

Understanding the Disenrollment of Children from Public Health Insurance Programs in Kansas

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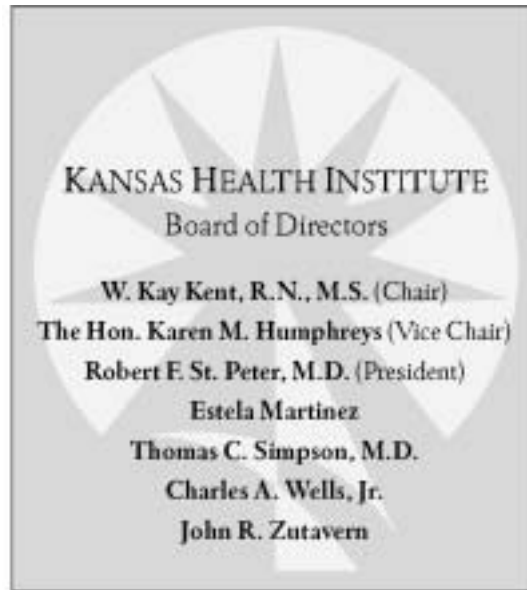
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The Kansas Health Institute is an independent, non-profit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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EXECUTIVE SUMMARY

The state of Kansas launched the HealthWave program in January 1999 in hopes of providing coverage to tens of thousands of low-income uninsured children that federal estimates suggested were in the state at that time. By June 2001, nearly 44,000 children had participated in HealthWave, although high levels of turnover kept caseload to about 23,000. New outreach efforts, including a joint HealthWave/Medicaid application form that parents could fill out and mail in to a central clearinghouse, supported enrollment in the new program and also contributed to a large increase in the number of children in Medicaid. Altogether, enrollment of children in public health insurance increased by about 51,000 (51%) between December 1998 and June 2001, with over half of the increase occurring in Medicaid.

Despite these enrollment successes, previous analyses of enrollment trends by the Kansas Health Institute have indicated that many children leave the HealthWave and Medicaid programs during their first year of coverage and that a majority do not remain in HealthWave and Medicaid for longer than a year. This report builds upon these earlier findings by providing a detailed analysis of the rates and correlates of disenrollment and churning in public health insurance among children who enrolled in Kansas' HealthWave and Medicaid programs between January 1999 and June 2001. In addition, this report analyzes for the first time the records of families who have mailed joint application forms to a central clearinghouse facility located in Topeka.

KEY FINDINGS:

- *Local SRS offices remain a vital point of intake for families wishing to enroll their children in public health insurance programs, especially for the lowest-income eligibles.* SRS has reported that as many as 60,000 children were enrolled as a result of the clearinghouse between 1999 and mid-2001. However, our analysis indicates that for a comparable time period, closer to 33,000 children were newly enrolled in public health insurance as a result of having submitted a mail-in application to the clearinghouse. By contrast, nearly 110,000 children were enrolled via the traditional method of applying in-person at a local SRS office. Overall, in-person applications accounted for more than 3 out of 4 (77%) new enrollments, including more than one-third (36%) of new HealthWave enrollments and more than 5 out of 6 (85%) new Medicaid enrollments. These findings demonstrate that mail-in applications have been an important new outreach tool for children eligible for public health insurance, but that local SRS offices

continue to enroll the vast majority of children. We also found a clear relationship between family income and the type of application submitted: right across the board, children in lower-income eligibility categories were much more likely to have applied in-person than children in higher-income eligibility categories. This finding further emphasizes the continuing importance of local SRS offices in the outreach and enrollment process.

- *Walk-in applicants are roughly three times as likely as mail-in applicants to disenroll before completing their first full year of coverage.* The results of the disenrollment analyses indicate that many children leave public health insurance after short-term enrollments: 18% of those entering HealthWave and 28% of those entering Medicaid leave public health insurance before completing their first year of coverage. Those most likely to leave early include younger HealthWave children and older Medicaid children, those living in more densely populated counties, low-income HealthWave families that are not asked to pay premiums, foster children and poverty-level Medicaid eligibles, and, especially, walk-in applicants at local SRS offices. We surmise that the difference in disenrollment rates between walk-in and mail-in applicants is due primarily to differences in the manner in which public health insurance enrollment cases are maintained by the local SRS offices and the clearinghouse.
- *As it implements consolidation, SRS faces the dual challenge of facilitating new enrollments while minimizing premature or unintended disenrollments.* The results of this study are suggestive of the potential benefits of the recent consolidation of HealthWave (Title XXI) and Medicaid (Title XIX) enrollment cases at the clearinghouse. Consolidation was designed in part to eliminate the premature disenrollments sometimes experienced by families enrolled in programs other than public health insurance. With consolidation, local offices will retain their vital role of enrolling new participants in HealthWave and Medicaid — especially the poorest eligibles — while case maintenance responsibilities will be handled primarily at the clearinghouse, which appears to have the better track record for maintaining enrollment during the 12-month period of continuous eligibility. A key challenge for SRS in the consolidation process is to successfully convey the message to local offices that they remain vital to the outreach and intake process even as case maintenance, a long-time responsibility of the local office, is being removed to the clearinghouse.
- *Many children wanting to remain in public health insurance experience periods of disenrollment around the time of re-enrollment.* “Churning” is a term used to describe the repeated entry and exit of children into and out of public health insurance. A child is considered to have “churned” if they re-enter public health insurance after a lapse in coverage. Our analysis indicates that nearly a quarter of all Medicaid children and more than a third of HealthWave children can expect to churn within 30 months of their initial enrollment. A good proportion of churning appears to occur as a result of temporary disenrollment around the time of the annual eligibility redetermination. In particular,

about 25 percent of HealthWave enrollees who leave public health insurance at the end of their first year of coverage subsequently return after a one to three month lapse in coverage. While it is conceivable that some of the churning that occurs around the time of redetermination may be the result of families who are ineligible at redetermination but become eligible 1-2 months later, the large number of these brief disenrollments suggests that many families who wish to maintain coverage experience delays in completing the redetermination process.

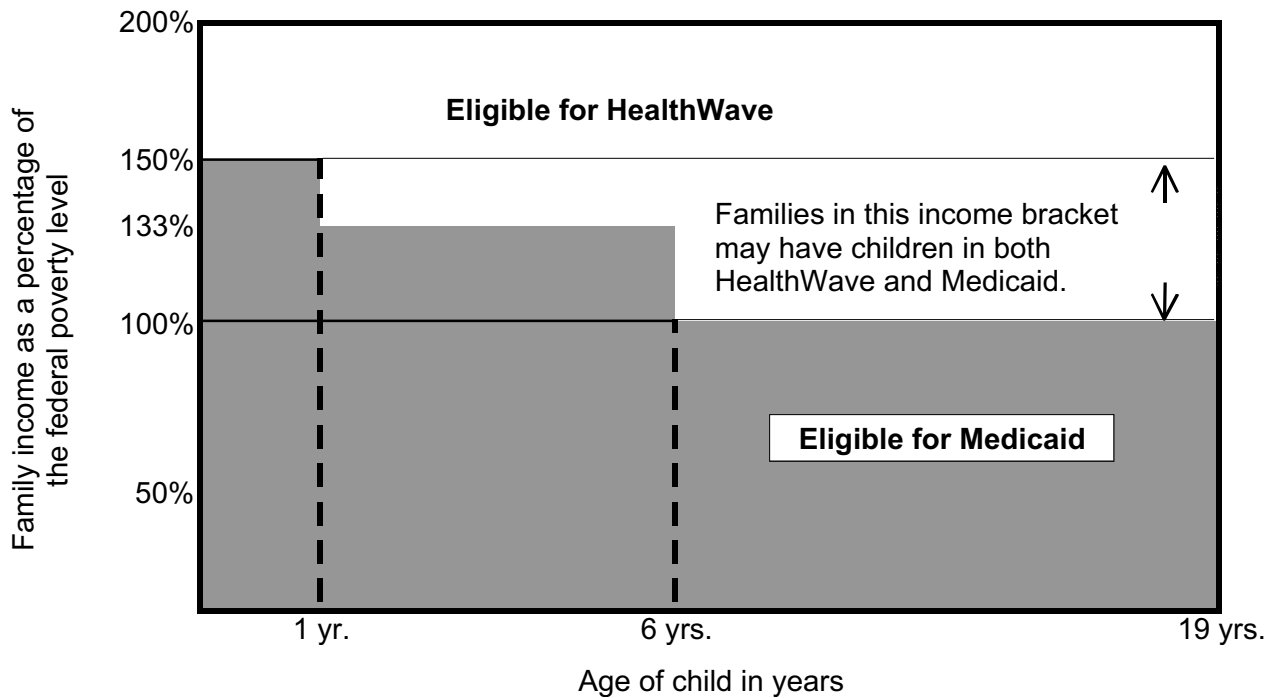
We have used enrollment and application data to investigate potential causes and determinants of disenrollment, but this data tracks children's health insurance status only so long as they remain enrolled in public health insurance and thus cannot provide an answer to one of the most important questions regarding disenrollments: how many of the children who leave public health insurance remain uninsured? The results presented above also lead to a number of questions about the redetermination process. How many of the disenrollments that occur at the time of redetermination are the result of burdensome administrative procedures? Which aspects of the redetermination process pose the greatest challenges to families attempting to re-enroll? What policy options might be available to improve re-enrollment rates? Many of these unanswered questions will be addressed in an upcoming Kansas Health Institute (KHI) analysis of individuals who do not re-enroll at the annual redetermination. As a part of its ongoing evaluation of the HealthWave program, KHI is in the process of interviewing the families of 600-800 children who were sent re-enrollment packets and who either failed to re-enroll or who experienced a brief disenrollment. Results are expected to be available in late 2002.

CHAPTER ONE: INTRODUCTION

The State Children’s Health Insurance Program (SCHIP) was established by the federal government in 1997 to reduce the number of low-income uninsured children across the country. The program provides matching funds to states at rates exceeding those available to states through the Medicaid program and allows states to use the funds to provide health insurance for children under 19 with family incomes above the Medicaid income thresholds and up to a SCHIP threshold established at the state’s discretion. In Kansas, the SCHIP program is called “HealthWave.” HealthWave covers children up to 200 percent of the Federal Poverty Level (FPL) who live in families with incomes that exceed the age-specific Medicaid eligibility thresholds. Figure 1 illustrates how the HealthWave program fills in coverage gaps that existed between the Medicaid thresholds and 200% of FPL. In establishing the SCHIP program, the federal government’s focus was on increasing health insurance coverage rates by enrolling eligible children into both the new SCHIP and the pre-existing Medicaid program. To this end, states were allowed to spend up to 10 percent of medical costs on administrative activities, including marketing and outreach — twice the historical proportion of administrative-to-medical expenses in the Medicaid program. Kansas contracted with a private firm called MAXIMUS to provide marketing and outreach services for the HealthWave program, and to operate a centralized clearinghouse that would receive a new mail-in application that included sufficient information to determine eligibility for Medicaid as well as HealthWave.

The initial focus of the SCHIP program was to increase public health insurance coverage by bringing as many children as possible into these programs. Despite initial reports of enrollment increases following SCHIP’s implementation, evidence soon began to emerge that many children stayed in public health insurance for only a brief period of time and that disenrollments from public health insurance might impede states’ progress in covering eligible uninsured children. For example, researchers found that children in several states did not remain enrolled for their full period of “continuous” eligibility.¹ At the same time the HealthWave program was introduced, the state of Kansas revised the eligibility rules for all children in public health insurance (i.e., those eligible for both Medicaid and HealthWave) to enhance continuity of

Figure 1
Income eligibility thresholds for children in
Medicaid and HealthWave



In 2001, 100% of the federal poverty level for a family of 4 was \$17,650.

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coverage by providing a full year of coverage to children who meet age, income, state residency, and other eligibility criteria, regardless of changes in income during the year. The 12-month continuous coverage policy was yet another step in the process of de-linking public health insurance coverage from cash assistance and other public assistance programs.²

This report builds on earlier work by the Kansas Health Institute that documented the presence of substantial *turnover*, *disenrollment*, and *churning* among children in Kansas' HealthWave and Medicaid programs. *Turnover* is a general term representing the total amount of enrollment activity in public insurance, including both entries (enrollments) and exits (or disenrollments). *Disenrollment* is defined to occur when an individual leaves public health insurance for at least one month. *Churning* is defined as the repeated entry and exit of an individual child over time. This report analyzes administrative data from the Kansas Department of Social and

Rehabilitation Services (SRS) to gain a deeper understanding of the patterns and potential explanations of turnover, with a specific focus on disenrollment and churning.

The report is organized as follows: Chapter Two includes a detailed description of the enrollment and application data used in the analysis. Chapter Three provides an overview of the basic enrollment trends and dynamics among children in the HealthWave and Medicaid programs during the study period. Chapter Four establishes an analytic framework for the disenrollment analysis. Chapter Five provides the results of the detailed analysis of disenrollment. Chapter Six provides the results of a targeted analysis of churning among children in HealthWave and Medicaid. Chapter Seven summarizes the report's principle findings and discusses their policy implications.

CHAPTER TWO: DESCRIPTION OF DATA

ADMINISTRATIVE RECORDS

The data used in this analysis include the state's official enrollment records for all persons who were enrolled in HealthWave or Medicaid as children (under the age of nineteen) at any time between July 1, 1998 and June 30, 2001. Complete month-by-month histories are available for this time period, although this study focuses on the timeframe beginning January 1, 1999, when the HealthWave program began. The enrollment records include the following information about enrollees:

- enrollee name
- date of birth, which enables determinations of age at various stages of enrollment
- gender
- unique personal identification number, which follows children across time and across public health insurance programs
- unique “case” or family identification number, which follows families across time and public assistance programs
- address, including county of residence, enabling descriptions of enrollees according to county-level population density and SRS administrative region
- family premium level for HealthWave enrollees, i.e., \$0 per month, \$10 per month, or \$15 per month (which is tied directly to family income and does not vary according to the number of children enrolled in HealthWave)
- Medicaid eligibility category: eligibility for Medicaid may result from the family's enrollment in a cash assistance program such as Temporary Assistance to Families (TAF), from the child's enrollment in an assistance program such as Supplemental Security Income (SSI) or foster care, or the child may qualify for Medicaid as a result of meeting a set of Medicaid-specific eligibility requirements.

This study also includes the first independent analysis of mail-in application records from MAXIMUS, the private firm under contract with the state to operate a clearinghouse where mail-in applications are received and evaluated by on-site eligibility workers.³ The application records

include all mail-in applications received by the clearinghouse from the beginning of operations in fall 1998 through June 30, 2001. This analysis relies on the following information contained in those records:

- applicant name
- complete address
- unique personal identification number (which will match the number in the enrollment records if the child has already been enrolled in public assistance programs or if the child is enrolled in public health insurance as a result of the current application)
- unique case/family identification number (will match enrollment records under similar circumstances)
- program assignment: the application records also contain an indicator of which health insurance program, if any, the applicant was ultimately assigned to. Because we were not able to independently validate the process by which these program assignment indicators were generated, our analysis does not rely on these indicators. Instead, this study matches the application and enrollment files in order to determine which children enrolled in public health insurance by mailing an application and which enrolled by applying at a local SRS area office (the matching process is described in detail later in this chapter).

DESCRIPTION OF CHILDREN IN THE HEALTHWAVE AND MEDICAID PROGRAMS

Characteristics of the children included in this study are summarized in Table 1, which includes demographic and program information on all children enrolled for any period in HealthWave or Medicaid between January 1999, the month HealthWave was introduced, and June 30, 2001.⁴

The Medicaid totals in Table 1 include only those individuals who were in Medicaid as children (less than 19 years of age) during this time period.

