing simple referrals; instead the process should be seamless and automatic for families.

Use new technologies to speed-up renewal. Technology offers the ability for states to truly create simplified renewal systems. Technology systems will allow: online processing and e-signatures for renewal applications; sharing of data across agencies that are serving the same families; gathering of information from existing primary data records (e.g., social security); and automatic updates for public health coverage files.[20]

State Examples

Rolling Renewals in Washington. Washington's data system automatically transmits new information given for food stamp and TANF recertifications into Medicaid files. Renewal periods for the programs are coordinated, so Medicaid can be automatically renewed. The system updates records, calculates eligibility, and sets a new 12-month continuous eligibility period without any labor by program staff.[21]

Automated Renewals in Pennsylvania. Pennsylvania's multi-program application, called COMPASS, allows families to renew coverage at any time of day, from anywhere. As part of a larger system that keeps client information records across programs, renewers can simply confirm rather than reenter data and there is no need to re-obtain stable information like citizenship status. COMPASS users "e-sign" their renewal applications, a process federally approved for Medicaid and CHIP.[22]

Resources

Renewal Procedures in Medicaid & CHIP for Children

New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations
Leighton Ku, Center On Budget And Policy Priorities, June 2007
This brief reports on new research indicates that increasing the continuity of children's

Medicaid coverage reduces subsequent hospitalizations for chronic health conditions like asthma or diabetes. The research—a new study conducted by Dr. Andrew Bindman and his associates at the University of California at San Francisco—indicates that improving the continuity of Medicaid coverage through 12-month continuous eligibility can improve children's health and avert unnecessary hospitalization costs.

Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices
Beth Morrow and Dawn Horner, The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, May 2007
Children fail to enroll and/or lose coverage primarily due to misinformation, difficult enrollment and renewal procedures, and inefficient administrative practices. This report explores how technological innovations can be applied to remove these impediments for Medicaid and CHIP enrollment and retention, while at the same time making the programs more efficient.

Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health
Covering Kids and Families National Program Office and the Southern Institute on Children and Families, April 2007
This report illustrates the many creative and collaborative ways the Covering Kids & Families coalitions worked to break down barriers to public health coverage for low-income children and adults. From 1997-2002, these coalitions encouraged the adoption of outreach, simplification, and coordination strategies across the states.

Seven Steps Toward State Success in Covering Children Continuously
Uchenna A. Ukaegbu and Sonya Schwartz, National Academy for State Health Policy and Lake Snell Perry & Associates, October 2006
In March 2006, the National Academy for State Health Policy convened a small symposium on child health coverage consisting of state and national public and private sector experts on child health coverage. This brief summarizes key suggestions, which emerged during the symposium discussion about lessons learned over the past decade of state efforts to increase rates of child health coverage. Meeting highlights are supplemented with additional information from the current literature, and examples from states.

Instability of Public Health Insurance Coverage
Laura Summer and Cindy Mann, The Commonwealth Fund, June 2006
This report examines the extent, causes, and consequences of instability in public coverage programs for children and families, focusing particularly on the phenomenon of "churning," which occurs when individuals lose and regain coverage in a short period of time. It also provides strategies that can make public program coverage more stable.

How Much Does Churning in Medi-Cal Cost?
Gerry Fairbrother, The California Endowment, April 2005
This report reviews the impact of "churning" in California. It finds that over 600,000 children enrolled in Medicaid (Medi-Cal in California) in 2003 had been disenrolled from the program within a three-year period, only to be later re-enrolled. It cost California over $120 million to re-process these eligible Medi-Cal children.

Staying Covered: The Importance Of Retaining Health Insurance For Low-Income Families
Leighton Ku and Donna Cohen Ross, Center on Budget and Policy Priorities, December 2002
This report examines reasons why many low-income individuals lose coverage, the effects of insurance loss, and strategies that can help people retain coverage. It shows that every person with public or private coverage at the beginning of a given year retained coverage throughout the next 12 months, the number of low-income children who are uninsured would decline by close to two-fifths over the course of a year. The number of uninsured low-income adults would decline by more than one-quarter.

Consequences of States' Policies for SCHIP Disenrollment
Andrew W. Dick, R. Andrew Allison, Susan G. Haber, Cindy Brach, and Eliz, Health Care Financing Review, March 2002
This issue brief reports on a study of disenrollment from CHIP by the Child Health Insurance Research Initiative (CHIRI). Looking at disenrollment in Florida, Kansas, New York, and Oregon the authors found that the administrative requirements imposed by states at renewal lead a large share of children to be dropped from coverage. In particular, results show that there is a strong and large association between disenrollment and recertification and that states without passive re-enrollment, approximately one-half of those enrolled at the time dropped out of CHIP.

Why Eligible Children Lose or Leave SCHlP: Findings From A Comprehensive Study Of Retention And Disenrollment
Trish Riley, Cynthia Pernice,Michael Perry and Susan Kannel, National Academy for State Health Policy and Lake Snell Perry & Associates, February 2002
NASHP—with seven states, Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah—undertook a project to examine CHIP disenrollment and how to retain enrollment of those children who continued to be eligible for the program but failed to complete the renewal process or make their premium payments. It provides results from a telephone survey of parents of current CHIP enrollees and those those who have a lapse in coverage.

Endnotes

[1] L. Dubay analysis of March 2005 Current Population Survey using July 2004 state eligibility rules.
[2] L. Summer & C. Mann, "Instability of Public Health Insurance Coverage For Children And Their Families: Causes, Consequences, and Remedies," Georgetown University Health Policy Institute, (June 2006).

[3] L. Ku & D. Cohen Ross, "Staying Covered: The Importance Of Retaining Health Insurance For Low-Income Families," Center on Budget And Policy Priorities, (December 2002).
[4] L. Ku, "New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations," Center on Budget and Policy Priorities, (June 2007).
[5] *op. cit.* (2).
[6] i*bid.*
[7] A. Dick, R. Allison, S. Haber, C. Brack, et. al., "Consequences of States' Policies for SCHIP Disenrollment," (March 2002).
[8] *op. cit.* (3).
[9] *op. cit.* (3); and *op. cit.* (2).
[10] *op. cit.* (3).
[11] G. Fairbrother, "How Much Does Churning in Medi-Cal Cost?," The California Endowment, (April 2005).
[12] *op. cit.* (2).
[13] Centers for Medicare and Medicaid Services, "Continuing the Progress: Enrolling and Retaining Families and Children in Health Care Coverage," (August 2001).
[14] Centers for Medicare and Medicaid Services, Letter from Health Care Financing Administration to State Medicaid Directors, (April 7, 2000).
[15] D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009).
[16] *op cit.* (2); and Southern Institute on Children and Families, "Covering Kids And Families: Promising Practices From The Nation's Single Largest Effort To Insure Eligible Children And Adults Through Public Health Coverage," (April 2007).
[17] See: L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).
[18] T. Riley, C. Pernice, M. Perry, & S. Kannel, "Why Eligible Children Lose or Leave SCHIP: Findings From A Comprehensive Study Of Retention And Disenrollment," National Academy for State Health Policy and Lake Snell Perry & Associates, (February 2002).
[19] *op. cit.* (15).
[20] B. Morrow & D. Horner, "Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices," The Children's Partnership and The Kaiser Commission on Medicaid and the Uninsured, (May 2007).
[21] *ibid.*
[22] Office of Management and Budget, Memorandum for the Heads of Departments and Agencies, M-00-10, "OMB Procedures and Guidance on Implementing the Government Paperwork Elimination Act," April 25, 2000.

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March 2009