Retaining Eligible Children and Families in Medicaid and SCHIP:

What We Know So Far

A Review of Research
Prepared for:

covering kids & families

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Introduction

Covering Kids & Families (CKF), a national program of The Robert Wood Johnson Foundation, sponsored this review of research on the issue of retention in Medicaid and the State Children's Health Insurance Program (SCHIP). This review was undertaken to help inform states, grantees and others working on retention by condensing the insights from many different studies and various experts into one document. Since this field of research is relatively new, this review represents insights into the area of retention rather than conclusions. Numerous reports were reviewed, allowing our insights to address a broad range of issues, contexts and experiences.

Lake Snell Perry & Associates (LSPA) conducted this study in March and April 2003, collecting and reviewing 51 studies and conducting 24 interviews with leading experts, authors, and Medicaid and SCHIP directors and their staffs. Most of the studies we found are very recent, with the majority having been conducted within the last two years. In fact, it became evident early on in our research that the topic of retention is still a relatively new and emerging area of study. This is not surprising given that SCHIP is still a young program. It was created in 1997, and the process for all states to establish programs and start enrolling children occurred from 1998 to 2000. However, Medicaid, which was created in 1966, is a much more established program.

This leads to another theme of our review: Most of the studies we found are about *SCHIP* retention, but not necessarily about *Medicaid* retention. Few studies focus on Medicaid specifically. This is a notable finding because in 2001, many more children were enrolled in Medicaid (22 million) than SCHIP (4.6 million).[1] Thus, in terms of sheer numbers, the potential benefits of increasing retention in Medicaid greatly outweigh the benefits of increasing retention in SCHIP. Another result of this focus on retention in SCHIP is that almost all of the research we reviewed related to retaining *children*, not retaining *adults*. There seems to be little information about retaining eligible adults.

The overall "newness" of this topic has implications for some of the findings in this document. For example, it appears that many of the studies we reviewed occurred during the same period. The authors we interviewed confirmed this point. While they tried to absorb other studies prior to conducting their own, many say there were few studies for them to consult. This leads to an important insight: Many of the studies we reviewed came to their conclusions independently of each other. For this reason, it is striking that so many of the studies draw similar

[1] The Medicaid figure comes from the Kaiser Commission on Medicaid and the Uninsured "Enrolling Uninsured Low-Income Children in Medicaid and SCHIP" Fact Sheet (May 2002). The SCHIP figure comes from Hill & Lutzky (forthcoming).

conclusions. They tend to identify the same kinds of barriers to retention and make similar recommendations for overcoming these barriers. This similarity is perhaps good news to states and others working on retention since so many of the studies offer a similar blueprint for addressing this issue.

Lastly, almost all of the studies we reviewed are state-specific. A number of them address retention issues in multiple states. For example, the National Academy of State Health Policy (NASHP) study involved seven states while the Child Health Insurance Research Initiative (CHIRI) study involved four. But just as many focused on a specific state. Because state Medicaid and SCHIP programs can be distinct in terms of eligibility requirements and rules, as well as disenrollment patterns, many of the generalizations we make in this report may not apply to all states. We designed this report to pull together many themes from disparate studies and authors and to encourage a full discussion of the various factors that play a role in retention. However, for ease of reporting, we do not specify which findings apply to which states.

Given the distinctions between state Medicaid and SCHIP programs, it is also worthwhile to note that certain retention strategies may be more appropriate in some states and localities than others, because of other Medicaid and SCHIP policies that exist in those states or because of the particular sociodemographic characteristics of the population. We also point out that states use different methods for measuring retention efforts and many also define retention differently. For these reasons, we caution the reader not to compare findings from different studies too literally. A full list of the studies we reviewed can be found in the “Sources” section at the end of this document.

In addition to reviewing studies, LSPA conducted interviews with many of the authors of these studies. See Table 1 for a list of those interviewed for this report.

Table 1: Expert Interviews

- R. Andrew Allison, Kansas Health Institute
- Cindy Brach, The Child Health Insurance Research Initiative (CHIRI)
- Marilyn Ellwood, Mathematica Policy Research Inc.
- Ingrid Aguirre Happoldt, Medi-Cal Policy Institute
- Ian Hill, Urban Institute
- Jane Humphries, Harvard University
- June Hutchison, San Bernadino Human Services System
- Penny Lane, The Center for Health Literacy and Communications Technologies, Maximus
- David Lanham, Maine Supporting Families, Department of Human Services
- Cindy Mann, Institute for Health Care Research and Policy, Georgetown University
- Sherise McDowell, Los Angeles Department of Public Services
- Gerry Polverento, Michigan Public Health Institute
- Penny Reid, Washington Health Foundation
- Donna Cohen Ross, Center on Budget and Policy Priorities
- Stephen Somers, Center for Health Care Strategies
- Kristen Testa, The Children’s Partnership

LSPA also conducted interviews with several Medicaid and SCHIP directors and their staffs. (See Table 2.)