- *Age at first observed enrollment.* [Note: Children may have numerous enrollments over time, some of which may begin and/or end before our study period. Here, as elsewhere in this report, we focus on the first *enrollment* (or entry) that we *observe* during our study period.] Children enrolling in HealthWave are generally older than children enrolling in Medicaid. Nearly three-quarters (72%) of HealthWave children entered the program as 6-18 year-olds, compared to fewer than half (44%) of Medicaid children. Also, infants (children less than 12 months old) make up a much larger percentage of Medicaid enrollees: 31% of Medicaid children enter as infants, compared to 3.2% of HealthWave children.

- *Gender.* A small but clear majority of HealthWave children are male, while the number of males and females in Medicaid is virtually identical.
- *County population density.* The majority of both HealthWave and Medicaid children are from urban or semi-urban counties, but proportionally fewer HealthWave (55.9%) than Medicaid (61.3%) children are urban/semi-urban.
- *SRS administrative region.* Children enrolled in each program are fairly evenly dispersed across SRS regions, with the exception of the Wichita area. Compared to HealthWave enrollees, Medicaid children are somewhat more concentrated in the Wichita and Kansas City regions.
- *HealthWave premium levels.* Nearly two-thirds (62.3%) of HealthWave children have family incomes under 150% of the federal poverty level and pay no premium. Just 12.5% have family incomes between 175% and 200% of poverty and pay the highest premium of \$15 per month.
- *Medicaid eligibility categories.* There are a number of ways in which a child may qualify for Medicaid, and the number and breadth of eligibility categories has grown steadily since the program began in the 1960s. Over the 1999-2001 period covered by this study, more than one-fifth (21.6%) of Medicaid children were eligible because they or their families were also enrolled in the TAF cash assistance program, while only 3.9% were eligible because of the child's enrollment in the SSI program.⁵ Another 4.9%, representing nearly 11,000 children, were eligible as foster children. Two-thirds (66.5%) were eligible as "poverty level eligibles" who did not receive cash assistance payments and qualified for Medicaid solely by virtue of their age and their family's income in relation to the federal poverty level.
- *First observed enrollment.* As might be expected, new enrollments in HealthWave peaked in the first six months of the program and have been relatively stable over the last 18 months of our study period. New enrollments in Medicaid have also been relatively stable since the first six months of 1999. Due to rules allowing retroactive enrollment in Medicaid, our database may undercount enrollment during the final 6-month period, possibly explaining the small drop in new enrollments observed in that period. Note that the huge number of first *observed* enrollments in the Medicaid program between January and June 1999 does not necessarily indicate an unusually high number of new enrollments during that time period, but instead reflects that fact that at the beginning of our study period a large number of children were already enrolled so that January 1999 is the first time we *observe* them in the program.

Table 1
Characteristics of children enrolled in HealthWave and Medicaid
between January 1999 and June 2001 (n=239,650)

	Children ever enrolled in HealthWave		Children ever enrolled in Medicaid	
	Total number in each category	Percentage of all HealthWave enrollees	Total number in each category*	Percentage of all Medicaid enrollees
Age at first observed entry into the program*				
Less than 12 months	1,389	3.2	38,771	31.3
1-5 years	10,602	24.4	30,488	24.6
6-11 years	18,377	42.3	27,375	22.1
12-18 years	13,026	30.0	27,183	22.0
Gender				
Male	22,127	51.1	108,833	50.1
Female	21,187	48.9	108,331	49.9
County population density (most recent address)				
Frontier	2,048	4.7	6,826	3.1
Rural	5,958	13.7	22,874	10.5
Dense rural	11,075	25.6	54,431	25.1
Semi-urban	5,857	13.5	31,892	14.7
Urban	18,408	42.5	101,244	46.6
SRS administrative region (most recent address)				
Chanute	4,534	10.5	22,942	10.6
Emporia	3,418	7.9	16,508	7.6
Garden City	4,281	9.9	19,933	9.2
Hays	2,770	6.4	10,270	4.7
Hutchinson	2,803	6.5	13,563	6.2
Kansas City	4,450	10.3	24,209	11.1
Lawrence	2,869	6.6	13,488	6.2
Manhattan	4,126	9.5	18,518	8.5
Olathe	4,156	9.6	17,403	8.0
Topeka	2,938	6.8	15,599	7.2
Wichita	7,001	16.2	44,834	20.6

Table 1 (continued)
Characteristics of children enrolled in HealthWave and Medicaid
between January 1999 and June 2001 (n=239,650)

	Children ever enrolled in HealthWave		Children ever enrolled in Medicaid	
	Total number in each category	Percentage of all HealthWave enrollees	Total number in each category*	Percentage of all Medicaid enrollees
HealthWave monthly premium (most recent)				
\$0 per family	27,031	62.3		
\$10 per family	10,915	25.2		
\$15 per family	5,438	12.5		
Medicaid experience prior to first HealthWave enrollment? **				
Yes	31,789	73.3		
No	11,606	26.7		
Medicaid program type (most recent)				
TAF-related			46,834	21.6
SSI			8,579	3.9
Poverty level eligibles			144,453	66.5
Foster care			10,698	4.9
Other			6,745	3.1
Date of first observed enrollment in the program				
January-June 1999	13,288	30.6	127,529	58.7
July-December 1999	6,793	15.7	25,988	12.0
January-June 2000	8,014	18.5	22,446	10.3
July-December 2000	7,012	16.2	22,099	10.2
January-June 2001	8,288	19.1	19,247	8.9
Program Total	43,395	100.0	217,309	100.0

Note: Some variables have a small number of missing observations. Percentages are calculated based on valid (non-missing) observations.

*Medicaid totals for age at entry do not include those children enrolled in December 1998 and January 1999. Medicaid ages are as of the first observed enrollment during the 1999-2001 period.

**Represents a lower-bound estimate for prior Medicaid experience: Medicaid enrollment records were checked only back to July 1998.

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DESCRIBING HOW CHILDREN APPLIED FOR PUBLIC HEALTH INSURANCE

The traditional method of applying for public assistance programs, including Medicaid, is to visit a local SRS office and apply in person. This method remains an option for families wishing to apply for Medicaid, and may also be used to apply for HealthWave. One of the enrollment-related improvements instituted when the HealthWave program was introduced in 1999 was a single simplified mail-in application form that families could use to apply for public health insurance for their children. The forms are sufficient for both HealthWave and Medicaid applicants, are much shorter than traditional Medicaid applications, and do not have to be hand-delivered to a local SRS office. Instead, these forms are usually mailed to a “clearinghouse” in Topeka for processing. The standard procedure for applicants during the study period was for the clearinghouse to maintain the enrollment cases for mail-in applicants. Maintaining an enrollment case entails the assignment of an eligibility worker who takes responsibility for the ongoing eligibility status of the child. That worker would, if necessary, disenroll the child for cause, e.g., turning age 19 (for HealthWave enrollees) or moving out of state, and administer the re-enrollment process at the end of the first year (and successive years) of coverage. In order to fulfill these functions, caseworkers are present at the clearinghouse, which is operated by a private firm under subcontract with the state. The primary differences between caseworkers at the clearinghouse and those at a local SRS office are proximity to the client and breadth of responsibility: clients have no face-to-face contact with clearinghouse caseworkers, and clearinghouse caseworkers do not maintain the child’s enrollment in other state assistance programs. Through June 2001, the clearinghouse had received approximately 56,000 mail-in applications. Of these, more than a third did not result in an enrollment in either program (38% based solely upon the application file’s program assignment variable), presumably due to a lack of eligibility or a failure to properly complete the application.

An exception to the enrollment process for clearinghouse applicants, at least during the time period studied, occurred when the applicant or the applicant’s family was found to have an open SRS case involving another assistance program. These applications were sent to the family’s local SRS office for processing and coordinated case management.⁶ If found eligible, the local office would maintain the child’s enrollment in public health insurance as well as the family’s

enrollment in other assistance programs. Local SRS offices also maintained enrollment of children who applied directly to the SRS office, although a small proportion of SRS applicants' cases were transferred to the clearinghouse for maintenance.

There are at least a couple of reasons why we would expect that children whose families submit mail-in applications to the clearinghouse could experience a different pattern of disenrollment from those who apply directly to a local SRS office:

- Families who mail in an application may be different than those who visit local SRS offices, e.g., they may live farther away from an SRS office, they may be less likely to have previous experience in Medicaid or be currently enrolled in other public assistance programs, or they may be in some demographic group targeted for marketing and outreach by SRS, MAXIMUS, and KCSL.
- Public health insurance may be administered differently by caseworkers at the clearinghouse than by caseworkers at local SRS offices. Children are far more likely to have had their case maintained by the clearinghouse if they applied to the clearinghouse than if they applied to an SRS office. Anecdotal evidence and extensive discussions with SRS officials indicate that local SRS offices often do not successfully apply the policy of providing 12 months of continuous coverage to children enrolling in public health insurance, instead applying the old policy of re-evaluating eligibility on a monthly basis.⁷

This report uses the method of application, e.g., clearinghouse v. SRS office, both as an indication of potential differences in the types of families and as an indicator for the location where cases are maintained.

CREATING AN INDICATOR VARIABLE FOR THE TYPE OF APPLICATION

In order to capture the potential differences between the enrollment experiences of children who enter public health insurance through the clearinghouse and those who enter through local SRS offices, we need a reasonable method for identifying enrollees who applied through the clearinghouse. The basic approach is to identify new⁸ enrollees using enrollment records and to then attempt to match them to clearinghouse applicants using the unique identification numbers that follow children and their families across time, SRS programs, and episodes of enrollment. There are at least two distinct ways to use this matching process to determine whether a new enrollee applied through the clearinghouse.

Identifying clearinghouse applicants, Method 1

The simplest and most liberal method would be to define a clearinghouse applicant as a new enrollee whose family also has a clearinghouse application on file, regardless of the relationship between the date the child enrolled in public health insurance and the date the application was received by the clearinghouse. This definition of a clearinghouse applicant provides an upper-bound estimate of the number and percentage of children enrolling through the clearinghouse. Using this approach, we identified 16,735 clearinghouse applicants who first enrolled in HealthWave (71% of those first enrolling in HealthWave), and 27,076 clearinghouse applicants who first enrolled in Medicaid (23% of those first enrolling in Medicaid) between January 1, 1999 and June 30, 2001, for a total of 43,811 applicants.

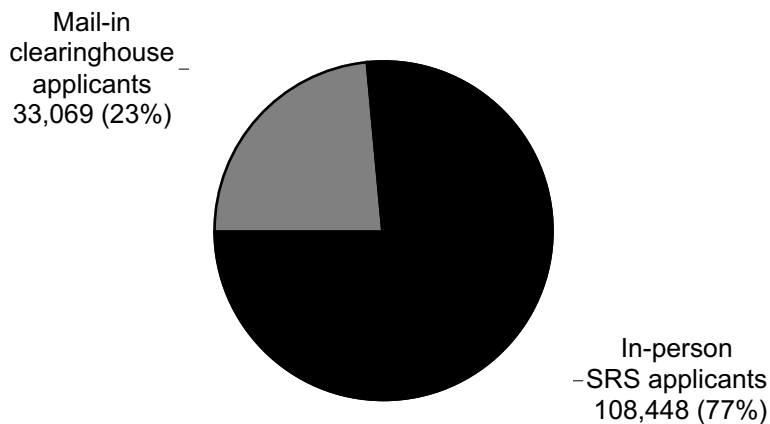
Nevertheless, given the level of churning and turnover observed in the HealthWave and Medicaid programs, the potential confusion surrounding the application process and the nature of the new HealthWave program, and natural variations in human behavior, there is at least a possibility that some families already enrolled in public health insurance might submit an application to the clearinghouse. In addition, families might submit an application but for some reason not enroll until they later visit an SRS office (e.g., they may have been initially ineligible for assistance, but later visited an SRS office following a family event that rendered the child eligible for assistance). To accommodate such concerns, a more precise definition of a clearinghouse applicant is recommended.

Identifying clearinghouse applicants, Method 2 (recommended)

The approach used throughout this analysis is to compare the timeframes of enrollment and application in an attempt to directly relate the application and enrollment events. This requires an understanding of the policies and procedures governing the application and enrollment processes for the HealthWave and Medicaid programs. For example, during the time periods covered by this study, children eligible for HealthWave were enrolled anywhere from 8 to 81 days *after* an application was received by the clearinghouse, while children eligible for Medicaid were typically enrolled in the program retroactively, between 1 and 90 days *before* the date the application was received.

Applying the timeframes associated with each program’s enrollment policies yields somewhat lower estimates of the number of new enrollees who came into public health insurance through the clearinghouse: 15,125 (64%) of the 23,644 children whose *first* public health insurance experience was in the HealthWave program, compared to 17,944 (15%) of the 117,873 children whose *first* enrollment experience was in Medicaid. The combined total of 33,069 children represents our point estimate of the number of children who entered public health insurance as a result of the clearinghouse between January 1999 and June 2001. This implies that the majority of new enrollments, 108,448 children (77%), were the result of a traditional walk-in application at a local SRS office [see Figure 2]. Note that second and subsequent *re*-entries into public health insurance (e.g., entries after some sort of lapse in coverage) were not included in these totals. If these re-entries were included, the total number of enrollments resulting from applications to the clearinghouse might be 4,000 - 5,000 higher.⁹

Figure 2
New enrollments of children in HealthWave and Medicaid
between January 1999 and June 2001



Note: Totals represent the number of children (< 19 yrs.) entering public health insurance for the first time between January 1999 and June 2001 (n=141,517).

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Regardless of whether the upper-bound or point estimate is used, and whether or not re-entries are included, this study's estimate of the total number of children enrolling as a result of the clearinghouse appears to be significantly lower than the clearinghouse vendor, MAXIMUS, and SRS have previously reported. Over the same time period included in this study, January 1999 through June 2001, SRS and MAXIMUS report *caseload* increases of about 60,000 children resulting from clearinghouse eligibility determinations. Because the MAXIMUS/SRS estimate is a measure of the clearinghouse's effect on caseload, rather than new enrollments, it is not directly comparable to this study's estimate. Caseload represents the total number of children in public health insurance at a specific point in time. Hence, the MAXIMUS/SRS figure is an estimate of the effect of the clearinghouse on total enrollment at a point in time, i.e., June 2001, and does not include children who may have enrolled through the clearinghouse but left public health insurance before June 2001. By contrast, this study's estimate includes all children who have enrolled for the first time after having applied through the clearinghouse, regardless of whether or not they were still enrolled in public health insurance in June 2001. If the two estimates were equal in all other respects, one might expect the MAXIMUS/SRS estimate to be significantly lower than this study's estimate because it includes only those clearinghouse enrollees who were still in the program in June 2001. It is not clear, then, why the MAXIMUS/SRS estimate of about 60,000 children is so much greater than this study's estimate of 33,069 children.

Table 2 includes further details about children who first enroll in public health insurance through the clearinghouse. Note in particular that:

- A much higher percentage of HealthWave children apply by mail to the clearinghouse.
- The percentage of Medicaid enrollees applying through the clearinghouse has fallen slightly over time (from more than 17% of 1999 applicants to fewer than 12% of 2001 applicants).
- A higher percentage of children from rural than urban counties enroll through the clearinghouse.
- There is substantial variation across SRS regions in the percentage of children enrolling through the clearinghouse, especially for Medicaid enrollees. The data does not support a full explanation of these differences, and several factors may contribute: there could be significant differences in the types of families that are eligible, e.g., families in some regions

may be poorer or more likely to be non-English speaking; there could be differences in the geography of regions that make it harder or easier to apply in person at an SRS office; there could be differences in the types and intensity of outreach across regions, e.g., eligible families in some regions may be more likely to have access to mail-in applications; and there could be differences across regions in the operations of the local SRS offices.

