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# Recent Patterns in Children's Medicaid Enrollment: A National View

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*Policymakers are looking for ways to improve health insurance coverage for children. In this issue brief, we provide a national view of Medicaid coverage during 2007, and examine how states that have adopted one promising policy—12-month continuous enrollment—compare with those that have not yet adopted it. We find that, overall, 72 percent of children who were enrolled in Medicaid during 2007 retained their coverage throughout the year, but children who were qualified under poverty-related provisions were less likely to remain enrolled than children who qualified under Section 1931 rules. Section 1931 rules require states to cover children in households below the state's 1996 cash assistance levels and states use poverty-related rules to cover children at higher income levels. Both groups were more likely to retain coverage in states with 12-month continuous enrollment policies, but the difference was larger for those who qualified under poverty-related provisions.*

## Issues Relating to Children's Coverage

Next to private health insurance, the Medicaid program is the largest provider of health insurance for children, with 29.2 million children enrolled in 2007.[1] The Children's Health Insurance Program (CHIP) picks up where Medicaid leaves off, covering 7.1 million children in 2007.[2] Medicaid covers eligible, low-income children and improvement of the program is part of recent efforts to improve children's access to health insurance. For example, in 2010 U.S. Department of Health and Human Services Secretary Kathleen Sebelius began The Secretary's Challenge: Connecting Kids to Coverage, a five-year campaign that calls on federal, national, and community groups to enroll five million children who are eligible for Medicaid and CHIP but remain uninsured.

These efforts to ensure that all eligible children have access to health insurance coverage can be hampered by high rates of disenrollment. Particular concerns have been raised about coverage interruptions in public insurance. An estimated 20 percent of children with household incomes below 200 percent of the federal poverty level (FPL) who have Medicaid at the beginning of a year become uninsured by the end of that year (Sommers 2007, 2010). A study of CHIP enrollees in six states estimated that the percentage of new CHIP enrollees in each state who remained in public insurance through the CHIP annual renewal period ranged from 59 to 82 percent (Merrill and Rosenbach 2006). By comparison, about one-tenth of low-income individuals in private health insurance plans become uninsured in a year (Ku and Cohen Ross 2002).

Another potential problem is churning, which occurs when eligible children leave the program only to re-enroll a short time later. This process is particularly problematic if children disenroll due to reapplication requirements or other, non-eligibility related reasons. In these cases, children lose the benefits of continuous coverage and states may also incur the costs of processing re-applications unnecessarily. One study estimated that about half of the children who disenroll from Medicaid or CHIP remain eligible for these programs and lack alternative coverage (Sommers 2005).

Re-enrolling these children in Medicaid creates administrative costs for the program. States with low rates of churning do not

### About This Series

The MAX Medicaid policy issue brief series highlights the essential role MAX data can play in analyzing the Medicaid program. MAX is a set of annual, person-level data files on Medicaid eligibility, service utilization, and payments that are derived from state reporting of Medicaid eligibility and claims data into the Medicaid Statistical Information System (MSIS). MAX is an enhanced, research-friendly version of MSIS that includes final adjudicated claims based on the date of service, and data that have undergone additional quality checks and corrections. CMS produces MAX specifically for research purposes. For more information about MAX, please visit: http://www.cms.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp.

