By Leighton Ku, Erika Steinmetz, and Brian K. Bruen

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Continuous-Eligibility Policies Stabilize Medicaid Coverage For Children And Could Be Extended To Adults With Similar Results

Leighton Ku (lku@gwu.edu) is a professor of health policy at the George Washington University, in Washington, D.C.

Erika Steinmetz is a senior research scientist in health policy at the George Washington University.

Brian K. Bruen is a lead research scientist in health policy at the George Washington University.

ABSTRACT **A key method of stabilizing Medicaid coverage is to provide beneficiaries with twelve months of continuous eligibility. Following the passage of the Children's Health Insurance Program Reauthorization Act in 2009, seven states adopted the continuous-eligibility option for children. That policy change led to a 1.8-percentage-point increase in the average length of child enrollment during fiscal year 2010 and increased annual costs for children by about 2.2 percent. The Medicaid and CHIP Payment and Access Commission has recommended offering states the option of giving adults twelve-month continuous eligibility for Medicaid. Our findings suggest that continuous eligibility could promote more stable coverage for adults enrolled in Medicaid at a modest cost.**

Medicaid "churning" is a term that refers to beneficiaries' dropping in and out of enrollment in the program. It can be caused by any number of factors, including fluctuations in family income and barriers created by paperwork. Medicaid churning is undesirable because it creates temporary gaps in insurance coverage.[1] Even brief gaps in Medicaid coverage can disrupt the continuity of health care services, which can then lead to otherwise preventable health problems such as those related to asthma, diabetes, and behavioral disorders. These care disruptions and negative health consequences can in turn lead to costly hospital admissions or emergency department visits.[2–5]

A policy designed to stabilize Medicaid coverage would provide twelve months of continuous eligibility, during which time a person who had been determined to be eligible for Medicaid would remain enrolled without having to reapply or verify his or her continued eligibility. Medicaid beneficiaries are now certified as eligible for program benefits for up to one year, but they may be dropped from the program for reasons including failure to submit a periodic update on eligibility status. Even when people reenroll in Medicaid after a period of ineligibility, there may be gaps in their insurance coverage that may have harmful consequences.

States already have the option to give children continuous Medicaid eligibility for twelve months. In March 2013 the Medicaid and CHIP Payment and Access Commission recommended that Congress amend the Medicaid statute to also grant states the option to give adults that continuous eligibility.[1] In May 2013 the Centers for Medicare and Medicaid Services (CMS) explained in a letter to state health officials and state Medicaid directors how states could adopt twelve-month continuous eligibility for parents and other adults using Section 1115 waivers under the Social Security Act.[6] The waivers provide increased flexibility for the states in designing Medicaid and Children's Health Insurance Program (CHIP) programs.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 encouraged states to adopt policies to increase children's participation in Medicaid. States that adopt at least five of eight enrollment or retention simplification policies for children—including twelve-month continuous eligibility, easing

of asset rules, and eliminating in-person interviews—and meet targeted enrollment levels can earn performance bonuses.[7] Between January 2008 and January 2011, the number of states that authorized twelve-month continuous eligibility in Medicaid rose from sixteen to twenty-three.[8]

This article assesses the impacts of the implementation of CHIPRA—specifically, those related to the adoption of twelve-month continuous eligibility between 2008 and 2010 and including the impacts on both the continuity of enrollment and the cost of children's coverage.

Study Data And Methods

We measured the average length of children's Medicaid enrollment during a year using the continuity ratio, which is measured for each state in a fiscal year.[9] The ratio is the average number of children enrolled in Medicaid per month during that year divided by the number of children enrolled at any point in that year, even if just for one month. This included CHIP-funded Medicaid coverage but not any state's separate CHIP program. CMS collects these data as its primary measures of Medicaid enrollment.

DATA The data were derived from the Medicaid Statistical Information System State Summary Datamart reports for fiscal years 2008–10, which were based on data submitted to CMS by state Medicaid agencies.[10] As of March 2013 data for fiscal year 2010 were missing for five states (Colorado, Idaho, Missouri, Utah, and Wisconsin), but data for fiscal year 2008 were available. We considered using data for fiscal year 2011, but these were incomplete for about half of the states.