- A much smaller percentage of infants than older children enrolling in both programs apply through the clearinghouse.
- Higher income families were more likely than lower income families to apply through the clearinghouse: within HealthWave, 68% of premium-paying families applied through the clearinghouse compared to 60% of non-premium-paying families; across programs, 15.2% of new Medicaid enrollees applied through the clearinghouse compared to 64% of new HealthWave enrollees. It is at least conceivable that confusion as to the applicability of the mail-in form to Medicaid may have limited the number of Medicaid eligibles applying through the clearinghouse. The dual-use form was modified over the course of the study period. The first version did not mention the Medicaid program at all. The second version added the following small print statement in the legal language just above the applicant's signature box at the end of the application: "I understand that some or all of the children for whom I am applying may receive similar health coverage under the Medicaid program if eligible." The HealthWave brochure disseminated along with the application form did not change over time and included only the following question and answer: "Q: What if a child is on Medicaid? A: Children on Medicaid already get these health care services, and are not eligible for HealthWave." It is difficult to know how these somewhat ambiguous messages regarding the application form's applicability to Medicaid may have interacted with other outreach activities (i.e., the media campaign) and the target populations' existing knowledge of Medicaid eligibility and application procedures to either encourage or discourage parents of Medicaid-eligible children from using the dual-use mail-in application.

Table 2
Path of Entry for Children Enrolling in Public Health Insurance
for the First Time, January 1999-June 2001* (n=141,517)

	First Enrollment HealthWave		First Enrollment Medicaid	
	Total number in each category	Percentage applying through Clearinghouse	Total number in each category	Percentage applying through Clearinghouse
Age at first observed entry into the program				
Less than 12 months	904	43.6	38,520	7.5
1-5 years	4,545	63.0	29,298	21.9
6-11 years	10,380	64.3	24,900	19.2
12-18 years	7,815	66.5	25,155	15.3
Gender				
Male	12,158	64.4	58,273	15.7
Female	11,481	63.5	59,496	14.8
County population density (most recent address)				
Frontier	1,281	72.1	3,992	23.3
Rural	3,445	67.5	12,642	19.1
Dense rural	6,102	60.6	30,761	14.1
Semi-urban	3,135	64.1	16,915	12.3
Urban	9,679	63.8	53,532	15.3
SRS administrative region (most recent address)				
Chanute	2,510	65.3	11,905	12.9
Emporia	1,921	65.0	9,007	14.4
Garden City	2,483	58.8	12,776	16.2
Hays	1,552	70.2	5,639	21.2
Hutchinson	1,540	59.7	7,211	14.8
Kansas City	2,350	65.0	12,594	17.0
Lawrence	1,548	61.9	6,839	13.3
Manhattan	2,271	63.9	10,109	15.5
Olathe	2,483	69.1	10,613	19.0
Topeka	1,515	70.9	7,442	17.3
Wichita	3,469	58.9	23,707	12.0

Table 2 (continued)
Path of Entry for Children Enrolling in Public Health Insurance for the First Time, January 1999-June 2001* (n=141,517)

	First Enrollment HealthWave		First Enrollment Medicaid	
	Total number in each category	Percentage applying through Clearinghouse	Total number in each category	Percentage applying through Clearinghouse
HealthWave monthly premium (most recent)				
\$0 per family	13,510	60.8		
\$10 per family	6,654	68.0		
\$15 per family	3,475	68.6		
Medicaid program type (most recent enrollment)				
TAF-related			24,166	3.7
SSI			2,137	5.4
Poverty level eligibles			85,067	19.8
Foster care			4,781	1.1
Other			1,722	1.5
Date of first entry in public health insurance				
January-June 1999	10,265	66.4	33,133	18.2
July-December 1999	4,161	73.7	25,161	17.9
January-June 2000	3,008	64.4	20,708	14.7
July-December 2000	2,927	39.2	21,021	10.5
January-June 2001	3,283	65.7	17,850	12.2
Program Total	23,644	64.0	117,873	15.2

Note: Some variables have a small number of missing observations. Percentages are calculated based on valid (non-missing) observations.

*Includes all children with an observed entry into public health insurance between January 1999 and June 2001. Children enrolled in Medicaid in both December 1998 and January 1999 are excluded. A small number of cases were excluded because of missing data on the path of entry (n=24).

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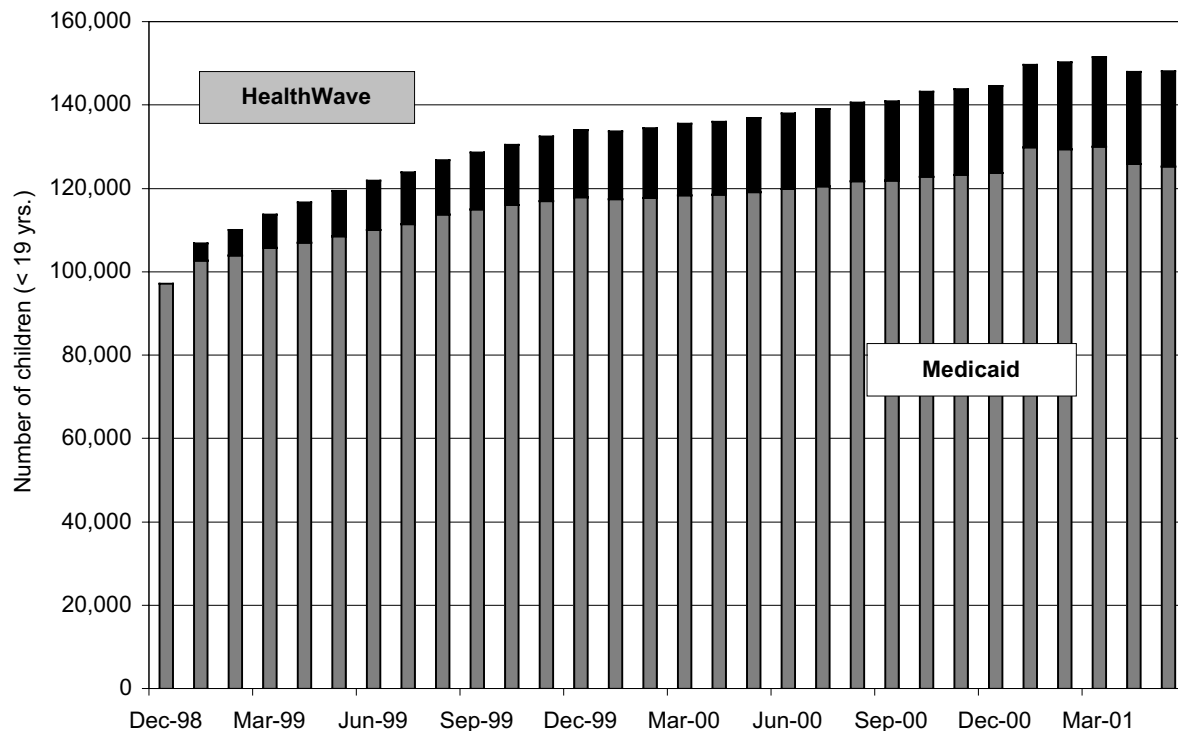
CHAPTER THREE: AN OVERVIEW OF ENROLLMENT DYNAMICS IN HEALTHWAVE AND MEDICAID

The basic enrollment trends among children in HealthWave and Medicaid are well documented: enrollment has increased substantially since 1999, but disenrollment has been identified as a significant concern.¹⁰ This section briefly updates these general results and provides the overall context for more detailed analyses of disenrollment and churning.

PROGRAM GROWTH

Total enrollment of children grew from fewer than 100,000 in December 1998 to nearly 150,000 in May 2001, an increase of about 51,000 children (52%) in the two-and-a-half year period that followed HealthWave's introduction [see Figure 3]. Over half of this growth (about 28,000 children) occurred in the Medicaid program.

Figure 3
Active caseload of children in public health insurance

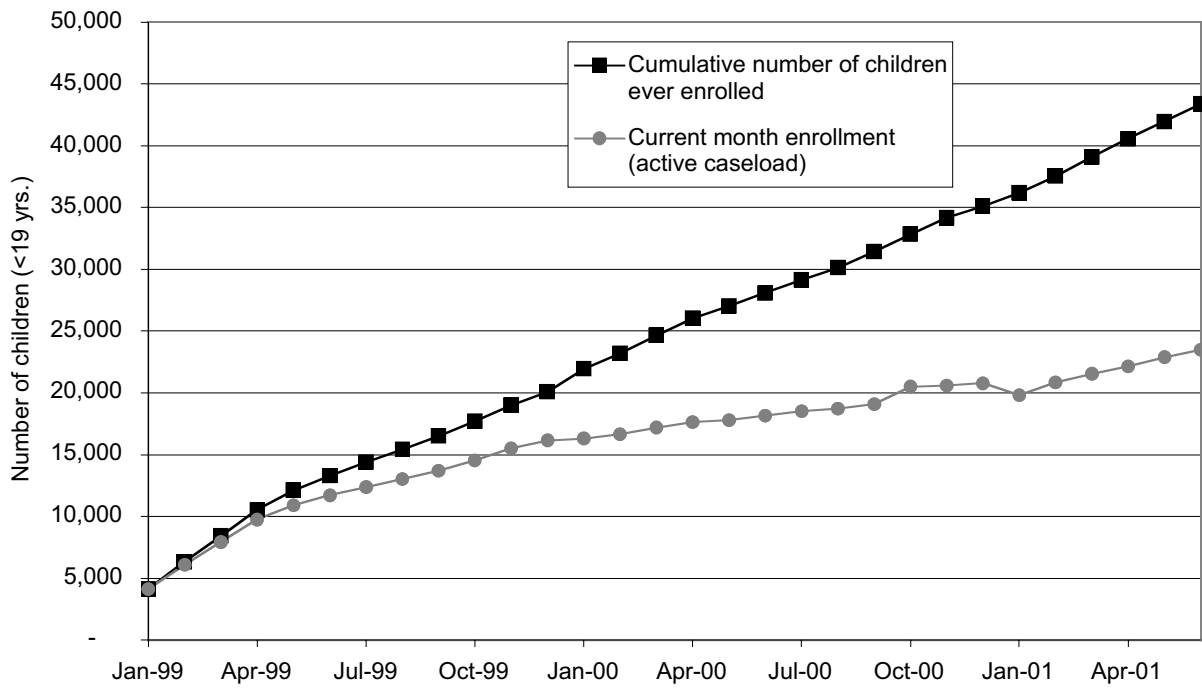


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TURNOVER

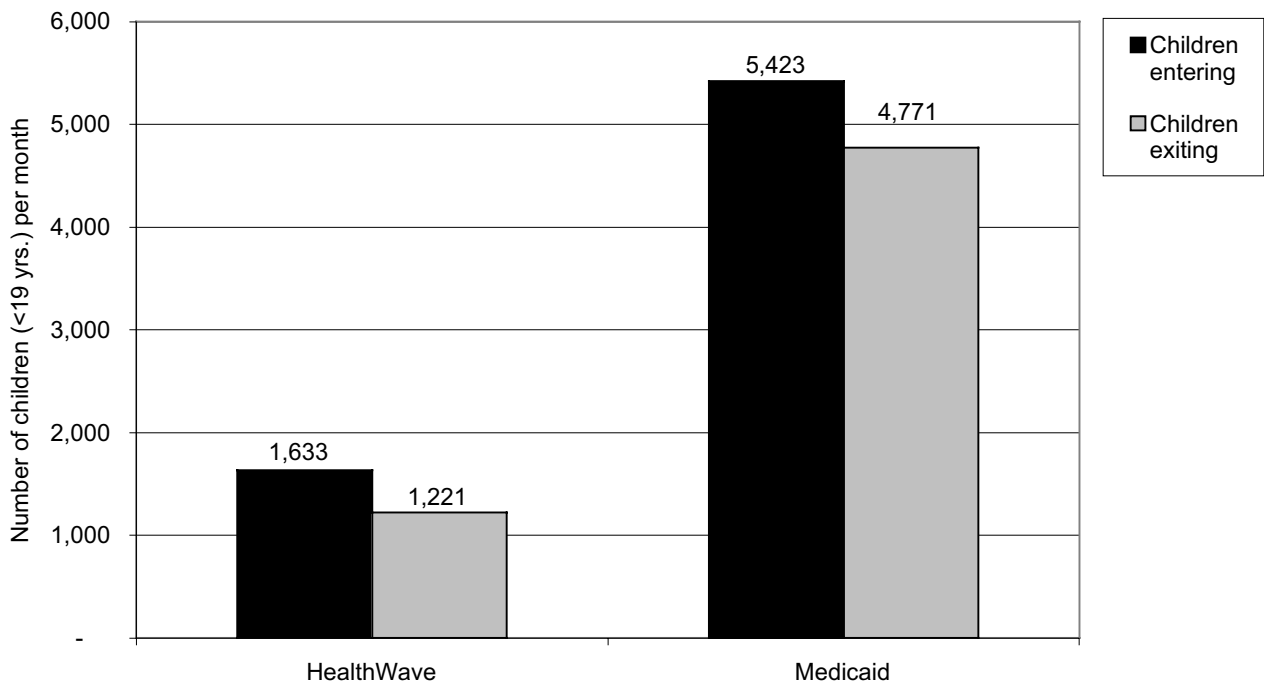
These enrollment gains mask the fact that many children have come and gone from public health insurance over the past 2 1/2 years. For example, Figure 4 illustrates the steadily increasing number of (unique) children who have been served by the HealthWave program: about 43,000 different children had been enrolled by June 2001. Due to disenrollments from the program, however, total program enrollment as of June 2001 had reached only about 23,000. Hence, by June 2001 at least 20,000 children had come and gone from the HealthWave program. Figure 5 shows the average levels of turnover in the Medicaid and HealthWave programs during 2000 and 2001: in each program the average number of children entering exceeds the average number exiting, yielding growth of a few hundred children per month despite gross entry and exit of between 1,000 and 5,000 per month.

Figure 4
Children ever- versus currently-enrolled in HealthWave



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Figure 5
Average monthly turnover in HealthWave and Medicaid, 2000-2001



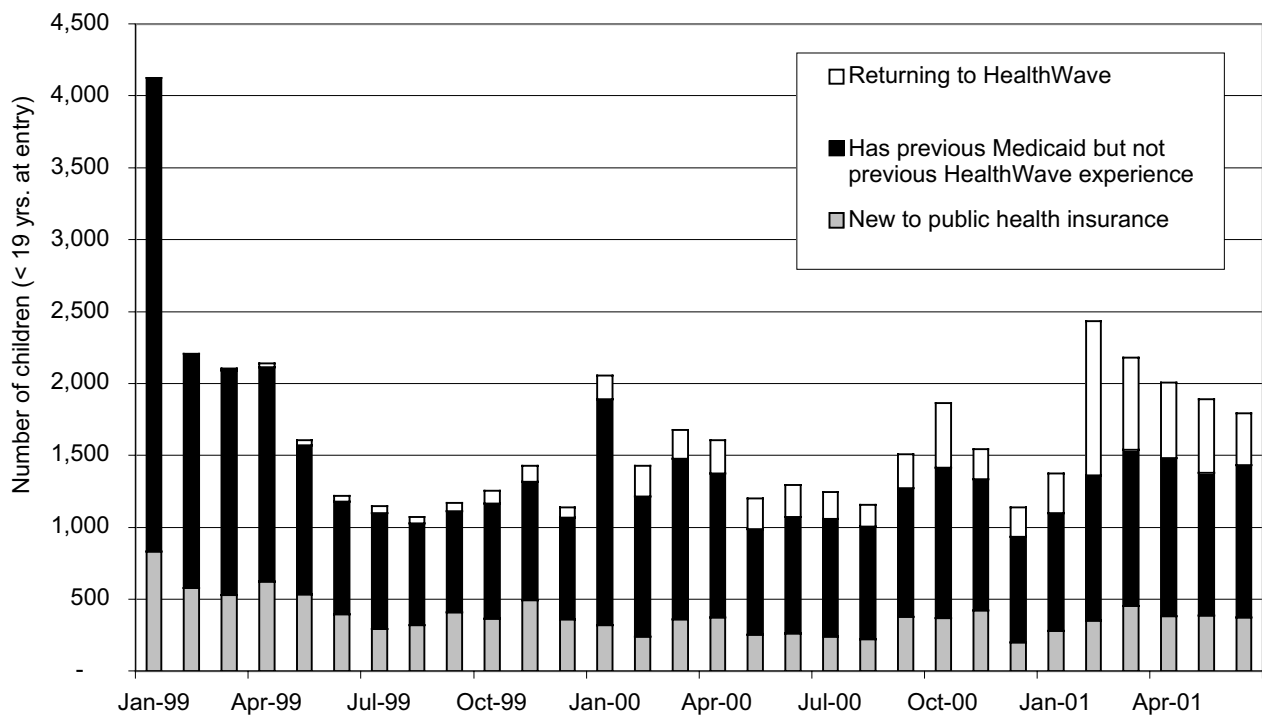
Note: Includes data for January 2000 through June 2001.