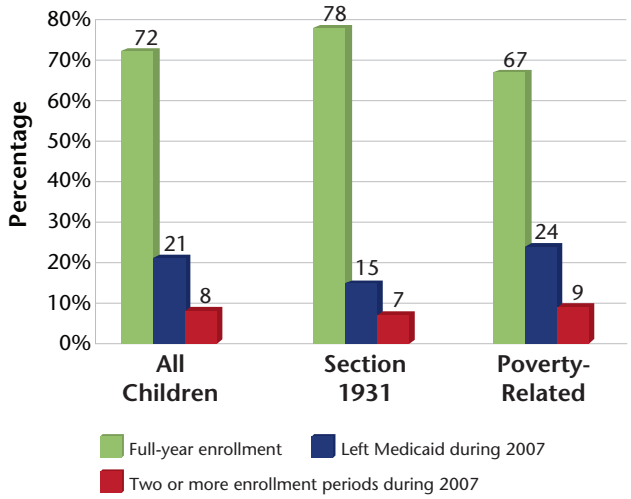
waste resources assessing applications for children who could have been continuously enrolled (Ku and Cohen Ross 2002; Irvin et al. 2001). One analysis found that the longer children were enrolled in Medicaid the lower their average monthly expenditures were, partly because they had more regular preventive care and partly because new enrollees may have pent-up demand for services that are more expensive than regular care (Ku et al. 2009). For example, in a three-year period, California spent an estimated $120 million to re-enroll 600,000 children who left Medicaid and then returned; most of them returned to the program within four months of leaving (Fairbrother 2005). States have to balance the administrative costs of re-enrolling children against the costs of providing coverage to those who are no longer eligible.

Twelve-month continuous eligibility, considered one of the most potentially effective policy tools for ensuring that all eligible children remain enrolled and reducing churning, has been slowly implemented by states since the option was introduced in 1998 (Cohen Ross and Marks 2009). By 2009, 16 states used full-year continuous eligibility for children enrolled in Medicaid and 30 states had this policy for CHIP enrollees (Cohen Ross and Marks 2009). Early analysis of the effects of this policy found that by implementing 12-month continuous eligibility for children states reduced administrative costs, increased average months of coverage for enrolled children, reduced average monthly costs per enrollee, and delayed disenrollment (Merrill and Rosenbach 2006; Irvin et al. 2001).

In this issue brief, we examine the enrollment patterns during calendar year 2007 for low-income children who were enrolled in Medicaid or Medicaid-expansion CHIPs as of January 2007. We use the Medicaid Analytic Extract (MAX) files, which allow us to present a near-national assessment across the 45 states and the District of Columbia that have the required data.[3] To conduct the analysis, we identified all children (from birth to 18 years old) in 46 Medicaid programs.[4] We then followed that cohort each month within the state Medicaid programs, excluding children who died on or before December 31, 2007. Note that, since we identified the cohort at a point in time, the length of time that the children were enrolled in Medicaid before January 2007 can vary substantially. Based on our analysis, we provide information on the relationship between 12-month eligibility policies and retention rates by comparing coverage patterns for children in states that offered 12-month continuous eligibility in 2007 with patterns in those that did not.

To best assess the relationship between retention patterns and continuous eligibility policies, we limit our analysis to low-income children whose enrollment in Medicaid is likely to be affected by policy changes. We exclude children who are subject to unique eligibility and disenrollment processes, including those who are: (1) medically needy, (2) enrolled in a Section 1115 demonstration, (3) receiving transitional Medicaid coverage, (4) enrolled in state supplemental cash assistance programs, (5) eligible for institutional care, or (6) covered as foster care children.

**Figure 1. Enrollment Patterns for Children Enrolled in Medicaid in January 2007, by Eligibility Group**




Source: Mathematica Analysis of 2007 MAX data.

## Children's Enrollment in the Medicaid Program

Across the 45 states and the District of Columbia, about 17 million low-income children were enrolled in Medicaid in January 2007. These included:

- 6.5 million children (or 38 percent) eligible under Section 1931 of the Social Security Act. Section 1931 requires states to cover children in households with income below the state's 1996 cash assistance eligibility thresholds, levels that are below the FPL in all states and well below that level in many states. These children are generally the lowest-income children enrolled in a state's Medicaid program.
- 10.5 million (or 67 percent) eligible under poverty-related rules. States must cover infants and children up to age 6 with household incomes up to 133 percent of the FPL, and children ages 6 through 18 with household incomes up to 100 percent of the FPL. Income eligibility levels for children eligible under poverty-related rules vary across states, with some states covering children only up to the minimum required levels and others expanding eligibility up to 250 or 300 percent of the FPL.