The continuity ratio measured the average percentage of the fiscal year in which Medicaid beneficiaries were enrolled—that is, the average length of enrollment in the year. The reference period was the federal fiscal year, October to September, which created limitations. For example, a child who enrolled in April 2010 and was covered for the next twelve months was enrolled for 50 percent of fiscal year 2010 and 50 percent of fiscal year 2011.

Nonetheless, changes in the ratios over the years should reflect actual increases in the average enrollment length. The ratio provided information only about Medicaid coverage; it did not indicate if a person had other insurance—such as through a separate CHIP program or private insurance—or was uninsured for the remainder of the year.

The accuracy of the data was limited by state and federal reporting. For example, changes in a state's computer system may have created data anomalies that were unrelated to actual enrollment or policy changes.

ANALYSIS We examined how states' continuity ratios were affected by state policies about continuous eligibility, other related state policies, and state economic changes from 2008 to 2010. Because of the limited sample size (forty-five states and the District of Columbia), a parsimonious ordinary least squares regression model was specified. We also examined a related policy: whether a state's certification period for children was increased from six months to twelve months during this time. And to measure other simplification polices, we examined whether a state received a CHIPRA performance bonus in 2010.

The dependent variable was the percentage-point change in the states' continuity ratios for children from 2008 to 2010. The main independent variable represented whether or not a state adopted twelve-month continuous eligibility between 2008 and 2010, based on surveys published by the Kaiser Commission on Medicaid and the Uninsured.[8,11,12] There was no Kaiser survey for 2010; we interpreted policies in effect in January 2011 as reflecting 2010 policies.

As noted above, we included the related policy of twelve-month certification for children. All but six states used a twelve-month period in 2008, and four of those six had implemented the twelve-month policy by 2010. State economic conditions might have led to lower incomes, which in turn might have led to longer continuous enrollment in Medicaid. Thus, we controlled for the percentage-point difference from 2008 to 2010 in the share of each state's population that had incomes of less than 200 percent of the federal poverty level, based on data from the American Community Survey.[13] Furthermore, we included as a binary variable whether or not a state received a CHIPRA performance bonus for 2010.[14]

As discussed below, we also examined the potential impact of states' changing their Medicaid certification periods from six months to twelve months for children. Huber-White estimators for robust standard errors were used to adjust for heteroskedasticity.[15] Since this article focuses on state policies, all analyses were unweighted and treated all states alike. A population-weighted model would be useful to demonstrate the weighted national impact, but that was not our purpose here.

This study used a pre-post difference design, which is functionally identical to a difference-in-differences model.[16] In the absence of a randomized design, this was a relatively rigorous method of examining impacts. Since differences within each state were measured, underlying cross-sectional demographic, policy, or structur-

al differences across states that might confound the analysis were eliminated.

Study Results

All but one of the states with complete data for fiscal year 2010 experienced an increase in the average duration of children's enrollment in Medicaid between 2008 and 2010 (Exhibit 1). However, the largest increases occurred among states that adopted twelve-month continuous eligibility between 2008 and 2010: Those states had a mean difference of 4.2 percent in the continuity ratio. States that had already adopted the policy in 2008 or had not adopted it as of 2011 had smaller increases (2.5 percent and 3.0 percent, respectively)—a significant difference ($p = 0.02$).

There were no significant changes in average continuity ratios in any of the three groups of states for the period 2006–08 (data not shown). Because the continuity ratios (and changes from 2008 to 2010) were not normally distributed, a nonparametric test was used. The changes appeared to occur after 2008, since a comparison of the 2006 and 2008 continuity ratios for states that implemented a policy of twelve-month continuous eligibility after 2008 failed to find significant differences.