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Figures 6 and 7 provide a different look at the movement into, out of, and between HealthWave and Medicaid by showing the public health insurance background of children who enter each program. Figure 6 shows that the number of children entering HealthWave each month without any previous history in public health insurance has remained consistent since the first six months of the program. So, too, has the number of entering children who have previously been enrolled in Medicaid (but not HealthWave). However, the number of entrants who have previously been enrolled in HealthWave, i.e., churners, has grown significantly over time since the program's introduction in January 1999. A somewhat different pattern is observed in the more mature Medicaid program [Figure 7]: here the number of enrollees who are returning to the program has been relatively constant over time (except for the large number of returnees in January 2001, which corresponds to a specific group of former TAF participants whose eligibility was temporarily reinstated pending formal eligibility reviews).¹¹ The number of entrants who are new

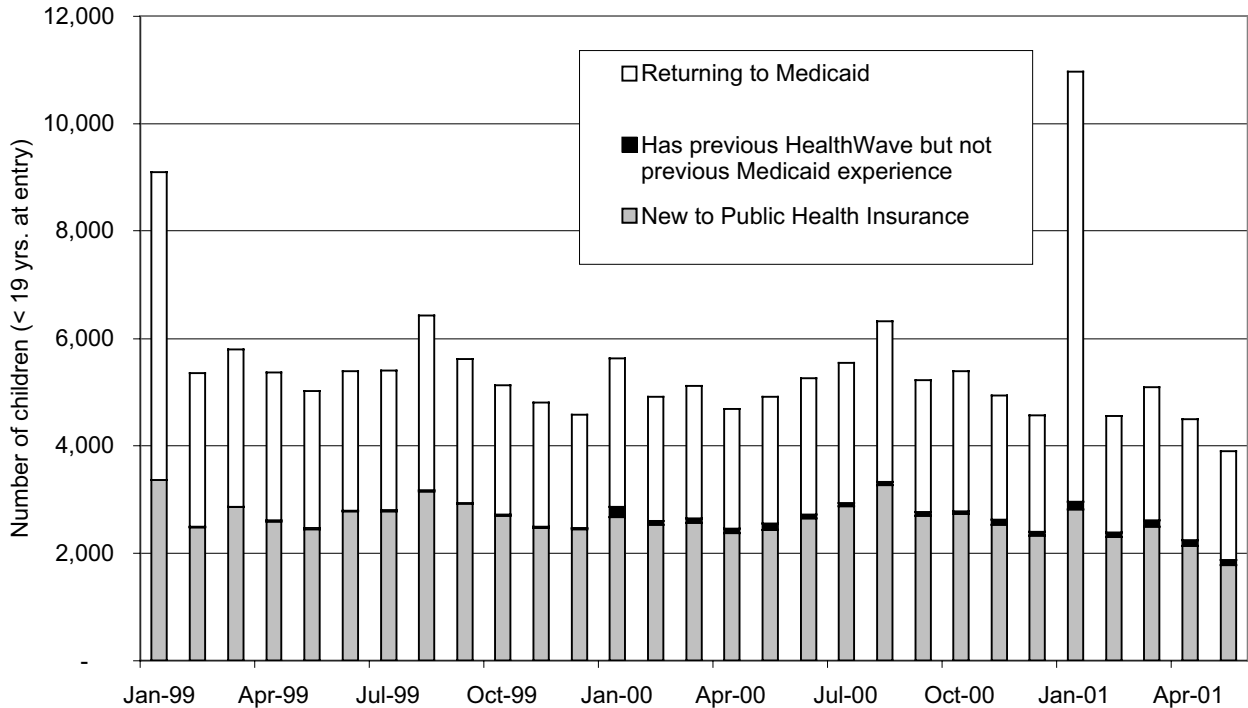
to public health insurance has remained relatively constant, and the number of entrants with previous participation in HealthWave, but not Medicaid, has remained small and relatively constant since January 2000. It is interesting to note that the large surge in enrollment in January 1999, which coincided with the introduction of HealthWave and the matriculation of one of the first groups of clearinghouse applicants, consisted of a rather normal number of enrollees without public health insurance experience, but an unusually large number of Medicaid returnees.

Figure 6
HealthWave enrollees by prior public health insurance experience



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Figure 7
Medicaid enrollees by prior public health insurance experience



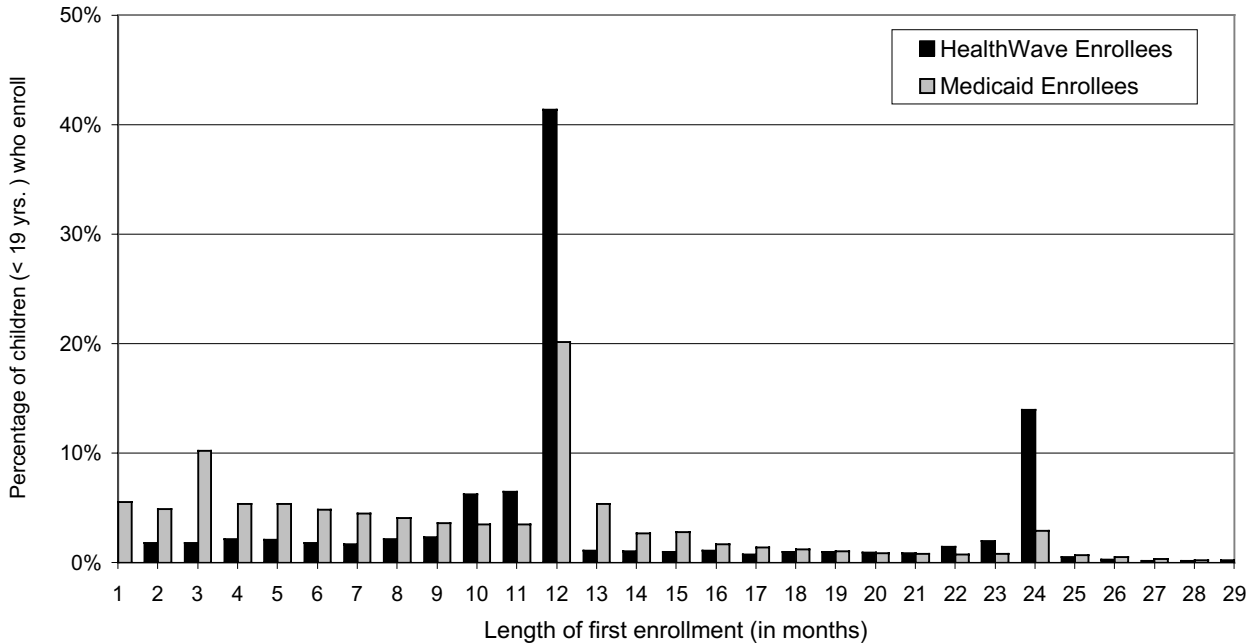
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DIENROLLMENT

How long do children remain enrolled in public health insurance? As a first step toward answering that question, Figure 8 shows the distribution of (first) enrollment lengths for children who have been observed to leave public health insurance, i.e., disenrollees. The most common length of enrollment in both programs is one year: among those who disenrolled during our study period, about 41% of new HealthWave enrollees and about 20% of new Medicaid enrollees disenrolled after exactly 12 months of coverage. Also, despite the policy of providing children with 12 continuous months of coverage in the same program, many disenrollments occur during the first year of coverage. Unlike the more detailed analysis of disenrollment discussed in Chapters Five and Seven, Figure 8 excludes children whose first enrollment extends through to the end of our study period (i.e., no disenrollment is *observed* because the enrollment doesn't end during our study period) and does not adjust for children who age out of public health insurance.

A more comprehensive methodology used in the analysis below makes these adjustments and provides a more accurate and complete picture of disenrollment. Nevertheless, the basic results will remain the same: many children leave public health insurance during their first year of coverage, and many leave after exactly one year of coverage.

Figure 8
Length of first enrollment for new enrollees



Note: Enrollments are measured according to the length of time the children remain continuously enrolled in public health insurance. Data includes only those children whose enrollments ended before June 30, 2001.

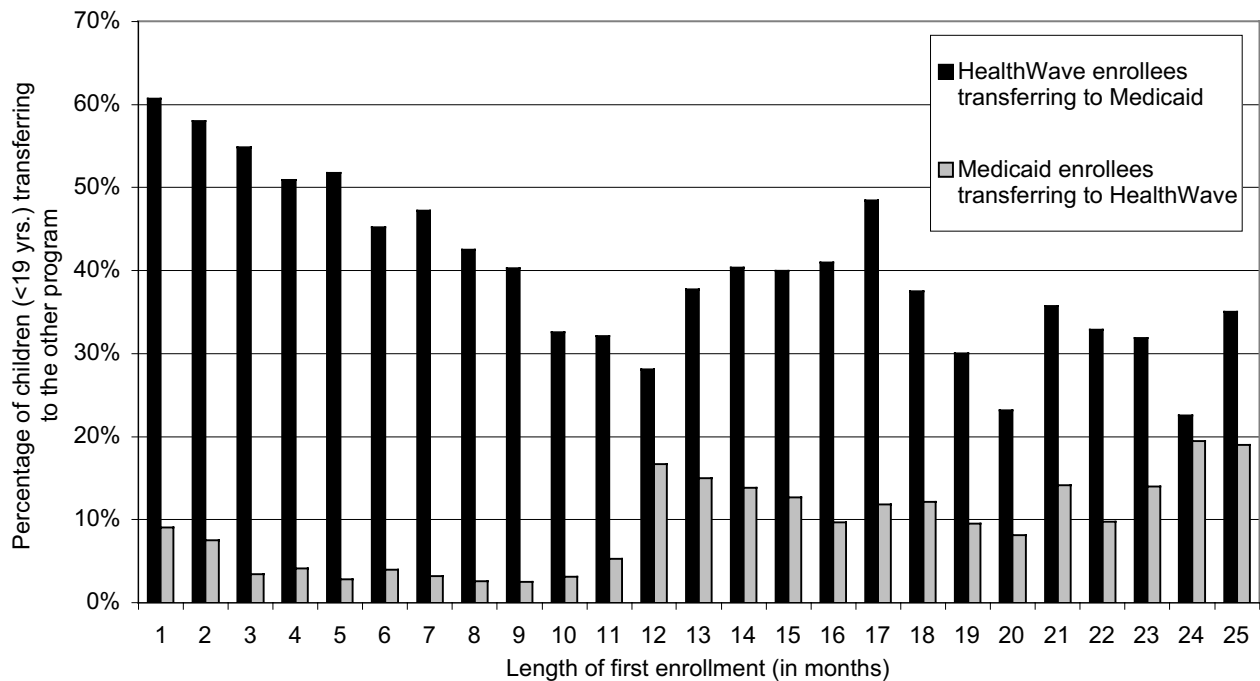
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TRANSFERS

Some of the children who leave HealthWave or Medicaid transfer directly into the other program, maintaining continuity of coverage. During the first 2 1/2 years of the HealthWave program, the period analyzed in this study, such transfers may have entailed a change in health plans, providers, and SRS points of contact for the families involved. These changes may have caused significant disruptions in access to care, causing families to expend time and energy in order to utilize public health insurance benefits following the transfer.¹² Figure 9 shows the percentage of children who leave a public health insurance program and transfer directly into the

other program. On average, 37% of children exiting HealthWave transfer directly into Medicaid (9% of Medicaid exits are transfers to HealthWave), but as the chart shows, transfers vary considerably by the length of initial program enrollment. HealthWave-to-Medicaid transfers appear to be most common during the first year of coverage and least common at the one- and two-year enrollment anniversaries, when redetermination of eligibility should take place. Curiously, these patterns appear to be reversed in the Medicaid program: Medicaid-to-HealthWave transfers generally increase with the length of initial enrollment and appear to be most prevalent at the one- and two-year anniversaries. The large number of transfers occurring at age one, when children in families between 133% and 150% of poverty are eligible to transfer from Medicaid to HealthWave [see Figure 1], helps to explain the large number of transfers at the one-year enrollment anniversary.¹³

Figure 9
Percentage of disenrollees transferring to the other program,
by length of first enrollment



Note: Includes only those children whose enrollments ended before June 30, 2001.

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CHURNING

Some children who disenroll from public health insurance will later return for a second period of coverage. The process of repeatedly coming into and out of a program is commonly referred to as “churning.” More than 19% of all the children whose first public health insurance experience (since January 1999) was in the HealthWave program are churners, i.e., they have multiple episodes of public health insurance. About half as many Medicaid children are churners (10.4%). These measures of churning are especially sensitive to the relatively short time span covered in our enrollment data set. Our data set covers only a single three-year period, so that at most only one-sixth of a person’s 18-year childhood could be captured. Some children may move into and out of public health insurance over a longer timeframe than could be reflected in the data we rely on for this analysis. For example, about a third of the births in Kansas each year are funded by Medicaid, and a great many newborns enroll in Medicaid [see Table 1]. It may be that some of the school-aged children in our dataset had an episode of Medicaid enrollment years ago when they were newborns, which is not reflected in our data and hence not included in the measures of churning calculated with that data. Moreover, some of the children in our dataset only recently enrolled and have not had as much time to churn as others. The more detailed analysis of churning in Chapter Six adjusts the results to take account of varying dates of entry into public health insurance. These adjustments result in a near doubling of the churning rate.

CHAPTER FOUR: UNDERSTANDING DISENROLLMENT

Children might leave public health insurance either during an enrollment year, i.e., during the period of continuous eligibility, or at the end of an enrollment year, when families must re-enroll. Whether a child remains enrolled in public health insurance both during the enrollment year and for subsequent years may be thought of as the result of an administrative process, family preferences, or some combination of the two. The two main types of influences on disenrollments are discussed separately below.

ADMINISTRATIVE CAUSES OF DISENROLLMENT

Despite the desire on the part of a family for their child(ren) to remain in public health insurance, and despite reasonable activity on their part to ensure continued participation, the program, through its policies or implementation, may sometimes disenroll their children from HealthWave or Medicaid. Administrative disenrollments might occur for a number of reasons:

- Children turning 19 years of age are automatically disenrolled from HealthWave even if they have not yet completed their first year of continuous coverage. Children in Medicaid may or may not be disenrolled upon turning 19.
- Children who move out of state no longer qualify for state benefits and are immediately disenrolled from coverage, even if the move occurs during the year of continuous eligibility.
- Children who move out of the home or are placed in the custody of the Kansas Juvenile Justice Authority are also immediately disenrolled from coverage.
- A child's family might experience an increase in income or another change affecting eligibility, and this change may lead to a disenrollment during the first 12 months of continuous coverage. It is the state's policy to provide children with 12 continuous months of coverage, during which time any changes in income or family characteristics are to be ignored. Changes in family characteristics that might affect a child's eligibility for public health insurance are to be acted upon only at the end of the coverage year. Nevertheless, SRS has acknowledged that "preventable administrative actions" sometimes occur which undermine the continuous coverage policy. SRS has attempted to address a specific type of administrative disenrollment that can occur during the coverage year due to the interaction of a child's enrollment in public health insurance with their own or their family's participation in other assistance programs. Because some of the other SRS assistance programs, including cash assistance and food stamps, require clients to provide SRS with a monthly report

documenting changes in family income and other information relevant to eligibility, the state's computerized multi-program public assistance eligibility system regularly receives information that *could* also be used to redetermine eligibility for health insurance.¹⁴ During HealthWave's first year, the computerized eligibility system was still programmed to redetermine Medicaid and HealthWave eligibility whenever new family information was received, even if these redeterminations preempted the 12-month continuous coverage policy. Despite attempts to correct the flaw in the computerized eligibility system, there continue to be a large number of premature disenrollments among children in both HealthWave and Medicaid. According to SRS, one explanation for the continuing problem is that some caseworkers may be manually redetermining HealthWave and Medicaid eligibility whenever new information is received from clients.