The majority (72 percent) of low-income children enrolled in Medicaid in January 2007 retained their coverage throughout the year (Figure 1). Children eligible under Section 1931 rules had

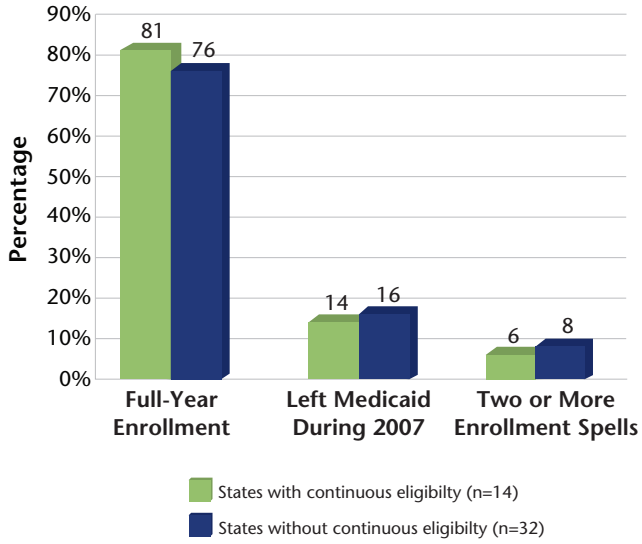
higher rates of full-year retention (78 percent). In comparison, about 67 percent of children eligible under poverty-related rules were enrolled for the entire year. Although full-year coverage rates vary considerably across states, this pattern of higher rates of full-year enrollment among Section 1931 children appeared in almost all of the 45 states and the District of Columbia.[5] Lower income eligibility rules under Section 1931 is one possible explanation for the higher retention rates among this group—household income in these families would have to increase more substantially before the children would no longer qualify for Medicaid. In addition to losing eligibility for income-related reasons, children may become ineligible because they age out of the program, or if the family moves out of state.

Since Section 1931 children had higher retention rates, it is not surprising that they were less likely to disenroll during the year. Fifteen percent of the Section 1931 children left their state's program during the year, compared with 24 percent of the children eligible under poverty-related rules. An additional 7 to 9 percent of low-income children left Medicaid and then re-enrolled within the year.

## Influence of Continuous Eligibility Policies on Retention in 2007

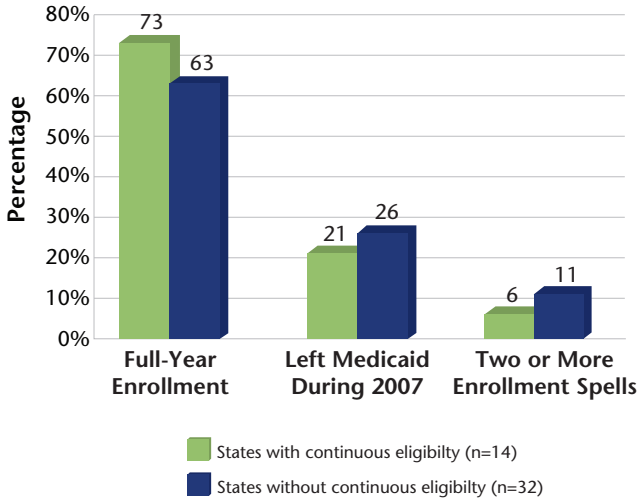
Each Medicaid program is unique, as every state strives to make its program meet the needs of its residents within its particular constraints. Attributing disenrollment patterns to a particular policy is difficult because states that adopt a policy may have different local issues than those that don't adopt it, and they typically adopt multiple policies at the same time. Nevertheless, we can compare retention outcomes in states that adopt certain policies with outcomes in states that do not to provide insights as to how the policy may be working. In this section, we consider the relationship between full-year continuous eligibility policies and enrollment patterns among children, but caution that we cannot interpret the relationship as a result of the policy.

**Figure 2.** Retention of Section 1931-Eligible Children for States, by Type of State Eligibility Policy




Source: Mathematica Analysis of 2007 MAX data.