Table 2: Interviews with Medicaid and SCHIP Directors

Jody Blalock Florida *KidCare* Outreach Director	Jackie Forba Montana CHIP Supervisor
Rose Ciarcia Connecticut *HUSKY* Program Director	Sharon Johnson Kansas *Healthwave* Title XXI Program Manager
Lisa Coss Ohio Department of Job and Family Services Program Manager	Roxanne Robles Arizona Health Care Cost Containment System (AHCCCS) Acute Care Eligibility Administrator
Lesley Cummings Managed Risk Medical Insurance Board Executive Director	Linda Schumacher *MaineCare* Health Planner

We are grateful for the insights these individuals gave to this review and to the larger project.

Contextual Note

It is important to consider the context in which this review of research on retention occurred. Currently, many states are facing budget shortfalls and are looking for ways to save money. Medicaid and SCHIP require considerable funds to administer and some states are looking for ways to reduce the costs of these programs. Some of the cost-savings ideas currently under consideration in a number of states (and already implemented in a few) go directly against the kind of policy and procedural improvements identified in this report. For example, a few states that currently have annual renewals for program beneficiaries are now considering quarterly renewal. Since much of the data shows that a substantial number of families leave SCHIP and Medicaid during the renewal process, this proposal is likely to mean that even more families will lose their health coverage and become uninsured.

The studies we reviewed for this project do not directly address this environment of budget constraints, nor do they consider how this may affect the willingness of states to take steps to retain families in Medicaid and SCHIP. This is because most of these studies were conducted in a better economic climate or before states started to actively consider "rolling back" many of the policy and process improvements they have made in recent years. However, this theme did emerge in many of the in-depth interviews.

A Note on Terms Used in This Report

Based on the research we reviewed, there are many terms used to describe families who lose SCHIP and Medicaid coverage. Some reports refer to them as "lapsed families" while others call them "disenrolled families." Other studies talk about "families who no longer have Medicaid or SCHIP" while others describe them as families who have "lost coverage" or who "leave the program," A few simply refer to "case closures" when a family fails to renew. The challenge is that some of these terms suggest that families make a deliberate decision to leave Medicaid or SCHIP, whereas in most cases it is not so clear-cut. Likewise, other terms seem to blame the program for incorrectly dropping eligible families from their rolls, which is also not always accurate. A recurring theme in the research is that loss of coverage is usually a combination of many different factors. It is impossible in most cases to pinpoint one exact cause for why some families lose coverage. However, it seems safe to say that in most cases the family as well as the program play a role. Since there is not an ideal term to describe these families, we use the term used most frequently in the studies we reviewed—*disenrolled* families.

States also use different terms to describe the renewal process required for Medicaid and SCHIP. Some states use "renewal" while others use "re-enrollment," "recertification" or "redetermination." We use the term *renewal* for this report because, once again, this term is used most frequently in the studies we reviewed.

Acknowledgements

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Strategic Summary

The Environment

A focus on enrollment, not retention: Experts believe that most of the emphasis in states has been on attracting new families to Medicaid and SCHIP and not as much on keeping them enrolled. Retention is a relatively new focus and states are still experimenting with ways to retain families.

States are concentrating their improvement efforts on the renewal process: This makes sense given that one study of SCHIP in three states found that roughly half of all enrolled families fall off the program during the renewal period. For this reason, many states are making changes to ease the renewal process. There also has been an increase in outreach and communications efforts on the grassroots level to help families successfully complete the renewal process. In addition, a number of states have improved their renewal notices, such as including a pre-addressed, postage-paid envelope, sending out reminders to families if they have not returned the forms, and other steps to inform families and help them renew.

States do not seem to be creating media campaigns about retention: Budget concerns are one reason. Some experts believe that states have much less money these days to promote Medicaid and SCHIP. Another reason is that states do not seem to know as much about what messages work for retention, although some believe the same kinds of messages that work for enrollment will also work for retention. Finally, some experts believe that statewide media campaigns may not be the best way to promote retention and instead feel that local, grassroots efforts to help families complete the renewal process can have more of an effect.

The Challenge

Difficulty understanding the scope of the challenge: While experts assert that retention in Medicaid and SCHIP is a "big problem" and that a significant number of eligible children lose coverage each year, it is difficult to grasp the extent of the challenge. Experts concur that it is nearly impossible to compare data and retention rates across states. They say that states calculate their rates differently, use different definitions of retention and case closure, and often have poor data systems that do not accurately track what happens to families. Therefore, it is difficult to understand how many eligible children lose coverage each year.

There are many reasons why retention matters: Experts assert that when children lose Medicaid or SCHIP coverage, it is likely that many become uninsured. Being uninsured means less access to health services and providers, which research shows leads to poorer health outcomes for many children. There are also financial reasons for addressing the issue of retention. Some experts argue

that continuous coverage through Medicaid or SCHIP saves money because people use fewer services over time. Others point to high administrative costs stemming from frequent enrollments and disenrollments as a result of churning – keeping families enrolled long term costs less.