Another aspect of the administration of public health insurance programs that may affect disenrollment is the level and form of program and enrollment information provided to participating families, e.g., information describing eligibility rules and re-enrollment procedures. The sufficiency of the information provided, and the effectiveness with which that information is imparted to program participants will affect the likelihood that families will maintain their child's enrollment. Families who are aware of the 12-month period of continuous eligibility may be more likely to challenge an administrative disenrollment during that period. Families who are aware of the need to re-enroll their children annually in order to continue to receive benefits, i.e., families who receive and understand the re-enrollment materials mailed to them by SRS, are more likely to follow through with the re-enrollment process. On the other hand, families with poor knowledge of program benefits, eligibility standards, or re-enrollment requirements, are less likely to maintain their child's participation in public health insurance.

DISENROLLMENTS INFLUENCED BY FAMILY PREFERENCES

Even if a disenrollment is caused by some administrative mistake, the intensity of the family's desire to maintain their child's enrollment may well affect: a) the likelihood that the family will know that their child has been disenrolled and that there may be some question as to the validity of the disenrollment; and b) the likelihood that the family will attempt to get coverage reinstated.¹⁵ Hence, some disenrollments during the coverage year may occur at least in part because the motivation of the family to maintain their child's enrollment has fallen below some threshold. Family preferences will also affect their decision about whether to reapply for an

additional year of coverage. For some families the perceived time, financial, and psychic costs of reapplying for continued coverage at the end of the first year in public health insurance may have risen to exceed the perceived benefits of another year's worth of coverage, or benefits may have fallen below costs. Families may take a number of factors into account when choosing to maintain their child's enrollment in public health insurance. For example:

- Their child may have particular health concerns that require expensive health care and a greater level of access than would be available and affordable were the child uninsured. Such families would place a high value on the benefits of continued public health insurance coverage. Other families with healthy children who seldom need health care may place a relatively low value on the benefits of public health insurance coverage.
- The family may be particularly sensitive to the potential financial costs associated with health risks that their children face, e.g., the costs of injury that might be sustained while participating in organized sporting activities. Such families would place a high value on the financial protection associated with continued health insurance coverage for their children.
- The family may (or may not) have access to subsidized coverage through an employer, and may (or may not) have income sufficient to purchase an individual policy.
- The family may already be participating in other public assistance programs, so that reapplying for Medicaid or HealthWave coverage would take only a very modest additional effort on their behalf.
- The family may have a strong bias against participating in public assistance programs, or may feel that there is some social stigma associated with continued participation.

In short, there may be any number of personal and family characteristics as well as social or health care market considerations that a family takes into account when deciding how diligent to be, if at all, in maintaining eligibility for their children in public health insurance.

Note that a very small percentage of families actively disenroll their children from public health insurance during the period of continuous coverage, presumably for the same reasons listed above. A family's knowledge and preferences regarding the continued participation of their child(ren) in public health insurance may be especially applicable to their decisions regarding re-enrollment. Near the end of the first year of coverage, SRS is to notify a family that coverage will soon end if the family does not successfully reapply. As shown below, the end of the first

year of coverage is the most prevalent time for a child to leave public health insurance. In terms of the potential causes or correlates of a disenrollment, this analysis makes little qualitative distinction between (premature) disenrollments during the first year of coverage and an exit from public health insurance at the end of the first year, the expected time of re-enrollment. Instead, the analysis assumes that the same characteristics that might affect a child's coverage during the year, e.g., age, gender, geographic residence, date of entry, etc., might also affect the likelihood of continued coverage beyond the first year, though to potentially different degrees.

POTENTIAL CORRELATES OF DISENROLLMENT

The data set used in this analysis includes several individual, family, and programmatic characteristics that may affect continued participation in public health insurance, either because they might correspond to some administrative action associated with disenrollment, or because they might affect the family's preference to maintain public coverage, or both. Characteristics analyzed as potential correlates of disenrollment include:

Program of entry

Disenrollment patterns have been observed to differ for children enrolled in HealthWave and Medicaid (see Kansas Health Institute Issue Brief #10). Such differences could arise because of differing program characteristics and/or because the children in each program tend to have different individual or family characteristics. For example, families with children in HealthWave tend to have higher incomes than families with children in Medicaid, which may also imply greater levels of education and ability to handle the paperwork and other challenges associated with continued participation in public health insurance.¹⁶ Or, families could prefer HealthWave over Medicaid because of differences in the perceived stigma associated with participation in each program: Medicaid may, for example, be more strongly associated with welfare. These differences in each program's appeal could result in wide differences in family preferences for continued enrollment. There may also be administrative procedures affecting disenrollments that differ by program, although this analysis attempts to measure these differences directly through the type of Medicaid eligibility and the method of application. There is a practical difficulty in relating enrollment durations (or disenrollments) to the program in which a child is enrolled: the

program can change over time as the child transfers from HealthWave to Medicaid or vice versa. In particular, because this analysis does not consider a transfer to be a disenrollment, but instead measures the continuing enrollment in public health insurance, program affiliations for enrollees can fluctuate over time. As a result, this analysis distinguishes children according to the program of entry, i.e., whether they entered public health insurance as a HealthWave or a Medicaid enrollee.

Age

Health needs and expected health costs certainly differ by the age of the child. For example, the recommended number of visits to dentists and physicians differ significantly by age (e.g., children under three do not generally visit the dentist, but this is the most intensive period of preventive physical health care visits for children).

Gender

Though the predicted effect on disenrollment is unclear, it is at least conceivable that health needs might differ by gender, leading to some difference in the net benefits of enrollment for girls and boys.

County population density

The population density of the enrollee's county of residence may affect continued participation in public health insurance in a number of ways. Those in rural counties, for example, may value participation in public health insurance differently than those in urban counties. In addition, public insurance provider networks may differ by region or rurality, leading to differential levels of real benefits to public insurance for those in one type of county versus another. Also, access to free care (i.e., an alternative form of access) may be greater in urban areas, potentially reducing the perceived benefit of public insurance.

SRS administrative region

Disenrollment rates might differ across regions of the state for a number of reasons. Enrollees in one region may differ in systematic ways from enrollees in other regions, e.g., in demographic characteristics or attitudes towards public assistance, and these differences may affect

disenrollment rates. It is also possible that procedures and policies affecting enrollment and disenrollment might differ across SRS administrative regions.

Family premium level (i.e., family poverty level)

HealthWave families who pay premiums may have a greater commitment to participation in public health insurance, and may feel less stigmatized, than families who do not pay premiums. Premium payers also have higher incomes than other publicly insured children — all are above 150% of poverty — and may place a greater value on health insurance relative to other potential purchases. Families with higher incomes may also tend to have more education, and thus be better able to negotiate the administrative challenges of continued participation. On the other hand, premiums also reflect a higher direct cost to the families who must pay them, and this cost may deter families from continuing to participate in the program. Hence, the predicted effect of premiums on the behavior of families is ambiguous.

Medicaid eligibility category

We distinguish between the five major subgroups of children in the Medicaid program: those in families who receive temporary cash assistance through the Temporary Assistance to Families (TAF) program; low-income disabled children who receive cash benefits through the Supplemental Security Income (SSI) program; children eligible for medical assistance due to income alone (poverty level eligibles); children in foster care; and all other children. These categorical distinctions reflect meaningful differences in the children and their families, which are likely to affect their health needs, their experience with the public assistance system, and the likelihood that children in each group will remain enrolled in public health insurance.

Date of entry

Date of entry refers to the 6-month time span during which the child entered public health insurance. The timeframe for enrollment could affect participation in at least a couple of ways. First, families who enrolled their children during the first six months to a year of the HealthWave program (and the first six months of the clearinghouse and marketing/outreach efforts) may have had a greater desire to participate in public health insurance than families who enrolled their children later. The children enrolled from these families could be sicker, more likely to use

health services, or their families may simply have a greater sense of the need to insure their children. Such families are likely to behave differently after their children are enrolled, and may exhibit different patterns of enrollment and disenrollment. The second way in which the timeframe for enrollment might be related to participation is if SRS' administration of the programs has changed or improved over time. For example, if SRS were to successfully address problems identified in earlier analyses¹⁷ that led to premature disenrollments from the program, then children enrolling in more recent groups would be more likely to stay in the program for at least a full year of coverage. A third factor that might result in changes in disenrollment patterns over time is the economy. A worsening economy, for example, might lead families to place a higher value on public health insurance benefits.

Method of application

Method of application refers to whether families applied at the local SRS area office or mailed in an application to the clearinghouse. As discussed in Chapter Two, families who applied through the clearinghouse may differ from families who applied directly to SRS in their attitudes towards public assistance programs and the intensity of their desire to provide coverage to their children. For example, those who visit the local SRS office specifically to apply for medical benefits may have gone to the greater effort than those who mailed in an application, while others may apply for medical benefits only after visiting the SRS office to apply for other types of assistance, thereby encountering lower marginal costs of also applying for health benefits. The method of application also serves as an (imperfect) indicator of the way in which enrollments are maintained by SRS.

Several of these characteristics have an ambiguous relationship with continued enrollment in public health insurance. In most cases, this ambiguity cannot be eliminated without additional information not contained in the data sets used in this analysis. For example, individual attitudes regarding the level of stigma associated with HealthWave and Medicaid can neither be observed nor reliably inferred using the limited information available in the enrollment and application database.

METHODOLOGY

The basic analytic approach taken in this analysis is to compare how long children remain in public health insurance according to the various characteristics identified above. The method for measuring retention is the Kaplan-Meier survival curve and its associated “hazard rates.” In this analysis, a Kaplan-Meier survival curve for public health insurance represents the percentage of children who remain continuously enrolled in public health insurance one to 30 months after their initial enrollment. Hazard rates represent the month-specific probabilities of leaving public health insurance.

To compute a Kaplan-Meier survival curve, all children included in the analysis are aligned according to their first month of enrollment, their second month, their third month, and so on, regardless of the calendar month in which they first enrolled, so that all first “spells,” i.e., periods of continuous enrollment, in public health insurance are observed together. In this fashion, one can observe the percentage of all first-time enrollees that remain in the program continuously for one month, two months, six months, a year, etc., up to the maximum number of months of enrollment contained in the data. If, for example, 2.5% of children leave public health insurance after one month of enrollment, then the survival curve would display a value of 100% for month one and 97.5% for month two, since only 97.5% of enrollees remained for at least two months. In this example, the hazard rate for month one is 2.5% and equals the probability that a child disenrolls after month one *given* that the child was present in month one. If 3% of the children who remain enrolled for at least two months leave after that second month, then the hazard rate for month two is 3% and the probability of surviving from month two to month three is $1 - .03 = 97\%$. The value of the survival curve for month three would be $97.5\% * 97\% = 94.6\%$. Hence, the coordinate for the survival curve in month X represents the probability that a new enrollee will remain in the program at least until month X, and can be calculated as the product of the probabilities of surviving the hazards faced in months 1 through X-1. The Kaplan-Meier survival curves presented in this analysis were computed using the LIFETEST procedure in SAS version 8.2. Since the LIFETEST procedure does not report hazard rates, they were derived from the reported coordinates of the survival curve. All survival curves and hazard rates reported in this analysis have been adjusted (censored) to account for children who age out of the program,

since children in HealthWave (and financed under Title XXI of the Social Security Act) are by federal law automatically disenrolled upon reaching the age of 19.¹⁸ While children enrolled in Medicaid are not automatically disenrolled upon turning 19, their enrollment experiences are censored at that point because this report limits its analysis to the experiences of children.

CHAPTER FIVE: DISENROLLMENT RESULTS

Tables 3 and 4 summarize the principle results of the Kaplan-Meier analysis of disenrollment by reporting cumulative attrition, or disenrollments, at two points in time that have been selected to indicate short- and longer-term enrollments. Table 3 indicates the percentage of new HealthWave and Medicaid enrollees who do not remain enrolled for a full year of coverage, i.e., they remain enrolled for one to 11 months but disenroll before completing the full year of continuous eligibility that state policy suggests they should in most cases receive.¹⁹ We use disenrollments that occur during the first year of coverage as a measure of *attrition in the short-term* since new enrollees are to be afforded a full year of coverage as a result of their initial enrollment. Table 4 indicates the percentage of new HealthWave and Medicaid enrollees who do not begin a second year of coverage, i.e., they remain enrolled for one to 12 months but disenroll before beginning their 13th month of coverage. Children who do remain enrolled for at least thirteen months are generally presumed to have re-enrolled for a second year of coverage, an indication of longer-term affiliation with public health insurance. We thus use the percentage of children who leave before beginning a second year of coverage as a measure of *attrition in the longer-term*.

ATTRITION IN THE SHORT-TERM V. ATTRITION IN THE LONGER-TERM

Measures of attrition in both the short- and longer-term include children who leave after one to 11 months of coverage. The difference between attrition in the short- and longer-term is that attrition in the longer-term also includes those children who leave after exactly 12 months of coverage. By including children who leave after exactly 12 months of coverage, attrition in the longer-term captures exits that occur at the intended timeframe for re-enrollment. Children who remain covered for 12 months but do not show up for a 13th month of coverage are, in general, presumed to have failed to successfully re-enroll for a second year of coverage. The percentage of children who leave public health insurance after exactly 12 months of coverage is used as a crude proxy for re-enrollment rates throughout this analysis.²⁰

Table 3
Percentage of Children Who Do Not Remain Enrolled in Public Health Insurance
for a Full Year (attrition in the short-term) *

Based on Kaplan-Meier survival analysis; censored for age and end of data (n=141,541)

	Children entering through HealthWave (n=23,663)	Children entering through Medicaid (n=117,878)
Age at first observed entry into the program		
Less than 12 months	29.8	25.7
1-5 years	20.1	25.4
6-11 years	17.1	28.3
12-18 years	15.7	35.3
Gender		
Male	17.6	28.0
Female	17.6	28.3
County population density (most recent address)		
Frontier	12.9	26.4
Rural	15.3	25.4
Dense rural	18.2	28.5
Semi-urban	17.7	28.4
Urban	18.8	28.7
HealthWave monthly premium (most recent)		
\$0 per family	19.1	
\$10 per family	15.0	
\$15 per family	17.1	
Medicaid program type (most recent enrollment)		
TAF-related		26.0
SSI		17.5
Poverty level eligibles		28.0
Foster care		43.5
Other		37.5
Date of first entry in public health insurance		
January-June 1999	17.9	27.3
July-December 1999	18.6	26.6
January-June 2000	18.2	26.6

Table 3 (continued)
Percentage of Children Who Do Not Remain Enrolled in Public Health Insurance
for a Full Year (attrition in the short-term)* (n=141,541)

Method of application to public health insurance	Children entering through HealthWave (n=23,663)	Children entering through Medicaid (n=117,878)
Local SRS office	33.6	31.0
Clearinghouse	9.6	12.6
Program Total	17.7	28.2

Note: Some variables have a small number of missing observations. Percentages are calculated based on valid (non-missing) observations.

*Represents children enrolled continuously for 1-11 months. Includes only those children with an observed entry into public health insurance between January 1999 and June 2001. Children enrolled in Medicaid in both December 1998 and January 1999 are excluded.