Adopting continuous eligibility between 2008 and 2010 was significantly associated ($p = 0.03$) with a 1.8-percentage-point increase in the continuity ratio (Exhibit 2). In contrast, changes in the percentage of a state's population that was low income, shifting from six- to twelve-month certification periods, and receiving a CHIPRA performance bonus were not significant. We examined variants of this model, and they yielded consistent results. Although the sample size is small, the significance and robustness of the results demonstrate the strength of the effect.

An alternative cross-sectional version of our model for 2010 assessed the effect of continuous-eligibility policies, the percentage of low-income people in a state, using twelve-month certification periods, and the performance bonus on the states' continuity ratios in 2010. The results were not as definitive as those of our primary model, since outcomes of a cross-sectional model may be shaped by unmeasured characteristics—in this case, of the states—while the pre-post model eliminates those factors. In the cross-sectional model, having a twelve-month certification period was associated with an increase in continuity ratios of six percentage points (results not shown). However, it is worth noting that only two states do not have twelve-month certification periods.

Discussion

We found that adopting a policy of twelve-month continuous eligibility increased the continuity of children's enrollment in Medicaid. Children's enrollment continuity improved in almost all states during 2008–10. However, it increased significantly more in states that adopted the policy after the implementation of CHIPRA. Increasing the length of certification periods was not associated with an increased continuity ratio, but the direction of this effect also appeared to be positive.

A state's receipt of a CHIPRA performance bonus in 2010 was not significantly associated with increased continuity, perhaps because most of the policies specified in the bonus criteria are aimed at simplifying enrollment in the program, instead of at improving retention. A state was required to have five of eight recommended policies in place before a bonus could be awarded. The date when these policies were adopted did not matter, and most of the states that received CHIPRA performance bonuses had adopted the requisite enrollment policies years earlier.

BENEFITS OF CONTINUOUS ELIGIBILITY This is the first study to demonstrate that continuous-eligibility policies increase the continuity of children's enrollment in Medicaid. Earlier research examined the effects of continuous eligibility on the total number of children enrolled in coverage and found mixed results. For example, Karl Kronebusch and Brian Elbel conducted a cross-sectional analysis of policy factors that affected children's enrollment in Medicaid and CHIP in 2000 and reported that having a continuous-eligibility policy did not affect enrollment.[17] In contrast, Cynthia Bansak and Stephen Raphael found that continuous eligibility promoted higher enrollment in CHIP in 2001.[18]

Our study is also the first to focus specifically on the average length of enrollment for children, which is what a continuous-eligibility policy is designed to affect.

The study also estimates the magnitude of the effect of twelve-month continuous-eligibility policies. The amount of time that a child is enrolled is directly related to the annual cost of coverage per child (months enrolled times the cost per member-month). Adopting continuous enrollment leads to a modest 2.2 percent increase in annual expenditures for children's benefits over a fiscal year (the 1.8 percent gain divided by the 80 percent baseline rate of the continuity ratio). In contrast, studies conducted more than a decade ago suggested that adopting a policy of twelve-month continuous eligibility might increase the cost of children's Medicaid benefits by 10–16 percent.[19,20]

EXHIBIT 1

Continuity Ratios For Children In Medicaid, By States' Implementation Of A Twelve-Month Continuous-Eligibility Policy, Fiscal Years 2008 And 2010