Reasons Why Eligible Children Lose Coverage

Procedural reasons: These include complex renewal forms, too much documentation required, frequent renewal (i.e., quarterly, or more often, as opposed to annually), face-to-face interviews, administrative errors (i.e., the program lost the renewal form or the family never received the packet) and language barriers (i.e., Spanish-speaking Latino families receiving the renewal packet in English and not Spanish).

Financial reasons: Experts are torn about the role of cost-sharing in retention. Some argue that families find the premium payment amount to be reasonable and prefer paying for their coverage (as opposed to receiving a "hand out"). Other data show that families sometimes find it difficult to pay their premiums and so occasionally miss payments, which leads to their child's loss of coverage. In addition, some experts believe that non-payment of premiums alone cannot explain the majority of disenrollments. They believe this is a catch-all category that states use and does not accurately reflect the real cause of loss of coverage. For example, the family moved out of state and therefore stopped paying premiums. Finally, some experts say the problem is not the premium amount but rather the inflexibility of SCHIP rules when a family misses payments. They say that states often have a rigid payment schedule that does not always reflect the less predictable financial status of enrolled families.

Awareness, attitude and lifestyle issues: A number of studies find that many families are unaware that they need to renew to keep their child enrolled in Medicaid or SCHIP. In addition, many families seem unclear about income eligibility levels and may be inaccurately "self-determining" that they no longer qualify for Medicaid or SCHIP. A number of experts also talk about the fluid economic and personal lives of enrolled families and how that can make staying enrolled difficult. For example, some studies find that a common reason families lose coverage is that they forget to mail or do not get around to mailing the renewal forms or premium payments. Finally, many studies indicate that stigma is not a major issue in terms of retention. These studies show that both enrolled and disenrolled families give high ratings to both programs and the majority of families want their disenrolled children back in the programs. However, a few studies do suggest stigma may be an issue for some families (i.e., they feel negatively towards Medicaid and SCHIP because of their links to welfare and public assistance).

Systems reasons: The research suggests that problems have resulted from the delinking of Medicaid from cash assistance. A substantial number of families

incorrectly lose Medicaid when they lose their cash assistance and/or food stamps. While intended to protect families from loss of coverage, delinking procedures, education and training are not always implemented effectively.

Health status and socioeconomics: There is newer research on factors such as health status, race, gender and income with regard to retention. While most authors stress that further research is needed on these issues, they highlight possible trends about who is losing coverage. For example, some studies assert that children with more health needs and who use more health services are more likely to retain their health coverage, while healthier children who do not use many health services tend to lose coverage at higher rates. Despite the logic of these findings, there is at least one study that contradicts them. It found that disenrollees tend to have poorer health status than current enrollees. Another emerging trend is that researchers are finding some racial and ethnic groups more susceptible to loss of coverage. Three different studies we reviewed found that African-American children were more likely to lose coverage than non-Hispanic white children. One study also looked at the role of income and found that lower income families—those earning less than 133 percent of the Federal Poverty Level—are more likely to lose coverage than those with higher incomes (over 200 percent of poverty). Finally, one study found that boys were slightly more likely to retain coverage than girls.

Improvement Ideas

Simplify the renewal process: Experts recommend that states consider: annual renewal (as opposed to quarterly); reducing face-to-face interviews; allowing families to self-declare income (instead of having to provide paycheck stubs); providing pre-filled renewal forms; creating simpler renewal forms; sending self-addressed, stamped envelopes that families can use to return their renewal forms; and, in some cases, passive renewal (the process in which families must only provide information if their income or other family circumstances have changed, otherwise they are assumed still eligible). Allowing "off-cycle" renewal for families who do not have income changes to report but want to renew before their year is up for convenience has also been recommended.

Reach out to families at risk of losing coverage: Many states are already implementing a number of the following ideas: contacting families in danger of losing coverage to encourage them to complete the renewal forms; improving renewal notices so that they are clearer and will grab the families' attention; keeping addresses up to date; sending out reminder notices before renewal deadlines; providing toll-free information lines in multiple languages so that families can call with questions about renewal; and developing renewal notices in multiple languages.

Provide renewal assistance: Experts recommend that states offer the same kind of assistance that many already provide to families when they enroll in Medicaid

and SCHIP. This would involve community-based "renewal assistors" to help families complete forms and to answer questions about the renewal process. Experts also recommend engaging physicians, hospitals, employers, health clinics, schools, managed care plans and other community-based organizations in the renewal process and in providing assistance to families who might lose coverage.

Coordinate programs and databases: A number of experts believe there are many potential benefits from states improving their databases so that they can better track the movement of families between various programs. They also recommend creating database systems that will automatically allow different programs to share information about enrolled families so that household changes only need to be reported once. This may cut down on the number of renewals in which families must participate, which will lead to higher retention.