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Note that Tables 3 and 4 distinguish between HealthWave and Medicaid enrollees but track enrollment over time according to whether children remain in public health insurance as a whole, regardless of program. Children who transfer from one program to the other are treated as if their enrollment continued. While transfers may have entailed significant barriers to access during the study period, the recent integration of HealthWave and Medicaid is intended to mitigate the effects of a switch in programmatic enrollment between title XXI to title XIX. By ignoring such programmatic transfers, the disenrollment results are intended to be most useful in the present context.

Table 4
Percentage of Children Who Do Not Begin a Second Year
of Public Health Insurance Coverage (attrition in the longer-term) *
 Based on Kaplan-Meier survival analysis; censored for age and end of data (n=141,541)

	Children entering through HealthWave (n=23,663)	Children entering through Medicaid (n=117,878)
Age at first observed entry into the program		
Less than 12 months	48.9	33.1
1-5 years	48.7	43.5
6-11 years	43.6	45.5
12-18 years	43.6	49.3
Gender		
Male	44.4	41.7
Female	45.2	42.1
County population density (most recent address)		
Frontier	42.6	40.5
Rural	42.0	40.2
Dense rural	44.5	43.1
Semi-urban	42.5	41.1
Urban	47.0	42.2
HealthWave monthly premium (most recent)		
\$0 per family	45.2	
\$10 per family	43.3	
\$15 per family	46.1	
Medicaid program type (most recent enrollment)		
TAF-related		31.3
SSI		19.1
Poverty level eligibles		45.0
Foster care		47.8
Other		42.2
Date of first entry in public health insurance		
January-June 1999	40.3	41.8
July-December 1999	51.4	42.9
January-June 2000	55.7	39.7
Method of application to public health insurance		
Local SRS office	45.7	42.7
Clearinghouse	43.9	37.0
Program Total	44.8	42.0

Table 4 (continued)
Percentage of Children Who Do Not Begin a Second Year
of Public Health Insurance Coverage (attrition in the longer-term) *

Note: Some variables have a small number of missing observations. Percentages are calculated based on valid (non-missing) observations.

*Represents children enrolled continuously for 1-12 months. Includes only those children with an observed entry into public health insurance between January 1999 and June 2001. Children enrolled in Medicaid in both December 1998 and January 1999 are excluded.

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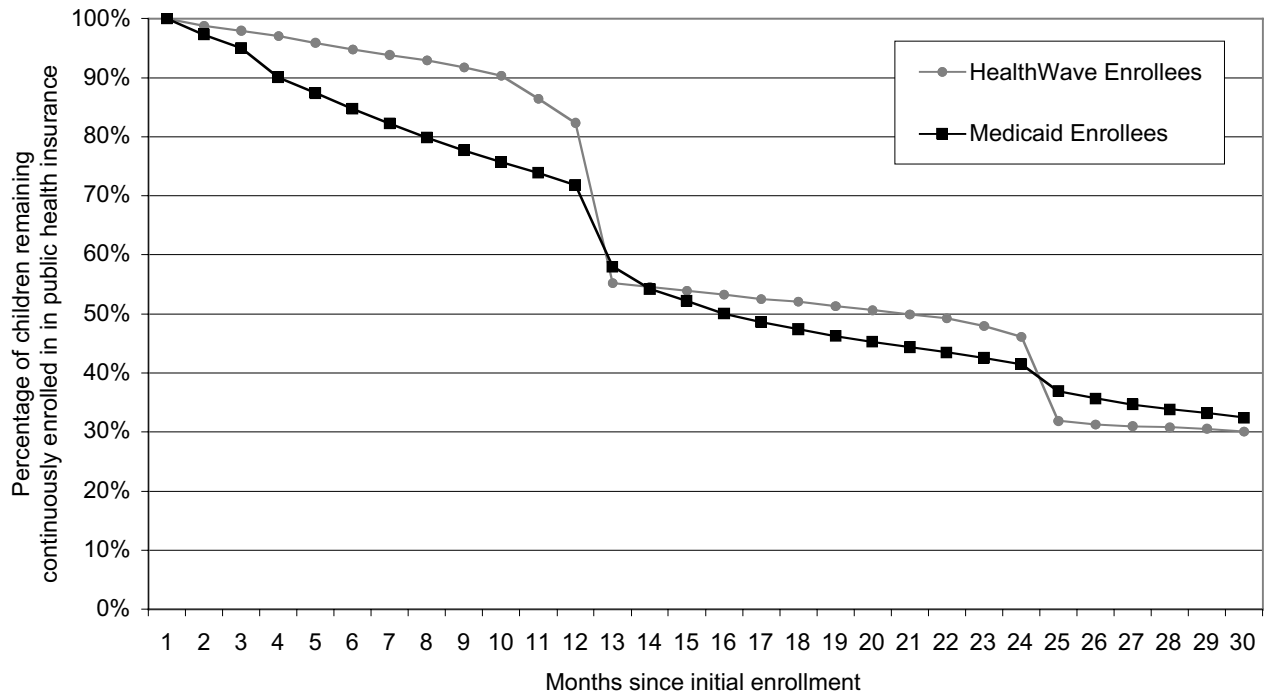
OVERALL DISENROLLMENT

The bottom rows of Tables 3 and 4 list rates of attrition in the short- and longer-term, respectively, for each program as a whole. About one in six (17.7%) HealthWave enrollees leave public health insurance during the first year of coverage, compared to more than one-quarter (28.2%) of Medicaid enrollees [Table 3]. The disparity is much lower for rates of attrition in the longer-term. A little more than two-fifths of enrollees into each program leave public health insurance before their 13th month of coverage: 44.8% for HealthWave v. 42% for Medicaid [Table 4]. The difference between rates of attrition in the short- and longer-term in each program reflects the large number (and percentage) of children who remain publicly insured for exactly 12 months, possibly because they reach but do not successfully complete the re-enrollment process.

Figure 10 displays the percentage of children entering each program who have remained continuously enrolled in public health insurance for 1-30 months. The downward slope of the curve reflects the rate at which children are exiting public health insurance each month. The curves take a sharp turn downward at 13 months, reflecting in large part the number of children who have reached the end of their first year of coverage and who do not successfully re-enroll. Retention patterns among those who remain in public health insurance longer than two years appear to differ significantly from the pattern observed during the first two years. In particular, Medicaid retention appears to exceed HealthWave retention beyond the two-year mark.²¹ There are several possible explanations for this flip in program-specific retention rates. A small proportion of Medicaid enrollees are expected to have a very long-term attachment to the program due to the presence of individual characteristics associated with long-term eligibility for

public benefits, e.g., disabled children on SSI. Given that Medicaid families are more likely to be involved in other public assistance programs, and that these programs typically require frequent visits to SRS area offices, it is also possible that that these frequent encounters somehow enhance the very long-term enrollment patterns of Medicaid children. For those families who remain eligible over the very long term, these frequent contacts with SRS personnel at the local level could contribute to longer and more continuous enrollments. Of course, frequent contacts with the public assistance system could have just the opposite effect on those families who do not remain eligible for long periods of time, since frequent contacts provide additional opportunities for changes to be made to the coverage status of enrollees.

Figure 10
Children remaining continuously enrolled in public health insurance



Note: Includes children beginning new enrollments between January 1, 1999 and June 1, 2001.

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AGE AT ENTRY

The results indicate a strong positive relationship between age and retention in HealthWave. A much higher percentage of children in the younger age groups leave public health insurance before completing their first full year of coverage [Table 3]. The differences across ages in rates of attrition in the longer-term are in the same direction, but are only about half as large [Table 4]. It is not immediately obvious why older children should remain in public health insurance for longer periods of time. Indeed, for Medicaid enrollees the results indicate just the opposite: children in the younger age groups have lower rates of attrition in both the short- and longer-term. In particular, children entering Medicaid before the age of one, many of whom are newborns, have the lowest rate of attrition in the longer-term: just 33% leave before beginning a second year of coverage. The longer-term retention advantage for newborns appears in month 13 and does not change appreciably thereafter, which may imply that the initial re-enrollment process at the end of the first year of coverage poses less of a barrier to those entering as infants.

GENDER

Rates of attrition in both the short- and longer-terms are virtually identical for males and females.

COUNTY POPULATION DENSITY

We find that rural HealthWave and Medicaid enrollees have somewhat lower rates of attrition in both the short- and longer-terms. The relationship between population density and program attrition is not perfect: enrollees from counties designated as dense rural experience higher attrition than children in the more densely populated semi-urban counties.

HEALTHWAVE PREMIUM LEVELS

Because premium payers have higher incomes but also pay a higher financial price for HealthWave, we have no clear prediction for whether they might have higher or lower levels of retention. Higher incomes may imply a potentially higher preference for health insurance, and may also signal the presence of higher levels of education that could make families better able to cope with the administrative hurdles of continuing enrollment. Higher prices, on the other hand, may dissuade premium payers from continuing their child's enrollment in HealthWave. Indeed, a

comparison of retention rates by premium level is somewhat ambiguous. Children in families paying a \$10 monthly premium have the lowest rates of attrition in both the short- and longer-term, while non-premium payers have the highest level of attrition in the short-term, and \$15 per month premium payers have the highest level of attrition in the longer-term. The different results for attrition in the short-term and longer-term could only be the result of a different pattern of exit in month 13, and thus suggest that re-enrollment rates may differ by premium category. This raises an important policy question regarding the use of premiums to help finance the HealthWave program: whether premium payers might fall behind in their payments and be dissuaded from re-enrolling for a second (or subsequent) year of coverage. The state's policy with regard to non-payment is to continue coverage during the enrollment year regardless of the status of the family's account, but to require that the family be current in their payments before re-enrolling for another year of coverage. Nevertheless, we have no data on the premium payment status of children in HealthWave, and a comparison of re-enrollment and subsequent return rates for premium payers and non-premium payers is inconclusive (see Chapter Six), so we are unable to comment about the potential effects of the non-payment policy on the re-enrollment behavior of families.

MEDICAID PROGRAM TYPE

The results in Tables 3 and 4 indicate wide differences in attrition patterns for different types of Medicaid enrollees. As one might expect given the long-term nature of many of the conditions leading to eligibility in the SSI program, attrition among this group of children is much lower than for other Medicaid children. Moreover, there is no discernable re-enrollment effect for these children: notice the relatively small difference between the attrition rates for SSI children in Tables 3 and 4, indicating that only a small percentage leave after exactly 12 months of coverage. Children whose families are enrolled in the TAF program (not all of whom actually receive cash payments) have the next lowest level of attrition: approximately one-quarter leave during the first year [Table 3], and nearly a third leave before beginning a second year of coverage [Table 4]. Children eligible by virtue of their age and their family's income are the largest group, so that their experiences differ little from Medicaid children as a whole. Also, rates of attrition in the longer-term for poverty-related eligibles is nearly identical to the overall

attrition rate for HealthWave children, whom poverty-related children most resemble. Foster children have the highest rates of attrition in the short- and longer-term, possibly reflecting the fluid nature of enrollment in foster care services. Nearly half (47.8%) of all foster children leave public health insurance before beginning a second year of coverage, with only a very modest re-enrollment effect in month 13 (note the small difference between rates of attrition in the short- and longer-term).

DATE OF ENTRY

The timeframe for enrollment is associated with very little change in rates of attrition in the short-term for HealthWave and Medicaid enrollees: enrollees during the first half of 1999 remained in the program at about the same rate as enrollees during the first half of 2000 [Table 3].²² There is also no discernable time trend in rates of attrition in the longer-term for Medicaid enrollees. For HealthWave enrollees, however, more recent enrollees have experienced significantly higher rates of attrition by the beginning of the second year [Table 4]. Because of the similarity of 12-month attrition rates for HealthWave enrollees, it appears that higher rates of attrition in the longer-term among more recent HealthWave enrollees are the result of lower re-enrollment rates (again using the disenrollment rate in month 13 — not shown — as an imperfect proxy). Re-enrollment could be lower among more recent enrollees for a number of reasons. For example, more recent enrollees could be healthier or their families otherwise less in need of public health insurance, especially when compared to the very first groups of HealthWave enrollees.

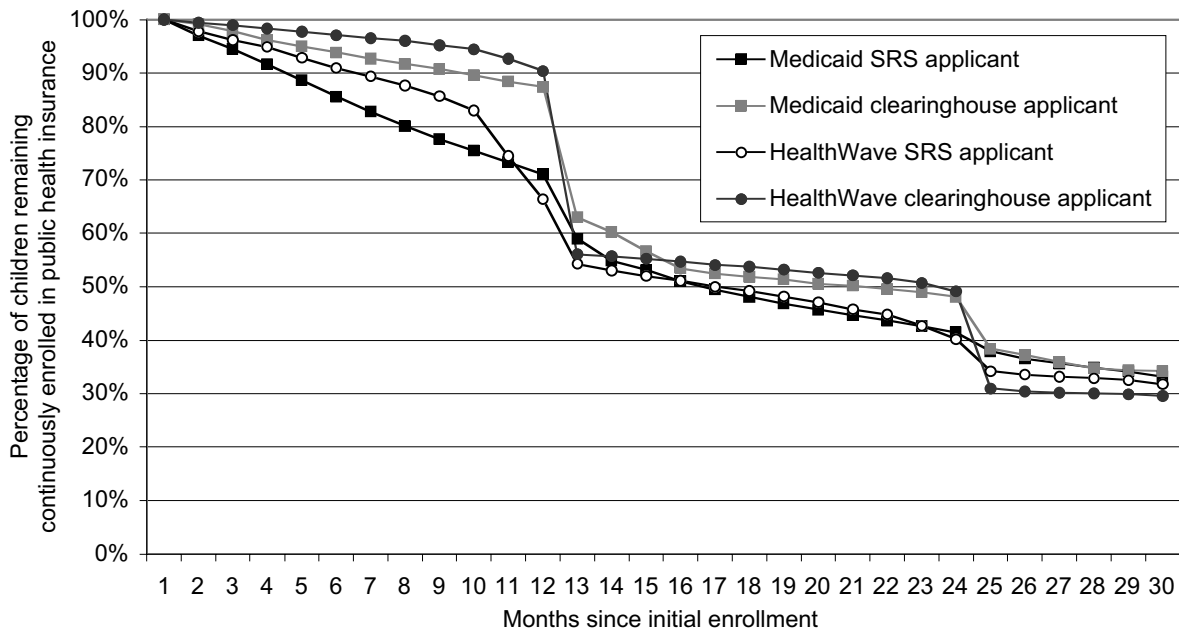
METHOD OF APPLICATION

Rates of attrition in the short-term differ substantially according to whether HealthWave and Medicaid enrollees applied to the clearinghouse or whether they applied directly to an SRS office. *Only about one-tenth of clearinghouse applicants leave the program “early,” i.e., during their first year of coverage (9.6% of HealthWave enrollees and 12.6% of Medicaid enrollees), while one-third of SRS applicants leave early (33.6% for HealthWave and 31% for Medicaid). Put another way, SRS applicants leave the program early at three times the rate of clearinghouse applicants.* Rates of attrition in the longer-term don’t vary substantially according to the method

of application for HealthWave enrollees, and vary by less than 6 percentage points for Medicaid enrollees.

There is a striking similarity in rates of attrition within each method of application and across programs. Figure 11 illustrates how the method of application appears to explain a good deal of the differences in attrition between HealthWave and Medicaid enrollees. Whether enrolling in HealthWave or Medicaid, clearinghouse applicants tend to remain in the program for a full year at a time, with exits bunched in months 13 and 25 (the months following presumed re-enrollment dates). Disenrollments among SRS applicants, on the other hand, are far less concentrated in the target re-enrollment months, and tend to occur during the enrollment year with much greater frequency than clearinghouse applicants.

