



Trends in New Enrollment in the HUSKY Program: 2010

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KEY FINDINGS

Connecticut has been largely successful in enrolling children and their families in the HUSKY Program, especially during the recent economic downturn. However, many children and families have difficulties staying enrolled, even when eligible and in need of coverage. Key findings:

- In 2010, nearly 81,000 children and adults were newly enrolled in the HUSKY Program. This number was down from 2009 when almost 95,000 were newly enrolled, but up from previous years. The increased number of new enrollees in recent years is likely due to eligibility expansions and increased need for coverage during challenging economic times.
- As in previous years, the net increase in enrollment was far less than the number of new enrollees in 2010. On average, net enrollment increased by about 39 for every 100 newly enrolled children and adults in 2010. This ratio has increased steadily since 2008, suggesting that retention may have improved in recent years.

Outreach and retention are important components of reducing the number of uninsured children in Connecticut. However, state funding for outreach ended in 2009 and federal funding ended in September 2011. Until overall employment and economic conditions improve, Connecticut families will be increasingly reliant on community-based social service providers for information and HUSKY application assistance. User-friendly policies and procedures that facilitate application processing and renewal will be even more important for maintaining coverage. In upcoming years, as Connecticut implements provisions of the Affordable Care Act, lessons learned in the HUSKY Program should be applied to ensure seamless, well-coordinated coverage for children and families in the HUSKY Program and, beginning in 2014, coverage obtained through the health insurance exchange.

In Connecticut, an estimated 24,000 children under 18 (3.0%) were uninsured in 2010.¹ Data from the Census Bureau's American Community Survey show that the rate varied in towns with population over 65,000, from 2.1 percent in New Britain to 9.9 percent in Stamford.² The three-year average uninsured rate for 2008-10 was significantly higher for Black and Hispanic children, compared with White children; children living in households with adults who had not completed a college education; and children living in households with income less than 200 percent of the federal poverty level.³ While the Connecticut's uninsured rate for children is far less than the national rate (8.0%), the number is high, given that Connecticut offers coverage for almost all children.⁴

Outreach is an important strategy for reducing the number of uninsured children in Connecticut. However, state funding for outreach ended in 2009. Federal funding under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was awarded to three outreach projects in Connecticut (total of \$1.5 million), but that funding ended in September 2011.⁵ Fortunately, Connecticut families can still rely on community-based social service providers for information and HUSKY application assistance. These community-based providers rely in turn on the Covering Connecticut's Kids and Families coalition for up-to-date information on HUSKY Program developments.⁶

Eligibility and affordability affect health insurance enrollment decisions. Children under 19 are eligible for HUSKY A (Medicaid) if they live in Connecticut, are US citizens or qualified legal residents, and live in families with income less than 185 percent of the federal poverty level (% FPL).⁷ Parents and relative caregivers are also eligible in households with income less than 185% FPL. Pregnant women are eligible for HUSKY A if they live in households with income less than 250% FPL.⁸ Uninsured children are eligible for HUSKY B (CHIP) in households with income that exceeds the HUSKY A levels. For families with income between 185% and 235% FPL (HUSKY B Band 1), there is no monthly premium. Families with income between 235% and 300% FPL (HUSKY B Band 2) pay monthly premiums (\$30/child; \$50/family maximum). Families with income at or above 300% FPL (HUSKY B Band 3) pay the unsubsidized state-negotiated group rate premium for each child (\$270.36/child/month). All families with children in HUSKY B make co-payments for some services.

Policies and procedures that facilitate application processing and renewal are also critically important to help families get coverage and keep coverage. CHIPRA includes provisions aimed at improving participation in publicly funded health programs.⁹ The law encourages states to adopt policies that facilitate enrollment in Medicaid and CHIP, and then financially rewards states that achieve enrollment targets. With the implementation of presumptive eligibility in HUSKY B, effective April 1, 2011, Connecticut has now adopted five program features that simplify application and renewal: elimination of in-person interviews, elimination of assets test, same application for Medicaid and CHIP, presumptive eligibility for children, and administrative redeterminations (pre-filled renewal applications). Connecticut has applied for a CHIPRA performance bonus based on increased enrollment in the program.