Relax premium payment rules for SCHIP: Experts believe that retention will improve if states build in more flexibility to help families who occasionally miss premium payments. Some states have already switched to an annual premium payment to address this problem, while others use automatic payment deductions and have created a universal premium amount (i.e., everyone pays $15 each month).

Measure the effectiveness of renewal strategies: Some experts believe that it is still unclear how changes such as passive renewal and self-declaration of income really affect retention.

Survey families who lose coverage: Some experts suggest that states conduct their own disenrollment surveys to better understand the reasons why families lose coverage. They point to data that shows that programs and families often give different reasons for disenrollment. Conducting these studies could help states improve their data systems and better understand reasons for disenrollment.

Encourage current enrollees to use necessary health services: A few researchers say there is a correlation between use of health services and retention in Medicaid and SCHIP. They assert that if families use necessary services, they are more likely to value the program and therefore stay enrolled.

Continue delinking Medicaid from welfare and food stamps: Some experts explain that some states still need to do a better job of ensuring that all families are offered Medicaid or SCHIP regardless of their involvement with existing programs like TANF and food stamps.

Gaps in Knowledge

Retention in Medicaid vs. SCHIP: There seems to be little research specifically on Medicaid retention. Yet there are features of Medicaid that make it distinct from SCHIP and suggest there may be unique factors involved in retention.

Adults vs. children: Since the primary focus with regard to retention has been SCHIP, which is a program for children, there has not been a focus on adult retention.

The demographics of who loses coverage: This report includes some new data about race, gender and income in terms of retention, but this is still a new topic.

Health status and retention: Although there are slightly more data on this issue, there is still not conclusive evidence that the health status of the individual matters in terms of retention.

For more details about these and other insights from our review of research, please refer to the full report of findings.

Communications Ideas

Those states currently working on retention tend to focus their communications efforts on the renewal process—trying out new formats for renewal notices and imbedding messages about the importance of renewal. Some of the ideas states are using include:

- Mailing postcards before and after the renewal packets are sent out to remind parents to complete the forms
- Redesigning the renewal notice into a checklist of items that families need to complete in order to renew instead of using dense and confusing text
- Creating two-sided renewal forms—one side in English and the other side in Spanish—to ease language barriers
- Using self-addressed, postage-paid envelopes for the return of renewal forms
- Printing renewal forms on a different color paper than other program communications (For example, "If it's blue, it is time to renew.")
- Developing a Medicaid/SCHIP newsletter to inform families of changes in the program and remind families to contact Medicaid or SCHIP if they are planning to move
- Attaching bright yellow stickers that say "Important Insurance Information" to renewal packets so that they are not thrown away
- Distributing refrigerator magnets featuring the renewal date to remind parents to renew
- Using the SCHIP logo and address on renewal packets instead of the Department of Health and Human Services to reduce stigma and to make the renewal packet more recognizable
- Creating training videos for outreach workers that include tips about renewal
- Using premium payment coupons (similar to those used for car payments) that include reminders about renewal and paying premiums on time

Detailed Findings

I. The Scope of the Challenge

One of the goals of this review is to learn the extent to which retention in Medicaid and SCHIP is a problem. The exact answer to this question is not easy to find, even after reviewing many studies and interviewing experts. Generally, the studies and the experts agree that retention is a "big problem" and there is a shared perception that a significant number of eligible children lose their Medicaid or SCHIP coverage each year. There is also some frustration because many of the causes of children losing coverage are perceived to be "fixable." However, data on the number of children losing coverage are confusing and vary greatly. We provide some examples of disenrollment numbers from states to show the wide range we encountered. Insights into the scope of this problem follow:

> "To date, there has been little large-scale quantitative research on disenrollment patterns."
>
> *Jane Miller and Julie Phillips, 2002*

Drawing state-by-state comparisons and national conclusions from state-level data about retention rates is difficult. The main challenge to understanding the scope of the problem is that states collect their data and calculate retention rates in different ways. This makes it difficult to look across states and understand what a typical retention rate is.

Experts agree that retention in Medicaid and SCHIP is a problem. Although they cite different retention figures and sources, most say that too many eligible children and adults lose their Medicaid or SCHIP coverage each year. Rosenbach et al. (2001) found that nationwide, 18 percent of children enrolled in SCHIP in 1999 were no longer enrolled by the fourth quarter of that year. More recently, figures indicate that between 10 and 40 percent of all children in a study of eight states were reportedly "lost" to the system at the year's end or at renewal, although data was not collected on whether they remained eligible (Hill and Lutzky, forthcoming). Also, Dick et al. (2002) found that more than 50 percent of enrollees in Kansas, New York and Oregon disenrolled after relatively short periods of enrollment (12 months or less) and most did not return.[2]

We also found some retention rates for children in Medicaid. These figures vary widely as well with 11 to 36 percent of children leaving the program within a year of enrollment. For example, Rosenbach et al. (2001) reveal that 11.1 percent of children in South Carolina's Medicaid program disenrolled in 1999 prior to completing one full year of enrollment. NASHP (2002) reveals that about 36

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[2] It should be noted that some states include children who have transferred to another health program in their disenrollment figures. For example, a child could be transferred to Medicaid out of SCHIP because the family income has decreased. Thus, these disenrollment figures should not be interpreted as the number of families who have lost coverage and who are now uninsured.

percent of children enrolled in Medi-Cal, California's Medicaid program, lose their coverage after a year.