Figure 11
Children remaining in public health insurance,
by entry program and type of application



Note: Month 3 hazard rate for Medicaid SRS applicants replaced with year 1 average in order to eliminate the effects of the Jan 2001 temporary TAF reinstatements.

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REGIONAL VARIATION

In addition to the characteristics listed in Tables 3 and 4, we found a great deal of variation in retention rates according to SRS region. There was at least a 50% difference across regions in the percentage of children who do not remain enrolled in public health insurance for a full year.

While this finding isn't fully understood, it merits careful consideration by administrators. A number of factors might contribute to inter-regional differences in rates of attrition. For example, how much of this variation is due to administrative differences across regions, e.g., differences in the way that administrators interpret SRS policies or differences in the administrative procedures associated with enrollment policies? In particular, are there differences in the way that the policy of providing 12 months of continuous coverage has been implemented across regions? How much of the variation is the result of differences in the types of children and families who participate in public health insurance? Certainly, there are differences across regions in the racial, ethnic, and socioeconomic distribution of enrollees, and these differences may well affect the propensity of children to remain enrolled.

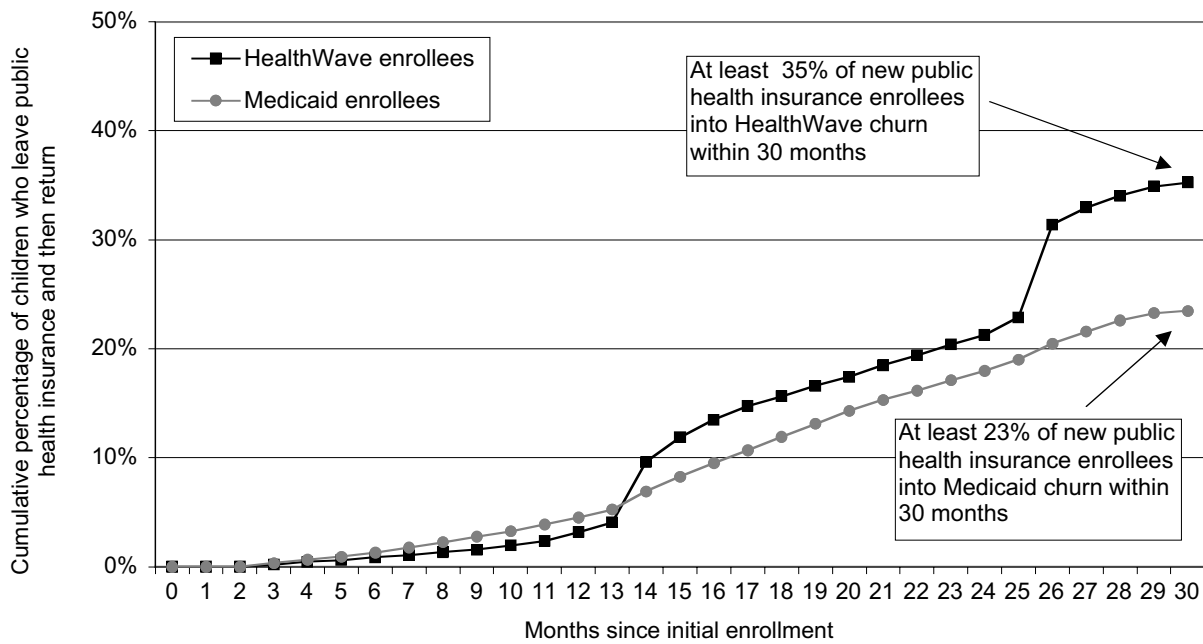
CHAPTER SIX: CHURNING RESULTS

This section summarizes an analysis of churning among children first enrolling in HealthWave and Medicaid between January 1999 and June 2001. Churning is defined as exiting public health insurance for some period of time (at least one month) and then returning for a subsequent episode of public coverage.

PREVALENCE OF CHURNING

A simple count of the number of children with multiple episodes of coverage could produce a misleading estimate of the prevalence of churning. At the end of our study period, some children in our records had only been enrolled for a short period of time, e.g., as little as one month for those who first enrolled in June 2001. Children enrolling in May and June 2001 could not have left public health insurance and returned (i.e., “churned”) during our window of observation. Many others might have been enrolled long enough to have churned, but they enrolled so recently that churning would be extremely unlikely. As a result, a reasonable estimate of, say, the likelihood that a newly enrolling child will eventually churn could be a good deal higher than would be indicated by simply computing the percentage of enrollees who have experienced at least two enrollment episodes. To correct for this undercount of churning, we employ methods similar to those used in the disenrollment analysis in the previous chapter to compute the percentage of children who churn within 1-30 months after enrolling.²³ Figure 12 shows that at least 35% of new HealthWave enrollees will churn within 30 months, compared to 23% of Medicaid children. Hence, about 50% more HealthWave enrollees than Medicaid enrollees churn within 30 months of their initial enrollment in public health insurance. Nevertheless, as with the disenrollment analysis, this look at churning does not distinguish between continuing enrollment in Medicaid or HealthWave, so that a child leaving one program directly for the other is considered to be continuously enrolled despite the transfer.

Figure 12
How many new enrollees eventually churn?
 (Represents time of first return to public health insurance)



Note: Data is age and end-of-period censored. A churning event is defined to occur upon re-entry into public health insurance after a lapse in coverage.

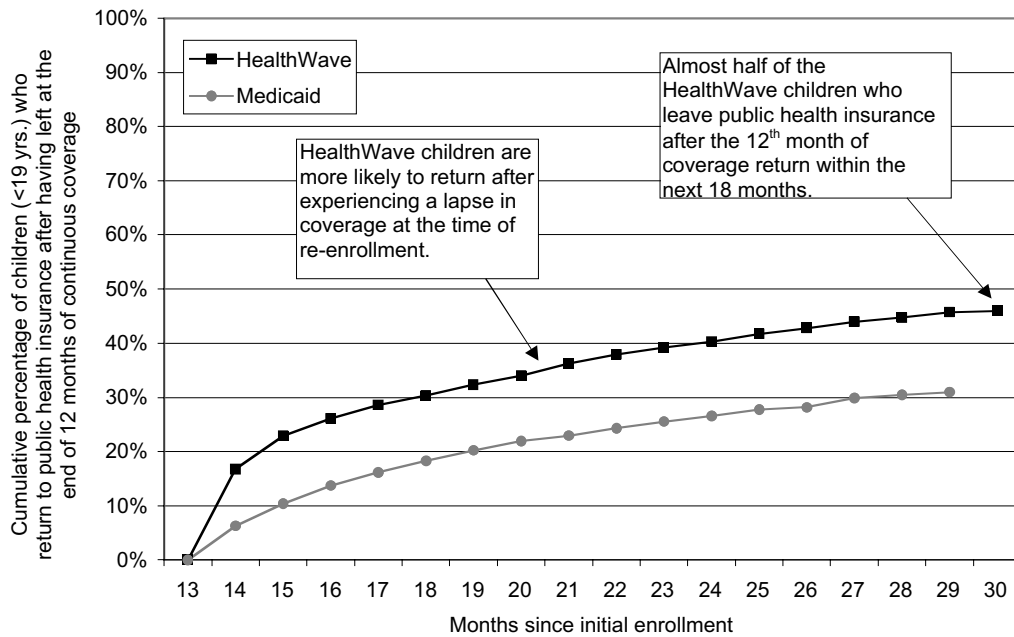
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CHURNING AT RE-ENROLLMENT

The upward slope of the curves in Figure 12 reflects the likelihood that a child will return to public health insurance (after a break in coverage) in that month. The HealthWave churning curves spike upward in months 14 and 26, and both of these spikes fall two months after the end of a period of continuous eligibility. These spikes in the curve indicate that a large number of children are *returning* to public health insurance at those times. Coupled with the fact that a large fraction of disenrollments occur after precisely 12 or 24 months of coverage (see Figure 8), this may imply that a significant percentage of churning events occur as a result of the disenrollment process. Indeed, 41.2% of all observed churning events among HealthWave enrollees follow an initial enrollment period of exactly 12 months. While re-enrollments do not always occur on an annual basis as would be expected given the 12-month continuous coverage policy, the data suggest that enrollment patterns in HealthWave generally adhere to an annual cycle, and we

proceed with this analysis of re-enrollment accordingly. Figure 13 provides a look at children who leave public health insurance after 12 months of continuous coverage, plotting the percentage who return to public health insurance 1 to 18 months later. The results indicate that nearly half (46%) of HealthWave children and nearly one-third of Medicaid children who leave public health insurance after their twelfth month of coverage (presumably due to the failure to re-enroll) return to public health insurance within the next year and a half. The probability of returning is 12 to 14% higher for initial HealthWave enrollees than for initial Medicaid enrollees, and most of this difference emerges in the first two months following the (presumed) re-enrollment period, which suggests that HealthWave’s higher churning rate may be the result of something to do with the re-enrollment process itself, rather than the result of differences in the dynamics of eligibility between the HealthWave and Medicaid populations. In particular, the brevity of these lapses in coverage (1-2 months) suggests that many of these children probably remained eligible throughout the period of disenrollment, and their subsequent return to public coverage suggests that — apart from some aspect of the re-enrollment process — they may have preferred to remain continuously enrolled.

Figure 13
How many of the HealthWave children who leave after a year of coverage later return to public health insurance?



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To provide a more in-depth look at the causes of churning, we calculate the percentage of various sub-groups of the HealthWave population who leave public health insurance after one year of coverage and then return within three months. We focus on this population because of the much higher rate of churning within HealthWave and because such a large proportion of HealthWave churning appears to be the result of the re-enrollment process. The results, which are displayed in Table 5, indicate that children who return to public health insurance after an exit at re-enrollment tend to be:

- *Older.* The older the child, the more likely it is that they will return to public health insurance soon after failing to re-enroll. Note that the children least likely to return are children enrolling as newborns (under one year of age). HealthWave newborns are also most likely to leave the program by the end of the first year of coverage [see Table 3]. Together, these results indicate that newborns are the most transient of HealthWave enrollees, leaving public health insurance after the shortest coverage episodes and returning at the lowest rate.
- *Premium payers.* Given that premium payers are not sanctioned for non-payment until re-enrollment, the finding that they are more likely than non-premium payers to return to public health insurance after a brief lapse in coverage suggests that some families may either need a break from premium payments, or may need a chance to catch up on unpaid premiums. Without data on premium payment status, however, these hypotheses cannot be tested.
- *More recent enrollees.* Children enrolling in the first half of 2000 (who remained enrolled for exactly 12 months) are more than twice as likely to return to public health insurance as children who enrolled in the first half of 1999 (and who also remained enrolled for exactly 12 months). More recent enrollees are also more likely to leave public health insurance in month 13, presumably due to the failure to re-enroll (on time). Together, these trends could signal a deterioration in the re-enrollment process that is causing delays for a greater proportion of families who wish to re-enroll. Nevertheless, the increase in delayed re-enrollments could also be the result of some unmeasured change over time in the types of individuals enrolling.
- *Clearinghouse applicants.* Children whose families applied to the clearinghouse are almost six percent more likely to return following an exit at re-enrollment than families who applied at a local SRS office. Clearinghouse applicants also are more likely to exit after exactly 12 months of coverage, at the time that the re-enrollment process should occur. Taken at face value, these patterns may indicate a problem or delay in the re-enrollment process for clearinghouse applicants. Given that clearinghouse applicants are much more likely than SRS applicants to have their enrollment case maintained at the clearinghouse, the higher rate of returns (and hence, churning) among clearinghouse applicants may suggest some differences between the re-enrollment processes at the clearinghouse and the local SRS office. For example, if families whose HealthWave case is maintained at a local SRS office are more

likely to re-enroll during a face-to-face interview than those families maintained by the clearinghouse, they may also be more likely to receive assistance in completing the re-enrollment process. However, these inferences regarding re-enrollment are based on the assumption that exit rates following the 12th month of enrollment reflect the percentage of children who do not successfully re-enroll. If the re-enrollment process does not always occur at the end of the first full year of coverage — as some of the data we have examined indicates — then exit rates following the 12th month of enrollment may be only partially the result of re-enrollment, clouding the interpretations offered above.

Table 5
HealthWave Enrollees Who Leave Public Health Insurance After One Year:
Do They Re-enroll After a One or Two Month Lapse?

January 1999-June 2001 (n=5,274)

	Number who leave after exactly 12 months of coverage*	Percentage who re- enroll in public health insurance after a one or two month lapse
Age at first entry into public health insurance		
Less than 12 months	109	12.8
1-5 years	1031	16.8
6-11 years	1881	18.0
12-18 years	2253	20.6
Gender		
Male	2704	18.9
Female	2570	18.6
County population density (most recent address)		
Frontier	295	17.3
Rural	852	19.7
Dense rural	1288	16.4
Semi-urban	685	16.6
Urban	2154	20.7
HealthWave monthly premium (most recent)		
\$0 per family	3115	14.6
\$10 per family	1430	24.0
\$15 per family	729	26.2
Date of first entry into public health insurance		
January-June 1999	3104	14.6
July-December 1999	1695	21.7
January-June 2000*	475	35.4

Table 5 continued
HealthWave Enrollees Who Leave Public Health Insurance After One Year:
Do They Re-enroll Within the Next Three Months?
 January 1999-June 2001 (n=5,274)

	Number who leave after exactly 12 months of coverage*	Percentage who re- enroll in public health insurance within the next three months
Method of application to public health insurance		
Local SRS office	4451	17.8
Clearinghouse	823	23.4
HealthWave Total	5274	18.8

Note: Some variables have a small number of missing observations. Percentages are calculated based on valid (non-missing) observations.

*Includes only those children for whom our data extends at least three months beyond their implied re-enrollment date at the end of the first year of coverage. Includes only those children with an observed entry into public health insurance between January 1999 and June 2001. Includes only those children whose first enrollment was in HealthWave. Children enrolled in Medicaid in both December 1998 and January 1999 are excluded.

CHAPTER SEVEN: DISCUSSION AND POLICY IMPLICATIONS

The state of Kansas launched the HealthWave program in January 1999 in hopes of providing coverage to tens of thousands of low-income uninsured children that federal estimates suggested were in the state at that time. The program has been successful in enrolling thousands of children. By June 2001, nearly 44,000 children had participated in HealthWave, although high levels of turnover kept caseload to about 23,000. New outreach efforts, including a joint HealthWave/Medicaid application form that parents could fill out and mail in to a central clearinghouse, supported enrollment in the new program and also contributed to a large increase in the number of children in Medicaid. Altogether, enrollment of children in public health insurance increased by about 51,000 (51%) between December 1998 and June 2001, with more than half of the increase occurring in Medicaid.

Nevertheless, earlier analyses of enrollment trends by the Kansas Health Institute indicated that many children leave the HealthWave and Medicaid programs during their first year of coverage and that a majority do not remain in HealthWave and Medicaid for longer than a year. This report builds upon these earlier findings by providing a detailed analysis of the rates and correlates of disenrollment and churning in public health insurance among children who enrolled in Kansas' HealthWave and Medicaid programs between January 1999 and June 2001. Rates of disenrollment from public health insurance were compared by characteristics available from SRS enrollment records, including the program of entry, age at first entry, gender, county population density, HealthWave premium level, Medicaid eligibility category, and date of first entry into public health insurance. These results differ from previous analyses by ignoring disenrollments from HealthWave and Medicaid that occur because a child has transferred directly into the other program. The recent integration of the HealthWave and Medicaid programs is intended to mitigate the potential ill effects that transfers from one program to the other might have had on access to care. The disenrollment and churning results in this report are presented net of program transfers in order to maximize applicability in the present (integrated) context.