Several policy and program changes have undoubtedly affected HUSKY enrollment trends in recent years. Eligibility was expanded for parents in 2007 and for pregnant women in 2008.¹⁰ Procedural changes were adopted in 2006 and the following years for verification of US citizenship and identity at the time of application or within a reasonable period after the applications are filed.¹¹ Premiums for families

with children in HUSKY B Band 2 (235-300% FPL) were increased mid-year in 2010.¹²

The purpose of this study is to identify trends in new enrollment among children and adults in HUSKY A (Medicaid) and children in HUSKY B (CHIP). This report on new enrollment in 2010 is part of a series on HUSKY Program enrollment dynamics issued by Connecticut Voices for Children. For the purposes of this study, newly enrolled children and adults (parents, relative caregivers, and pregnant women) were defined as those who had not been enrolled at any time in the 12 months before they first appeared in the HUSKY enrollment database in 2010.¹³ A “retention ratio” was calculated by comparing new enrollment to net enrollment changes from the end of one year to the next.

FINDINGS

HUSKY enrollment: Overall, enrollment in the HUSKY Program grew steadily in recent years (Table 1). However, nearly all the enrollment growth has been in HUSKY A (Medicaid), not in HUSKY B (CHIP).

Table 1. HUSKY Program enrollment, 2006-2010

Year ^a	HUSKY A		HUSKY B
	Children	Adults	
2010	239,531	125,370	15,657
2009	223,443	108,076	13,654
2008	214,211	98,464	16,132
2007	204,561	88,547	16,796
2006	211,991	90,070	15,163

^a Enrollment as of January 1

New enrollees: In 2010, there were almost 81,000 newly enrolled children and adults in the HUSKY Program (Table 2). About six out of ten new enrollees in HUSKY A were children. The number of new enrollees in HUSKY B was down considerably from the previous year.

Newly enrolled children in HUSKY A were likely to be very young (43% under 2) and Hispanic (31%). Most newly enrolled children in HUSKY A resided in towns other than Bridgeport, Hartford, and New Haven (83%).

Table 2. Newly enrolled children and adults in the HUSKY Program, 2009 - 2010

	2010	2009
HUSKY A total	79,469	89,281
Children	46,557	52,962
Adults	32,892	36,319
HUSKY B total	1,507	5,594^a
Band 1	882	3,108
Band 2	508	1,971
Band 3	117	515
HUSKY total	80,976	94,875

^a Previously reported to be 7,088 new enrollees in HUSKY B (Band 1: 3,794; Band 2: 2,544; Band 3: 750) ; for this report, revised to eliminate duplicate counts of children with both B and EMS identification numbers during a systems change-over in 2009.

New enrollment in 2010 was down nearly 15 percent from the previous year, but up from new enrollment in each year from 2006 to 2008 (Table 3).

Table 3. Trends in new enrollment in the HUSKY Program, 2006-2010

	HUSKY A	HUSKY B	HUSKY Total
2010	79,469	1,507	80,976
2009^a	89,281	5,594	94,875
2008^a	72,010	3,680	75,690
2007^b	70,760	4,231	74,991
2006^b	62,844	3,457	66,301

^a 2009 HUSKY B enrollment revised (see footnote to Table 2).
http://www.ctkidslink.org/publications/h11newenrollees2008_09.pdf.

^b <http://www.ctkidslink.org/publications/h08newenrollees.pdf>

Net increase in enrollment: As in previous years, the net increase in enrollment was far less than the number of new enrollees in the HUSKY Program (Table 4). Put another way, for every 100 new enrollees in 2010, HUSKY Program enrollment increased by about 39 children and adults over the one-year period. This ratio has increased fairly steadily since 2006, suggesting that retention may have improved in recent years.

Table 4. Retention in the HUSKY Program, 2006-2010

	New HUSKY enrollees	Net enrollment change	“Retention ratio”
2010	80,976	31,501	38.9
2009^b	94,875	27,997	29.5
2008^b	75,690	17,148	22.7
2007^c	74,991	19,267	25.7
2006^c	66,301	-9,096	-13.7

“Retention ratio”: Net increase (decrease) in enrollment for every 100 new enrollees in the calendar year.

^b Net enrollment count revised from previous report
http://www.ctkidslink.org/publications/h11newenrollees2008_09.pdf.