II. Why Retention Matters

The studies we reviewed and the experts we interviewed offer many reasons why retaining eligible children in Medicaid and SCHIP is important. They give health-related and financial reasons for retaining children. Basically, most assert that children have greater access to quality health care and health providers when they have continuous coverage. Better access, according to these experts, leads to healthier children. The financial arguments put forth relate to the cost savings to Medicaid and SCHIP, health plans, families, and society as a whole through retention. Their main point is that retaining families costs less than re-enrolling them at a later date. Following are insights into this issue:

Health Reasons for Retention

Although many children leave Medicaid and SCHIP to pick up other insurance, some become uninsured. The studies we reviewed offered a wide range of estimates of the number of children who become uninsured after losing Medicaid or SCHIP coverage. For example, a report by the Montana Department of Health and Human Services (2001) found that 61 percent of children who left SCHIP became uninsured, while in Kentucky the percentage was 23 percent (Love et al., 2001). And in Connecticut's HUSKY Part A (Medicaid) program, the percentage of children who became uninsured was 11 percent (The Children's Health Council, 2000).

Retention is important because it reduces the number of uninsured. As one report claims, "If every person with public or private coverage at the beginning of a given year retained coverage throughout the next 12 months, the number of low-income children who are uninsured would decline by close to two-fifths over the course of a year. The number of uninsured low-income adults would decline by more than one-quarter," (Ku and Cohen Ross, 2002). According to Kenney and Haley (2001): "As findings from the 1999 National Survey of America's Families demonstrate, the number of uninsured children could be reduced perhaps by 10 percent if children who enrolled in SCHIP or Medicaid remained enrolled."

Many of the children who lose coverage may still be eligible. Many studies report that a number of the children who leave SCHIP and Medicaid are probably still eligible for coverage (Dick et al., 2002). The NASHP (2002) study found that one-third (31%) of families who lost SCHIP coverage due to non-renewal and non-payment of premiums were still eligible for the program. The majority (69%) were, in fact, ineligible because they obtained private insurance (54%), their income increased (22%), they switched to another program such as Medicaid (12%), their child aged out (7%), or for some other reason (4%). However, this study is not conclusive because it only looks at two categories of disenrollees

(non-renewals and non-payment of premiums) and because it relies on families' explanations for loss of coverage, which may be inaccurate.

When children lose coverage and become uninsured, they lose access to care, particularly to preventive services. There are many studies that describe the disadvantages of being uninsured (Miller and Phillips, 2002; Ku and Cohen Ross, 2002; Humphries, 2003; Wirthlin, 2002a). Not having insurance has been associated with poorer access to care, lower quality of care and adverse health outcomes (due to delayed care because families cannot afford to pay out of pocket). According to the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), children without insurance are four times more likely to delay seeking care than their insured counterparts (2000). Children covered by health insurance are more likely to use preventive health services than those who are uninsured. Some studies add that uninsurance results in inefficient and expensive use of emergency room or hospital care for conditions that could have been prevented had care been sought on a regular basis.

Uninsured children are more likely to lack a close doctor-patient relationship. Experts assert that consistent health coverage promotes continuous relationships between patients and their health care providers and such relationships help patients obtain primary and preventive health services on a timely basis (Ku and Cohen Ross, 2002). Children without insurance are eight times less likely to have a regular source of medical care (ACP-ASIM, 2000). Insured children are also more likely than their uninsured counterparts to have visited a physician and treated vision problems (Caring Foundation for Children, 1997). Those who remain covered by SCHIP specifically are more likely to receive coordinated, comprehensive, preventive health services (Mann 2001; Miller and Phillips, 2002; Shenkman et al., 2002c).

> "Plans and providers who rely on public insurance payments lose anticipated revenues during periods of disenrollment."
>
> *Tassi and Bachrach, 2002*

Even leaving Medicaid and SCHIP for brief periods can cause problems. When children leave SCHIP and re-enroll later, they still suffer problems in their care. As mentioned previously, relationships with providers and access to care may be interrupted, thereby reducing continuity with primary care providers and subsequent quality of care (Ku and Cohen Ross, 2002). Unmet needs have been shown to persist when coverage is transient (Rosenbach et al., 2001). If enrollees stay insured for only brief periods of time, health plans do not have the incentive to invest in preventive care. Furthermore, it is difficult to hold plans accountable for providing appropriate care and health outcomes when children are enrolled only for brief periods (Tassi and Bachrach, 2002). In addition to problems gaining access to care, gaps in coverage can also lead to problems obtaining prescriptions and paying medical bills. Gaps can also undermine the effectiveness of insurance, since gaps of two or more months can make people subject to pre-existing condition exclusions when trying to obtain private coverage (Ku and Cohen Ross, 2002).