State	Continuity ratio		Difference, FY 2008 to FY 2010
	FY 2008	FY 2010	
IMPLEMENTED 2008–10 (7 STATES)[a]			
AK	78.0%	83.5%	5.4%
IA	78.4	81.9	3.5
MT	74.4	77.8	3.5
NM	85.0	86.6	1.7
ND	72.5	79.0	6.5
OH	83.7	86.6	2.9
OR	72.3	78.5	6.2
IMPLEMENTED BEFORE 2008 (16 STATES)[b]			
AL	81.2	83.1	1.9
CA	77.5	80.4	2.8
ID	78.3	—[c]	—[c]
IL	87.5	89.6	2.2
KS	75.3	79.2	3.9
LA	88.8	91.3	2.5
ME	85.2	88.4	3.2
MI	83.6	86.4	2.7
MS	78.9	81.5	2.6
NJ	84.8	86.6	1.8
NY	83.4	85.1	1.7
NC	80.4	82.8	2.5
SC	82.7	85.0	2.2
WA	82.3	85.0	2.7
WV	80.8	81.6	0.9
WY	75.2	78.5	3.3
NOT IMPLEMENTED AS OF 2011 (28 STATES)[d]			
AZ	76.3	87.8	11.5
AR	83.2	86.5	3.3
CO	71.8	—[c]	—[c]
CT	85.2	87.5	2.4
DE	79.3	82.7	3.4
DC	86.5	88.6	2.2
FL	73.6	79.3	5.7
GA	74.7	78.8	4.1
HI	88.0	89.7	1.6
IN	81.8	84.7	2.9
KY	80.6	82.8	2.1
MD	82.9	85.4	2.5
MA	84.3	83.2	-1.1
MN	78.7	80.8	2.1
MS	83.4	—[c]	—[c]
NB	80.0	82.9	2.9
NV	71.7	76.0	4.3
NH	79.4	82.0	2.6
OK	79.7	84.0	4.3
PA	81.4	84.8	3.4
RI	83.5	84.7	1.1
SD	79.7	81.4	1.7
TN	85.2	88.4	3.2
TX	74.7	76.9	2.2
UT	67.3	—[c]	—[c]
VT	83.5	85.6	2.1
VA	81.4	83.2	1.8
WI	75.9	—[c]	—[c]

SOURCE Authors' analysis of Medicaid Statistical Information System data (see Note 10 in text). **NOTES** The continuity ratio measures the average percentage of the fiscal year that Medicaid beneficiaries were enrolled—that is, the average length of enrollment in the year. See the text for a fuller explanation. Differences, FY 2008 to FY 2010, may not match fiscal year data because of rounding. [a]Mean difference, FY 2008 to FY 2010, 4.2 percent. [b]Mean difference, FY 2008 to FY 2010, 2.5 percent. [c]Data for fiscal year 2010 were missing as of March 2013. [d]Mean difference, FY 2008 to FY 2010, 3.0 percent.

EXHIBIT 2

Results Of The Multivariate Regression Model For The Implementation Of A Policy Of Twelve-Month Continuous Eligibility In Medicaid, Fiscal Years 2008 And 2010

Variable	Coefficient	*p* value[a]	95% CI[a]
Adopted 12-month continuous eligibility, FY 2008 to FY 2010	1.8%	0.03	0.2%, 3.4%
Adopted 12-month certification period, FY 2008 to FY 2010	1.1	0.12	−0.2, 2.0
Change in percent of state population below 200% of poverty	40.2	0.24	−27.3, 107.8
Received CHIPRA bonus, FY 2010	−7.1	0.21	−1.9, 0.4
Constant	1.6	0.06	−0.1, 3.3

SOURCE Authors' analysis of Medicaid Statistical Information System data (see Note 10 in text). **NOTES** $N = 46$. $R^2 = 0.194$. The dependent variable is percentage change in state continuity ratios for children (see Exhibit 1) from FY 2008 to FY 2010. CI is confidence interval. CHIPRA is the Children's Health Insurance Program Reauthorization Act of 2009. [a]Using robust standard errors.

There are three major differences between our analysis and earlier work. First, prior studies were conducted twelve to fourteen years ago. Since then, states have made major efforts to simplify Medicaid and CHIP enrollment and retention, which may have lengthened enrollment and diminished the incremental effect of implementing a twelve-month continuous-eligibility policy. Second, children's Medicaid income eligibility has expanded, which may reduce churning by widening the income window. Third, the earlier studies were projections of expected effects, but ours was based on empirical analyses of states that have implemented the eligibility policy.

This study suggests that the effects of implementing a continuous-eligibility policy are smaller than the earlier estimated effects, raising enrollment length by about two percentage points in states that adopt the policy. Children were already covered for about 80 percent of the year, on average, so they were already close to the upper limit of coverage. There are also reasons why some children may not remain enrolled for a full year, even with a continuous-eligibility policy: Children may lose Medicaid coverage before twelve months have elapsed because they age out of eligibility or their families move out of state.