^c Net enrollment count revised from previous report
<http://www.ctkidslink.org/publications/h08newenrollees.pdf>

DISCUSSION

National data show that most of the uninsured children in the US are eligible but not enrolled in public coverage. In fact, one in four uninsured children nationwide disenrolled from the Medicaid or CHIP coverage that they had the previous year.¹⁴ In states with separate Medicaid and CHIP programs, as in Connecticut, children are more likely to lose coverage.¹⁵ Other risk factors for losing coverage include being the only enrolled child in the household.¹⁶ Children with more frequent office visits for care are less likely to disenroll.¹⁷

Connecticut has been largely successful in enrolling children and their families in the HUSKY Program, especially during the recent economic downturn. However, the results of this study and earlier reports have shown that retention is problematic, especially for those renewing coverage.¹⁸ National data suggest that disenrollment may have peaked in 2006.¹⁹

Coverage continuity is an important dimension of quality in health care. Systematic assessment of enrollment dynamics is key to understanding which aspects of program policy and which interventions best serve families with children who need coverage.^{20, 21} Historically, the Medicaid program has been plagued by coverage instability, or “churning.”²² Gaps in coverage and loss of coverage disrupt ongoing care, result in unmet needs for care, and contribute to poor health outcomes. Under CHIPRA, new measures for assessing program quality will include attention to duration of coverage.

Lessons learned in monitoring enrollment and retention in Medicaid and CHIP will be useful for anticipating and addressing the potential for “churning” as children and adults move between Medicaid and CHIP and private health care coverage purchased through the health insurance exchanges. Fluctuating income and changes in family composition will affect eligibility for health insurance options available beginning in 2014. Analyses of national data for low income adults suggest that more than 50 percent of low income adults may experience a change in program eligibility within a year, including a sizeable proportion that will lose and regain Medicaid coverage.²³

Results of enrollment studies in the HUSKY Program indicate that individuals are particularly vulnerable times of transition within programs (renewals) and between programs (redetermination of eligibility for separate programs). For example, age-related eligibility redeterminations can result in gaps or loss of coverage.²⁴ Seamless and well-coordinated eligibility processes, using the same income counting and household composition rules, will reduce gaps due to switching programs. Continuous eligibility, that is guaranteed eligibility for a specified period of time even if income fluctuates, could go a long way toward reducing enrollment instability. At the least, reducing the frequency of administrative redeterminations (as opposed to redeterminations triggered by changes in income or family

composition) could prevent coverage disruptions. Community-based assistance from knowledgeable, trusted social and health services providers is very important for reducing confusion associated with notices and procedures, especially for families with language barriers or low literacy. Finally, ongoing, systematic monitoring of disenrollment and discontinuity of coverage will help with identifying problems and formulating data-driven policy and administrative solutions. To the extent that new eligibility determination functions are built on existing systems, it is critically important to address the systemic problems that currently contribute to disenrollment and uninsured eligible children.

CONCLUSION

During the recent severe economic downturn, publicly funded coverage has become increasingly important for Connecticut residents who have lost jobs or employment-based coverage. In recent years, the percentage of uninsured children has not increased.²⁵ No doubt, some significant proportion of new HUSKY enrollment in 2010 and recent years is attributable to the economic challenges facing Connecticut’s families. The HUSKY Program has done just what it is designed to do: provide coverage for children and families who are unable to obtain affordable coverage on the job or on their own.

ACKNOWLEDGEMENTS

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¹ US Census Bureau. American Community Survey. Three-year average uninsured rate (2008-10). www.census.gov.

² Uninsured rate for children in New Britain is significantly less than the statewide rate, but not statistically different than the rates for children in other towns with population over 65,000.

³ US Census Bureau. American Community Survey 2008-10. Table S2701. Available at: www.census.gov.

⁴ Undocumented immigrant children are not eligible for coverage in Connecticut’s HUSKY Program. Children who are otherwise eligible for coverage in HUSKY B (CHIP) are not eligible until they have been uninsured for at least 2 months.

⁵ CHIPRA outreach grants from HHS were awarded to Community Health Center Association of Connecticut (\$988,177), Community Health Center, Inc. (\$400,584), and Catholic Charities in Hartford (\$104,423) for a two-year period beginning in September 2009.

⁶ Covering Connecticut’s Kids and Families is a statewide coalition sponsored by Connecticut Voices for Children, with funding from the Connecticut Health Foundation. From 2000 to 2005, the project was funded by The Robert Wood Johnson Foundation. Community-based health and social service providers, as well as Department of Social Services staff, are active participants.