Financial Reasons for Retention

Continuous coverage saves money for the program and families. Ku and Cohen Ross (2002) argue that longer periods of coverage may cost the programs less per month. Recent analysis of the Medical Expenditure Panel Survey (MEPS) indicates that average monthly Medicaid expenditures fall as people are enrolled for longer periods. Rather than costing twice as much to provide coverage for twice as long, as one might presume, people tend to use fewer medical resources when they are covered for a longer period. Other studies point to the administrative costs (to both states and health insurance plans) of disenrollment as being high (Tassi and Bachrach, 2002; Humphries, 2003). In addition, more frequent enrollments and disenrollments associated with "churning" have also been found to add to state administrative costs as eligibility workers must deal with more transactions (Thompson, 2003). Citing an example from California, Testa et al. (2003) explain this administrative cost-savings in more detail:

> "Cost-savings analyses are sparse and have to be done correctly to be relevant. State specific policy analyses are a good place to start."
>
> *Kristen Testa, The Children's Partnership*

> When an eligible child is mistakenly dropped from coverage, a family has to reapply to get their child's coverage back, creating additional hassles for the family and greater expense for taxpayers. It costs about $139 to enroll or re-enroll a child in Medi-Cal, while it costs about $22.50 monthly to "maintain" a case. So, for example, if a child is erroneously dropped from Medi-Cal coverage five months after enrolling, the cost of monthly maintenance and re-enrollment is $252 during that eight-month period, compared to $180 if the child had stayed enrolled continuously.

SCHIP will become costlier unless "healthier" children are retained. Dick et al. (2002) argue that if disenrollments do in fact result in "adverse selection" (sicker children remaining/healthier children leaving programs), then SCHIP programs will become costlier (on a per capita basis) to operate and participating managed care plans would then be receiving inadequate capitation payments.

Families and society as a whole benefit financially from continuous enrollment. Dick et al. (2002) point out that families are at risk for the cost of services utilized during their period of disenrollment. "Families might not even realize that they are uninsured, use services, and then be presented with a bill." According to Donna Cohen Ross, the greater problem is that a disenrolled family would be turned away by a provider when they need care. Humphries (2003) adds that society as a whole benefits because it results in "a higher level of worker production, and by saving on avoidable health care expenditures."

III. Barriers to Understanding the Challenge

A number of factors make it difficult to understand the challenge of retention. As previously mentioned, states calculate retention rates differently and tend to focus mainly on SCHIP and children, not Medicaid. However, there are other factors that make this topic challenging. First, some studies say there is an inconsistency between state data and families about why families lose coverage. Second, a number of studies assert that state databases are inadequate in terms of tracking disenrollment. Third, definitions of retention vary from state to state. Fourth, there is disagreement over which causes of disenrollment are "preventable" and which are not. Finally, "churning" related to Medicaid and SCHIP means that it is difficult to understand how many families actually lose coverage and become uninsured. These issues are explored in this section.

> "Perhaps the most basic finding is that sometimes what seems like a decision on the part of parents to let their children's enrollment lapse is often much more complicated and ambiguous."
>
> *NASHP, 2001*

There is an inconsistency between state data and families regarding why families lose coverage. State records may not accurately reflect why families lose or leave Medicaid or SCHIP. According to the NASHP study (2002), there is an inconsistency that makes it difficult to pin down actual reasons for the loss of coverage. One example: a number of parents report that they left SCHIP because they obtained health coverage through their employer, so they simply did not renew. However, the state records only indicate that the parents did not complete the renewal process. This study asserts that this inconsistency is caused by families not communicating with states about their reasons for leaving the program; they simply do not return the renewal forms or just stop paying their premiums. It should also be noted that caseworkers can be limited by state policy in their ability to record reasons for loss of coverage (i.e., they can only record what they know, which is often less precise than what they are told by families).

This gap means that states may not fully understand the reasons why families lose coverage. In the NASHP study, roughly two-thirds of the families identified in state records as "lapsed" (i.e., no longer enrolled but still eligible for the program) reported that they were in fact ineligible for the program based on existing state policies. Most of the families said they had let their coverage lapse because they had found private coverage, had an increase in household income, or were otherwise no longer qualified for SCHIP. In other words, "failed to renew," according to administrative data, does not tell the whole story about why many families are no longer enrolled in the program. Shenkman et al.'s study (2002b) of SCHIP retention in Texas echoes the NASHP findings, showing that a significant difference exists between administrative data on disenrollment and what families themselves report. In particular, they found that a major proportion of disenrolling families report that their income was too high, that their children shifted to Medicaid, or that they obtained private coverage, whereas state records only show the family failed to complete the renewal process.