In addition, this report analyzes for the first time the records of families who have mailed joint application forms to a central clearinghouse facility located in Topeka. Through June 2001, the clearinghouse had received applications resulting in an estimated 33,069 new enrollments in HealthWave or Medicaid, while the remaining 108,448 new enrollments are attributed to walk-in applications at a local SRS office [Figure 2]. Mail-in applications were found to account for 64% of new HealthWave enrollments and about 15% of new Medicaid enrollments [Table 2]. Mail-in applications were especially important for children at higher income levels, while lower income families, e.g., Medicaid recipients and, especially, recipients of cash assistance payments, were most likely to have applied at an SRS office. These results suggest that local SRS offices remain a vital point of intake for families wishing to enroll their children in public health insurance programs, especially for the lowest-income eligibles.

The results of this study of disenrollment indicate that many children leave public health insurance after brief enrollments: 18% of those entering HealthWave and 28% of those entering Medicaid leave public health insurance during their first year of coverage. Those more likely to leave early include: younger HealthWave children and older Medicaid children, those living in more densely populated counties, non-premium payers, foster children and poverty-level Medicaid eligibles, and local SRS office applicants [Table 3]. In particular, the analysis uncovered roughly a three-fold difference in disenrollment rates for local SRS applicants as compared to children whose families applied to the clearinghouse. About one-third of SRS applicants disenrolled before completing their first year of coverage, compared to about one-in-ten clearinghouse applicants. After controlling for the type of application, the differences in short-term disenrollment rates between HealthWave and Medicaid children nearly disappear [Figure 11]. The strength of the association between the type of application and the level of premature disenrollment is striking. Consider what would have happened if walk-in applicants enrolled in each program had experienced the same rate of premature disenrollment that mail-in applicants did²⁴: the total number of premature disenrollees would have been reduced by over half.

Why do walk-in applicants disenroll at three times the rate of clearinghouse applicants during the first year of coverage? Previous studies have indicated the potential role of preventable administrative actions as a cause of premature disenrollment. It turns out that there is a strong relationship between the type of application and the location and nature of case management that HealthWave and Medicaid children experience:

- most walk-in applicants during the study period were case-managed at a local SRS office,²⁵ and according to SRS policy, all HealthWave and Medicaid children case-managed at the local SRS office were in families who also participated in other programs; and
- most mail-in applicants were case-managed at the clearinghouse, and the clearinghouse was only supposed to case-manage children in families that were not also participating in other SRS programs.

The explanatory power of the type of application may thus be due to the different types of case management provided to walk-in applicants, who were usually case-managed at local SRS offices because their families participated in other assistance programs, and mail-in applicants, who were usually case-managed at the clearinghouse because their families were not involved in other assistance programs.

Of course, case management may be only one of a number of factors that contributed to the difference in disenrollment rates between walk-in and mail-in applicants. Extensive discussions with SRS personnel, however, suggest that the high rate of premature disenrollment among walk-in applicants was indeed due to case management in local offices. In particular, they point to preventable administrative actions associated with the joint administration of multiple assistance programs. An example is a local caseworker setting a child's redetermination date for public health insurance too early (i.e., before the 12-month anniversary of initial enrollment) in order to align it with the redetermination date of another SRS program that the child's family participated in.²⁶ Another example is a local case worker using information obtained from a family in the administration of another assistance program to review the child's eligibility for public health insurance even before reaching the redetermination date for public health insurance. These actions do not necessarily imply any overt desire on the part of caseworkers to undermine the 12-month continuous coverage policy. Other factors may complicate their

straightforward application of the policy. For example, when reporting requirements or periods of coverage differ across programs, local caseworkers must exert additional effort in order to adhere to each program's separate rules — up to and sometimes including the need to override (i.e., “work around”) pre-programmed elements of the state's computerized multi-program eligibility system.

This report also analyzed longer-term attrition patterns for children enrolled in public health insurance. One way to measure attrition in the longer-term is to identify children with at least thirteen months of continuous coverage, thus encompassing the first year of coverage plus one month. Continued enrollment into the thirteenth month serves as an indication that the child has re-enrolled for a second year of coverage. A little over half of the children enrolling in public health insurance remain for longer than a year (55% for HealthWave and 58% for Medicaid). Those most likely to experience longer-term enrollment in public health insurance include older HealthWave children, younger Medicaid children, SSI and TAF participants, and those enrolling early in the program. Note in particular that the mode of application, local office versus clearinghouse, was associated with only a 2-5% difference in longer-term attrition rates [Table 4]. In general, variation in rates of attrition in the longer-term were much lower than the variation observed in rates of attrition in the short-term, which implies that disenrollment rates at the end of the first year of coverage — when re-enrollment is supposed to occur — tend to be highest among groups that experience the lowest amount of early disenrollment. There is an important distinction to be made here between the presumed timing of re-enrollment and the official administrative procedures that occur at re-enrollment. Because disenrollments during the first year of coverage are sometimes associated with the premature initiation of the re-enrollment process by SRS, it could well be that the re-enrollment process causes more than just those disenrollments that occur at the end of the first year of coverage. Variation in the timing of re-enrollment could help explain why cumulative disenrollment rates for various groups of enrollees converge about 13-14 months after entry (see Figures 8 and 9). It may take until months 13 or 14 for all children to go through their first re-enrollment process, but until that time, there is a great deal of variation in the timing of re-enrollment, and this timing appears to be a function of where, and how, enrollment cases are maintained. In any event, it is clear that re-

enrollment is a critical point of risk for families who wish to retain public health insurance coverage.

These disenrollment results are suggestive of the potential benefits of the recent consolidation of HealthWave (Title XXI) and Medicaid (Title XIX) enrollment cases at the clearinghouse. Consolidation was designed in part to eliminate the premature disenrollments sometimes experienced by families enrolled in programs other than public health insurance. Preserving the role of local SRS offices in the outreach and intake process, while removing the case maintenance function to the clearinghouse, is an intuitive functional division of responsibilities. With consolidation, local offices will retain their vital role of enrolling new participants in HealthWave and Medicaid — especially the poorest eligibles — while case maintenance responsibilities will be handled primarily at the clearinghouse, which appears to have the better track record for maintaining enrollment during the 12-month period of continuous eligibility. As it implements consolidation, SRS faces the dual challenge of facilitating new enrollments while minimizing premature or unintended disenrollments. In addition to the imposing administrative challenges associated with ensuring the proper flow of enrollment and case maintenance information from the local offices to the clearinghouse (and back in some cases), SRS must successfully convey the message to local offices that they remain vital to the outreach and intake process even as case maintenance, a long-time responsibility of the local office, is being removed to the clearinghouse.

While consolidating enrollment cases at the clearinghouse has the potential to significantly increase retention rates during the period of continuous eligibility, it will do nothing to address re-enrollment rates. Indeed, measured re-enrollment rates (the percentage of children covered in month 12 who return for month 13) could go down with consolidation if case maintenance improves and re-enrollments are more uniformly concentrated at the end of the enrollment year. Even after consolidation, re-enrollment rates will remain an important policy target in any effort to improve overall retention.

An analysis of churning patterns indicates that nearly a quarter of Medicaid children and more than a third of HealthWave children entering during the study period could expect to leave and return within 30 months. A good proportion of churning appears to occur as a result of temporary disenrollments at the time of re-enrollment. This is especially true for HealthWave enrollees: nearly half of the children who leave public health insurance at the end of their first year of coverage return within the next 18 months, and many of these return after coverage lapses of just one or two months. The brevity of these lapses in coverage (1-2 months) suggests that many of these children probably remained eligible throughout the period of disenrollment, and their subsequent return to public coverage suggests that — apart from some aspect of the re-enrollment process — they may have preferred to remain continuously enrolled. The conditions for churning have changed somewhat in the months since the study period for this analysis ended. Beginning in October 2001, children re-enrolling within a month following their re-enrollment date will be retroactively enrolled back to the beginning of the second year of coverage, eliminating the 1+ month lapse in coverage they would have experienced had they re-enrolled late during our study period. Nonetheless, it is unclear whether families will behave as if they were continuously covered during this interim period, and it remains to be seen whether these temporary lapses in public coverage will result in any difficulties with access to care.

This report analyzes administrative data, and thus follows children only so long as they remain enrolled in public health insurance. The data are used to investigate potential causes and correlates of disenrollment but cannot provide an answer to one of the most important questions regarding disenrollments: how many of the children who leave public health insurance remain uninsured? The results presented above also lead to a number of questions about the re-enrollment process itself. How many of the disenrollments that occur at the time of re-enrollment are the result of burdensome administrative procedures? Which aspects of the re-enrollment process pose the greatest challenges to families attempting to re-enroll? What policy options might be available to improve re-enrollment rates? Many of these unanswered questions will be addressed in an upcoming study of non-re-enrollees by the Kansas Health Institute. As a part of its ongoing evaluation of the HealthWave program, KHI will interview the families of 600-800

children who were sent re-enrollment packets and who either failed to re-enroll or who experienced a brief disenrollment. Results are expected to be available in the fall of 2002.

ENDNOTES

¹ A continuous eligibility period is the length of time children may be enrolled before they must reapply to demonstrate their continuing eligibility. For further discussion see:

— Kansas Health Institute. (2001, March). *Children's Enrollment in Kansas Public Health Insurance Programs Since the Introduction of HealthWave* (Issue Brief No. 10).

Topeka, KS: Allison, R.A., LaClair, B.J., and St. Peter, R.F.

— Kansas Health Institute. (2001, March). *Dynamics of HealthWave and Medicaid Enrollment: Into, Out of, and Between Two State Programs* (Issue Brief No. 11). Topeka, KS: Allison, R.A., LaClair, B.J., and St. Peter, R.F.

—Allison, R.A. *Children's Enrollment in Kansas Public Health Insurance Programs After Implementing SCHIP*. Presentation at the Academy of Health Services Research and Health Policy 2001 Annual Meeting. Atlanta. June 10, 2001.

—Haber, S.G. *Does SCHIP Provide Continuity of Coverage to Low-Income Children? Lessons from Oregon*. Presentation at the Third Annual Meeting of Child Health Services Researchers. Atlanta. June 9, 2001.

—Dick, A.W., Allison, R.A., Haber, S.G., Brach, C., and Shenkman, E. (2002). Consequences of States' Policies for SCHIP Disenrollment, *Health Care Financing Review*, 23(3).

² The initial steps toward de-linkage occurred when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. With the new Temporary Assistance to Needy Families (TANF) programs, which replaced the Aid to Families with Dependent Children (AFDC) programs, PRWORA introduced time limits to the nation's principle cash assistance program for non-elderly families. Nevertheless, Medicaid benefits, which had always been tied directly to AFDC eligibility, were now tied to *historical* AFDC eligibility criteria *without* time limits.

³ After an initial screen, some applications are forwarded to local SRS area offices for an assessment of eligibility.

⁴ The groups of Medicaid and HealthWave enrollees summarized in this table are not mutually exclusive: some children were enrolled in both programs (usually not simultaneously) during the time period studied.

⁵ Not all families enrolled in these programs receive cash benefits.

⁶ Under the centralized enrollment and eligibility maintenance process instituted on July 1, 2001, this diversion of a mail-in application is far less likely to take place.

⁷ See Kansas Health Institute Issue Brief #11, March 2001.

⁸ A new enrollee is defined as a child with an entry into public health insurance on or after January 1999, excluding children enrolled in both December 1998 and January 1999.

⁹ If the same percentage of entrants in each program applied through the clearinghouse, and if all subsequent re-entries were included in the analysis, as many as 2,800 additional HealthWave entrants and 1,800 additional Medicaid entrants may have applied to the clearinghouse. This estimate is based on the analysis in Chapter Five, which shows approximately equal long-term survival for clearinghouse and SRS entrants.

¹⁰ See Kansas Health Institute Issue Briefs #10, #11 and #12.

¹¹ These families had been inappropriately disenrolled from the Medicaid program, i.e., without a review of their continuing eligibility for Medicaid, after leaving the TAF program. The vast majority of these families were disenrolled from Medicaid (for a second time) in April 2001.

¹² See Kansas Health Institute Issue Brief #11 for further discussion.

¹³ The eligibility stair-steps (see Figure 1), which occur at ages 1 and 6, do appear to have an effect on the number of Medicaid transfers. Separate analysis of transfers by age indicates that the number of Medicaid children transferring to HealthWave is highest for children who have just turned 1, with a smaller spike among children who have just turned 6. These spikes in the number of Medicaid transfers to HealthWave likely represent children in families with (relatively) stable incomes who age into HealthWave.

¹⁴ This system is known within the state as “KAECSES,” which stands for the Kansas Automated Eligibility and Child Support Enforcement System.

¹⁵ Improper disenrollments that are eventually reversed by the family may or may not be reflected in the data analyzed in this report. It is possible that after an improper disenrollment, the family might succeed in getting their child re-instated prospectively, but not retrospectively, especially if retrospective coverage is not needed by the family to cover costs incurred during the lapse in coverage. In such cases, the official enrollment records that we use will show a lapse in coverage. It is not clear how prevalent such re-instatements are, although informal discussion with program administrators suggests that they are not common.

¹⁶ The age-specific brackets for HealthWave and Medicaid overlap for families between 100 and 150% of poverty, making it possible for one family to have children of different ages in both programs simultaneously (having a child with a disability or special need might also lead to this). Earlier work by the Kansas Health Institute indicates that at least 23% of families with a child in HealthWave also have a child in Medicaid.

¹⁷ See Kansas Health Institute Issue Briefs #10 and #11.

¹⁸ The disenrollment rates are also censored to account for the fact that while our data (and all enrollment histories) ends abruptly in June 2001, many enrollments may have continued long afterward. To make the necessary adjustments, enrollment histories are removed from the calculations in the month in which their history reaches the end of the study period. For example,

if June 2001 occurs in the fourth month after a child enrolls in public health insurance, then the child's enrollment experience is used to calculate the percentage of children who disenroll in month 4, but not month 5.

¹⁹ Children not covered by Kansas' continuous coverage policy include children eligible for Medicaid by virtue of their participation in SSI or foster care.

²⁰ The percentage of children leaving public health insurance after exactly 12 months of coverage should not be viewed as a strict re-enrollment rate since it is likely that many children are asked to re-enroll at some time other than the end of their first year of coverage. Analyses using additional datasets from SRS indicate that a large fraction of children are asked to re-enroll either before or after their first year of coverage has come to an end. As a result, the percentage leaving after exactly 12 months of coverage reflects a mixture of those who have failed to complete the re-enrollment process and those who were not asked to complete the process at this time but who left public health insurance for another reason.

²¹ It is possible that the very long-term (26-30 months) retention advantage for Medicaid enrollees is understated in our data (and in Figure 10). The group of HealthWave enrollees for whom we have at least 26-30 months of data is limited to the very first group of HealthWave enrollees from the first half of 1999. As discussed below, this group exhibits significantly higher 13-month retention than more recent HealthWave enrollees. Hence, we might expect the difference in 26+ month retention to increase when comparing more recent groups of HealthWave and Medicaid enrollees.

²² Few enrollees during the second half of 2000, and none from the first half of 2001, could have experienced at least 12 (nor 13) months of coverage by June 2001, the end of our data window, and so these two cohorts of enrollees are excluded from this analysis of attrition in the short- and longer-term.

²³ Standard Kaplan-Meier survival functions were used to compute the percentage surviving without a churning event. Figure 12 displays the cumulative percentage of children who churn (leave and then return) 1-30 months after their initial enrollment, correcting (censoring) for those children who reach the age of 19 during the study period, and removing enrollment histories from the calculations when the history reaches the end of our window of observation (June 2001).

²⁴ In other words, what if all children were subject to the disenrollment rates represented by the upper lines in Figure 11?

²⁵ Additional analysis using a list of children scheduled to complete the re-enrollment process in August 2001 suggests that clearinghouse applicants are far more likely than SRS applicants to have their enrollment cases maintained by the clearinghouse (and vice-versa).

²⁶ Matching the list of children scheduled to complete the re-enrollment process in August 2001 against enrollment records indicates that children whose cases are managed by the clearinghouse are far more likely to be asked to re-enroll on the intended 12-month schedule, while children case-managed by a local office are more likely to be asked to re-enroll early.