It is plausible that the net Medicaid budget effects of continuous enrollment are less than 2.2 percent for states adopting a continuous-eligibility policy, because of lower administrative costs. For example, in New York a decade ago, the administrative costs of enrolling a child in Medicaid or in that state's Child Health Plus program were about $280.[19] Churning these children in and out of the system clearly imposes substantial additional costs.[21] One study from the same time period found that Medi-Cal, California's Medicaid program, lost about 600,000 children over three years because of churning, but the children were reenrolled when policies were changed again. The processing of their reenrollment cost $120 million.[22] Avoiding such administrative costs may offset some of the increases in benefit costs.

POTENTIAL DISADVANTAGES One potential disadvantage of a continuous-eligibility policy is that managed care capitation payments might have to be paid by the state even if a child has moved out of state. This cost could be mitigated by monitoring enrollment data for address changes reported by the US Postal Service or by other administrative approaches, and then terminating eligibility for those who no longer reside in the state.

We found that the states that adopted continuous eligibility between fiscal years 2008 and 2010 increased the average length of enrollment. But we also found that the length of children's coverage increased in all but one state (Exhibit 1). This might be because there were broad efforts across all states to improve children's coverage in the wake of CHIPRA. In contrast, there were no changes in average continuity ratios in the preceding years.

However, a review of other enrollment simplification policies revealed that there were few changes in other relevant policies in 2008 and after. The number of states with a policy of continuous eligibility in Medicaid rose from sixteen to twenty-three between January 2008 and January 2011. During the same period, the number of states with twelve-month certification periods increased from forty-five to forty-nine, the number that did not require in-person interviews to renew Medicaid eligibility rose from forty-eight to fifty, the number without asset tests went from forty-seven to forty-eight, and the number with joint Medicaid/CHIP applications rose from thirty-three to thirty-six—changes that were relatively minor overall.[8] CHIPRA may have encouraged states to make diffuse changes that improved the continuity of children's coverage, but it is difficult to isolate any specific changes other than the implementation of twelve-month continuous eligibility.

EXPANSION TO ADULTS Although states already have the option of offering continuous enrollment for children, there is no comparable option for adults. The Affordable Care Act specifies that adults enrolled under the new Medicaid expansion category have a twelve-month certification period, but there may still be problems related to beneficiaries' failure to submit periodic reports or fluctuating income. Our study found that increasing the certification period did not have a significant impact on continuity of enroll-

ment, but what effect there was appeared to be an increase in continuity.

The Medicaid and CHIP Payment and Access Commission has explained that churning in and out of Medicaid and interruptions of coverage have harmful health effects on both adults and children. However, the implementation of federal modified adjusted gross income standards in Medicaid under the Affordable Care Act will limit some of the flexibility that states now have in assessing the income of adults in Medicaid.[1]

To counter the decreased flexibility in how income is interpreted and its potential to disrupt Medicaid coverage, the Medicaid and CHIP Payment and Access Commission has recommended that states be allowed to offer adults as well as children twelve-month continuous eligibility. The adoption of this proposal could also address the historic weakness in continuity of coverage for adults compared to children in Medicaid: Adult coverage averaged 71 percent in 2010, compared to 80 percent for children.[23] CMS has also supported extending twelve-month continuous eligibility to parents and other adults, using Section 1115 waivers.[6]

Conclusion

If the findings from our study of children are applicable to adults, then implementing twelve-month continuous-eligibility policies could improve the continuity of Medicaid coverage for adults as well as children, and the cost of such policies could be modest. Such changes—coupled with the expansions of Medicaid coverage authorized under the Affordable Care Act and the coordination of enrollment in Medicaid, CHIP, and the new health insurance exchanges—might help reduce gaps in health insurance coverage and thereby promote better continuity and quality of health care services. ■

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NOTES

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