Some experts suggest that computer databases used to track disenrollment patterns are inadequate, antiquated and suffer from a lack of standardization, making accurate measurement difficult if not impossible. In an eight-state survey conducted by the Urban Institute for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), Hill and Lutzky (forthcoming) looked at redetermination and renewal processes and found that varying capacities exist to report children's retention data. Specific problems encountered include: most states are only able to provide SCHIP data, not Medicaid data; all states had different data sets, categories, and/or ways of defining retention and renewal; and all states had different reporting practices, with some monitoring only renewal and not closure data. The authors conclude that "state data systems are inadequate and imperfect in their ability to precisely report on the outcomes of the [retention] process." However, this does not mean that states cannot use their own data systems to learn about disenrollment patterns in their state. It does mean, however, that it may be impossible to compare disenrollment patterns across states.

> "A major barrier is in data collection, reporting and monitoring to assess what is going on in children's health insurance programs."
>
> *Kristen Testa, The Children's Partnership*

Most states rely on automated eligibility systems to determine eligibility, which can cause problems. According to Rosenbach et al. (2001): "It is difficult to incorporate SCHIP rules when the systems are primarily designed for welfare and food stamp eligibility. A number of states felt that their systems served as a barrier to enrollment and re-enrollment (Alabama, Delaware, Kansas, Minnesota, New Hampshire, New Jersey, Ohio, Rhode Island and West Virginia)." In West Virginia, for example, the system "automatically and erroneously transfers children from SCHIP to Medicaid if something changes in the child's case." In California, Medi-Cal's data and reporting capacity is said to be particularly "sparse" because it does not collect from counties the number of children who lose Medi-Cal or the reasons for dropping coverage, while *Healthy Families* does not track renewal rates, the percentage of eligible children who remain covered after annual renewal, or when children losing coverage become uninsured (Testa et al., 2003).

Definitions of "retention" and "disenrollment" vary. In some states, disenrollment means a family dropped out of the program—period. If the family re-enrolls later, it is not counted toward retention; rather it is regarded as a new enrollment. Other states do not consider a family disenrolled if they re-enter the program within a few months of leaving it. Vicki Grant of the Southern Institute on Children and Families defines retention as "retaining any health care coverage regardless of whether it is Medicaid, SCHIP or private coverage." Using this definition, switching from SCHIP to Medicaid or to private coverage would not be considered a "retention problem;" rather it is only when a family loses coverage or has a gap in coverage and becomes uninsured that there is a problem. According to Ian Hill at the Urban Institute, inconsistent definitions provide "another good example of how definitions and data collection variations make measurement that much more challenging."

What is an ideal rate of retention? Another challenge is that there does not seem to be agreement on an ideal retention rate. According to Marilyn Ellwood of Mathematica Policy Research, the real difficulty lies in determining an "ideal rate of turnover," since a certain amount of turnover can be appropriate, and hence does not necessarily reflect a failure on the part of either program. In addition, measuring turnover is very state-specific, meaning it is dependent on state rules and regulations, such as income thresholds and the current state of the economy. Furthermore, because Medicaid and SCHIP are public health programs and because enrollees are low-income and often have no other options in terms of health coverage, the stakes are higher than they are for commercial health plans. This means that states and others working on retention tend to have a very low tolerance for any disenrollment of an eligible child from their programs.

"In addressing retention, state officials recognized that they could not easily define what an 'appropriate' or 'ideal' rate of retention for SCHIP enrollees might be."

Wooldridge et al., 2003

Appropriate vs. inappropriate disenrollment complicates measurement. According to Amy Bingham, Utah Department of Health, "SCHIP retention and disenrollment can become a complex issue, especially when you start getting into why children leave a program and defining which reasons are preventable and which are not." NASHP (2001), for example, defines "possibly preventable" reasons for losing SCHIP coverage as premium non-payment or non-completion of the renewal process. Non-preventable or "appropriate" reasons include: children who aged out, children who move out of state, an increase in family income so that they are no longer eligible, a switch to the Medicaid program, or obtaining other insurance. But NASHP also admits that "the line between preventable and non-preventable reasons for disenrollment is often hazy." Wooldridge et al. (2003) also attempt to distinguish what is appropriate versus inappropriate in terms of reasons for disenrollment. They argue that "some attrition in the program is appropriate, as families obtain private coverage through new jobs, lose jobs (and income) and become Medicaid eligible, move out of state, or their children reach age 19. However, some causes of disenrollment, according to these authors, are inappropriate. These include "administratively complex redetermination procedures and parental confusion regarding the steps they must take to retain their children's coverage in SCHIP and/or Medicaid."