⁷ In 2010, \$40,792 annual income for family of 4.

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- ⁸ In 2010, \$55,125 annual income for a family of 4. For the purpose of determining family size, a pregnant woman counts as 2 when applying for pregnancy coverage.
- ⁹ Children’s Health Insurance Program Reauthorization Act of 2009. Public Law III-3.
- ¹⁰ Parents: income threshold increased from 150% FPL to 185% FPL, effective July 1, 2007, the same as for their children. Pregnant women: income threshold increased from 185% FPL to 250% FPL, effective January 1, 2008.
- ¹¹ Beginning in July 2006, proof of citizenship and identity was required for all new applications; those with coverage were permitted to submit documentation at the time of renewal in the following year. Beginning in 2009, new applicants were given a “reasonable opportunity” period of 90 days to gather and submit documentation. In 2010, the Department began matching personal identifying information electronically with the Social Security Administration.
- ¹² Until June 30, 2010, premiums for families with income between 235% and 300% FPL (HUSKY B Band 2) were \$30 per child per month (\$50 maximum per family). Effective July 1, 2010, these premiums were increased to \$38 per child per month (\$60 per family per month maximum). In February 2011, the premium was rolled back to the lower rate after CMS determined that the increase violated the maintenance of effort requirements in the Affordable Care Act. Credits and refunds were processed by the Department’s enrollment broker. Currently, the monthly premiums are \$30/child (maximum \$50/family) for Band 2 and \$270.36/child (no family max) for Band 3.
- ¹³ **Methods:** Using HUSKY Program enrollment data from the Department of Social Services, Connecticut Voices constructed a longitudinal enrollment database for HUSKY A and B with monthly enrollment records from January 1, 2005 to present. Children and adults were counted as newly enrolled if they had not been enrolled in the 12 months prior to the first month in which they appear in the enrollment database in 2010. Net enrollment changes were calculated using HUSKY Program enrollment summaries for December one year to the December enrollment the previous year, provided by the Department of Social Services and available at www.ctkidslink.org/covering_data.html. (In previous reports, the net increase in enrollment was calculated by subtracting January 1 enrollment from December 1 enrollment; the counts are revised in this report.) The “retention ratio” was calculated by comparing the net increase in annual enrollment with the number of new enrollees to determine how much program enrollment increased for every 100 new enrollees. Previous reports on new enrollment in 2006-07 and 2008-09 are available at <http://www.ctkidslink.org/publications/h08newenrollees.pdf> and http://www.ctkidslink.org/publications/h11newenrollees2008_09.pdf
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- ¹⁵ Sommers BD. The impact of program structure on children’s disenrollment from Medicaid and SCHIP. *Health Affairs*, 2005; 24(6): 1611-1618.
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- ²² Summer L, Mann C. Instability of public health insurance coverage for children and their families: Causes, consequences, and remedies. New York, NY: The Commonwealth Fund, 2006. Available at: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Jun/Instability%20of%20Public%20Health%20Insurance%20Coverage%20for%20Children%20and%20Their%20Families%20%20Causes%20%20Consequence/Summer_instabilitypubhltinschildren_935%20pdf.pdf. Fairbrother GL, Emerson HP, Partridge L. How stable is Medicaid coverage for children? *Health Affairs* 2007; 26(2): 520-528.
- ²³ Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Affairs*, 2011; 30(2): 228-236.
- ²⁴ Lee MA. HUSKY Program coverage for infants: Maintaining coverage when babies turn one. New Haven, CT: Connecticut Voices for Children, April 2011. Available at: <http://www.ctkidslink.org/publications/h11husky1yearolds.pdf>. Lee MA, Langer S. HUSKY Program coverage for 18 year olds: recommendations for avoiding gaps or loss of coverage. New Haven, CT: Connecticut Voices for Children, October 2010. Available at: <http://www.ctkidslink.org/publications/h10huskycoverage18yolds.pdf>
- ²⁵ Based on analysis of Connecticut data from the US Census Bureau conducted by Connecticut Voices for Children and reported in a press release issued September 22, 2011 (http://www.ctkidslink.org/media/press_releases/h11insurancecensusrelease.pdf).