**Figure 3.** Retention of Children Eligible Under Poverty-Related Rules, by Type of State Eligibility Policy




Source: Mathematica Analysis of 2007 MAX data.

Fourteen states had full-year continuous eligibility for children in Medicaid in 2007.[6] This policy allows children to maintain coverage for 12 months even if their family experiences a temporary change in income or status. Children in continuous eligibility states had slightly higher retention rates and lower rates of churning during 2007 than states without this policy. This relationship is stronger for children eligible under poverty-related rules. Eighty-one percent of Section 1931 children in continuous eligibility states retained coverage throughout 2007, compared with 76 percent in states without such policies—a difference of 5 percentage points (Figure 2). However, 73 percent of the children eligible under poverty-related rules in states with continuous coverage were retained, compared with 63 percent in states without continuous eligibility—a difference of 10 percentage points (Figure 3).

Two continuous eligibility states with high rates of full-year enrollment account for some of the differences between continuous eligibility states and other states, but not for the entire difference. California has a very large Section 1931 program for children and about 82 percent of these children were retained for all of 2007. When this state is removed from the analysis, full-year enrollment for continuous eligibility states drops to 78 percent. Similarly, Illinois has a large poverty-related program for children and the state retained 89 percent of these children for the full year in 2007. When this state is removed from the analysis of poverty-related children, rates of full-year enrollment drop to 68 percent.

## Key Findings

This issue brief assesses Medicaid coverage patterns across the country, taking advantage of the availability of MAX data, which provide person-level information for state Medicaid programs in a consistent format. We examine the Medicaid coverage patterns for a cohort of children who were enrolled in the program in January 2007.[7]

We found that almost three-quarters of the children enrolled in Medicaid remained enrolled throughout 2007, and 8 percent disenrolled and re-entered the program within the year. Children who were eligible under Section 1931 provisions were more likely to remain enrolled for the full year, and less likely to leave the program; this result is not surprising, given that they have the lowest family incomes and, as a result, are the least likely to become ineligible due to income improvements.

For children eligible through poverty-related provisions, we found higher levels of full-year retention and lower levels of churning in states with 12-month continuous eligibility policies. Children who receive coverage under these provisions generally have higher household income and are more likely to become ineligible due to fluctuations (even temporary ones) in household status. We cannot attribute the differences across the states to the policy; however these results are consistent with earlier findings that continuous eligibility may help retain low-income children whose eligibility status fluctuates and may reduce churning—which could help reduce Medicaid administrative costs.

## Endnotes

[1] Medicaid Analytic Extract (MAX) data, 2007

[2] http://www.statehealthfacts.org/comparetable.jsp?yr=30&typ=1&ind=871&cat=4&sub=61

[3] LA, OH, RI, VA, and WV were excluded from this analysis. These states report some or all of the children in Section 1931 and poverty-related groups as 'other' enrollees in MAX data. We cannot separately identify the children in these states who are equivalent to Section 1931 children and poverty-related children in other states.

[4] Data constraints allowed us to follow children within the Medicaid program within their own states. If a child were to move across state lines, or if he or she were to enroll in a state CHIP program, we were unable to identify that here.

[5] Full-year enrollment rates include children who retained Medicaid enrollment even if their basis for eligibility changed during the year. For example, a child covered under poverty-related provisions who shifted to coverage as a child with disabilities or moved to another Medicaid eligibility group or Medicaid-expansion CHIP coverage would be counted as remaining in Medicaid for a full year. Children who moved to separate CHIP coverage are not identified as remaining in Medicaid for the full year.

[6] Cohen Ross, Horn, and Marks 2008. The 14 states are: AL, CA, ID, IL, KS, ME, MI, MS, NC, NJ, NY, SC, WA, and WY.

[7] Like all studies, this analysis has limitations, as we can only observe children's coverage within each state's Medicaid program, and cannot account for enrollment in other types of health insurance, including separate CHIP programs. Furthermore, the data are truncated at one year; thus our estimates of re-enrollment will be lower than they would have been if we had multiple years of data.

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