ISSUE BRIEF

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TRENDS IN PUBLIC HEALTH

Continuous Coverage: Removing Barriers to Children's Health Care

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This brief is based on Mathematica's study of continuous coverage for children in the Medicaid program. Continuous coverage allows children to maintain their eligibility for Medicaid and SCHIP for a specified period, regardless of changes in income or family structure. In 1997, the Balanced Budget Act (BBA) gave states the option of providing up to 12 months of continuous coverage for children through age 18 enrolled in these programs. States using this policy option are likely to improve the stability and continuity of coverage and care. Using 1994-1995 Medicaid enrollment and payment data from California, Michigan, Missouri, and New Jersey, we examined discontinuous coverage among children and modeled the likely impacts for states that choose to implement the continuous coverage option. We also used claims data from California to look at how use and costs of emergency room services were related to discontinuous coverage.

The Downside of Discontinuous Coverage

The large number of children who lack health insurance has been a source of concern for public officials and policymakers. Research has shown that insured children receive more health care services than uninsured children. For children to benefit fully from health care coverage, however, it must be stable and ongoing. This is particularly important for younger children, who need immunizations and other primary care to ensure a healthy start in life. Furthermore, an established relationship with a provider can improve the timeliness of preventive care, compliance with care regimens, and coordination with specialists, as well as family satisfaction with care. Discontinuous coverage—defined as losing coverage, only to re-establish it within a few months—does not promote these favorable patterns of care. Adopting a policy of continuous coverage in Medicaid and SCHIP can be a key part of state efforts to improve children's access to a medical home and to promote stable, continuous care. However, many factors contribute to discontinuous coverage, including complex enrollment and eligibility determinations. Difficulties also arise from confusing communications with families and changing family circumstances that affect eligibility. States must address these issues in order for children to benefit fully from continuous coverage under public insurance programs.

Who Is At Risk?

Discontinuities affected a relatively small proportion of Medicaid children in the study. Between five and nine percent of qualified children experienced gaps in their Medicaid coverage of two or more months during 1995. Continuous coverage would lower this figure to two to four percent of children who qualify. However, gaps in coverage would still occur because some children would continue to fail to meet annual redetermination requirements and others—such as those in medically needy programs—would not be eligible for continuous coverage.

We found some children at greater risk of discontinuous coverage, including adolescents ages 15 to 19, Hispanics, children qualifying for Medicaid under the poverty-related eligibility provisions, and children who spent part of the year in a state's medically needy program. Our models showed that these disparities would diminish under continuous coverage. For example, 19 percent of Hispanic children receiving Medicaid in one of our study states experienced discontinuous coverage, but less than 6 percent would have experienced it under a policy of 12-month continuous coverage. Previous research suggests that adolescents and Hispanic children have more problems accessing the health care system. Consequently, they would most benefit from a policy of continuous coverage, while

at the same time helping a state meet the Healthy People 2010 goal of reducing health disparities across segments of the population.

The Impact on States

A policy of 12-month continuous coverage would likely have the following additional ramifications for states' Medicaid and SCHIP programs:

- The total number of months of coverage provided to Medicaid children during a calendar year would increase 10 to 16 percent.
- The average cost per enrollee month would decline slightly; states may want to review the capitated payment rates they pay to managed care plans after implementation of continuous coverage.
- Total Medicaid payments for children who qualify would rise. In the study, these payments increased by about 9 to 15 percent.
- Administrative costs associated with disenrollments, re-enrollments, and redeterminations would fall substantially in states that currently use a six-month redetermination period. As of July 2000, 12 state Medicaid programs and 3 separate SCHIP programs redetermined eligibility this frequently.
- Emergency room utilization patterns would probably stay the same, as children would continue to face barriers to care, such as lack of transportation.

Many states have already realized the benefits of this policy option. As of July 2000, 15 Medicaid and 22 SCHIP programs had implemented 12-month continuous coverage for children. Fiscal concerns have prevented other states from adopting this coverage. Policymakers want to make sure that the costs associated with continuous coverage are commensurate with improvements in the quality of care children receive.

States that adopt continuous coverage will still need to address other issues that affect continuity of coverage, including fluctuations in family income. Enhancing the flexibility of eligibility, enrollment, and redetermination processes is also likely to be key to future progress. States are also learning how to simplify enrollment, based on their experiences with welfare reform and SCHIP implementation (Table 1).

TABLE 1

STRATEGIES USED TO SIMPLIFY ELIGIBILITY AND ENROLLMENT

- Shorten and streamline applications and other forms, including web-based applications
- Allow mail-in and online applications
- Create preprinted redetermination forms that require families to report only changes occurring since establishment of eligibility or the last redetermination
- Permit self-declaration of income and resources
- Encourage assistance and educational efforts by community-based organizations
- Provide enrollment facilitators
- Deploy enhanced followup efforts when families do not respond to requests for information

Increasing provider participation rates in Medicaid and SCHIP could also help. Doing so would improve the likelihood that children could access their provider of choice, regardless of their insurance coverage. In addition, promoting closer patient-provider relationships —perhaps by requiring families to choose a primary care provider—is likely to promote attachment to a medical home.

Broadening the Research Effort

This study sheds light on how continuous coverage affects publicly financed insurance programs and children's access to care, but a full accounting of all costs and benefits has yet to be made. Our findings are consistent with research that shows health insurance coverage improves access to preventive care services. But improving access also raises costs, by increasing use of services. Over the long term, improved access to a medical home and continuous care are likely to improve children's health status, thereby reducing health care costs. Further research is needed to illuminate the extent to which continuous care can lessen these future costs and improve children's health over time.

This study was conducted for the Health Resources and Services Administration. For the full report, visit our web site at www.mathematica-mpr.com/PDFs/redirect.asp?strSite=discontinuous.pdf or call Publications, (609) 275-2350. Mathematica® is a registered trademark of Mathematica Policy Research, Inc.

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