"Churning" (leaving the program and re-enrolling later) also poses challenges to measurement. The issue of churning has always had a negative association with retention rates, first with only Medicaid, now with SCHIP as well (CHIRI, 2002; Testa et al, 2003; NASHP, 2002; Dick et al., 2002; Rosenbach et al., 2001; Humphries, 2003). Some studies that have looked at this issue show that a certain percentage of families who lose coverage return to the program within a twelve-month period, while others go to a different program (i.e., from SCHIP to Medicaid or vice versa). According to Humphries (2003), "In September of 2000, about 50 percent of Medicaid closures [in Washington State] were due to failure to renew. Half of which returned to the program within eight months, suggesting children were still eligible at the time of disenrollment and thus making churning a great concern." The CHIRI study (2001) suggests that "movement among insurers is the norm in the American insurance market, and children in SCHIP appear to be

as mobile as their private sector counterparts." Furthermore, according to Kansas Health Institute economist and CHIRI co-author R. Andrew Allison, "The findings suggest the potential benefits of increased coordination between SCHIP and Medicaid, both in terms of making it easy to transfer between the programs and structuring their delivery systems to maximize continuity of care."

IV. Why Eligible Children Lose Coverage

The focus of most of the studies we reviewed is on identifying reasons why eligible children lose their SCHIP coverage. Perhaps the most important part of our review, this section explores in detail the reasons that experts give for the loss of SCHIP, and to a lesser extent, Medicaid coverage.

To a striking degree, the studies we reviewed and experts we interviewed agree on the main reasons for loss of coverage. They tend to focus on "preventable" reasons for loss of coverage that states could "fix," such as easing the renewal process or raising awareness among parents about the need to renew. Most studies do not address state policy reasons for disenrollment—such as age and income limits—in any depth. Our review follows suit and addresses only preventable reasons for disenrollment. Most of these reasons can be grouped into the following categories:

- Procedural reasons (problems associated with the renewal process)
- Financial reasons (cost-sharing in SCHIP)
- Awareness, attitudes and lifestyle reasons (such as parents being unaware that they needed to renew)
- Systems reasons (the delinking of Medicaid from other public programs)

> "The degree to which renewal, or redetermination, processes are client-friendly can powerfully affect participation rates in Medicaid and CHIP."
>
> *Thompson, 2003*

There are also other reasons given for disenrollment that are subtler and have been studied less. These include socioeconomic factors, interaction with the health system, health status, and the role of case-workers. We include a discussion of these factors at the end of this section.

A. Procedural Reasons

Most studies cite problems with the renewal process as a leading cause for disenrollment. For example, the CHIRI study (2002) reported that large drops in enrollment occurred at the time of renewal—up to 50 percent in Kansas, New York and Oregon (three of the four states in their sample). Wooldridge et al. (2003) assert that children lose coverage during this period because they do not complete the renewal process. Experts are quick to point out that while almost all states' enrollment processes for Medicaid and SCHIP have undergone some degree of overhaul and have been simplified, their *renewal* processes have not yet received the same degree of attention. As Cohen Ross and Cox (2002) assert, "Many of the same measures to streamline the initial enrollment process should be applied to the re-enrollment process to ensure that eligible children retain their coverage if appropriate." There are many aspects of the renewal process that studies say are difficult for families. These include the following:

- **Complex renewal forms:** Some states use lengthy, cumbersome, legalistic renewal forms. This can pose problems for families not familiar with the requirements for public programs or who have limited literacy skills (NASHP,

2002). Also, in many cases, while parents were given assistance to complete the initial application forms, they may not be receiving the same level of assistance with renewal forms. The Managed Risk Medical Insurance Board (MRMIB, 2001), the organization that administers California's SCHIP program, reports that most families (73%) need assistance in completing renewal forms.

- **Too much documentation required:** Experts say that income verification often requires income tax returns and pay stubs, which some families have difficulty supplying given fluctuating employment patterns. Furthermore, families are often required to resubmit as well as update documentation used in the original application process (Rosenbach et al., 2001; National Health Policy Forum, 1999).

- **Annual vs. more frequent renewal:** Studies suggest that more frequent renewal requirements, such as quarterly or every six months, lead to higher disenrollment levels.

> "There is strong anecdotal evidence that administrative actions may be a major cause of premature disenrollment during the first year of coverage, but previous studies have not been able to quantify the potential contributions of this or any other specific factor."
>
> *R. Andrew Allison, 2002*

- **Active vs. passive re-enrollment:** The CHIRI study (2002) found that passive re-enrollment, (i.e., requiring families to provide information and documentation *only* if their income or other conditions have changed since their enrollment) sharply reduces disenrollment.

- **Face-to-face interviews:** In some states, families must still submit to face-to-face interviews to renew, which can pose a logistical challenge, especially for lower-income working parents who often lack transportation and in some cases translation assistance. For example, families receiving both *BadgerCare* and food stamps in Wisconsin must complete an in-person food stamp redetermination interview every six months (Dick et al., 2002). Notably, all states continue to require interviews for food stamp renewal.

- **Administrative errors related to renewal:** Families report submitting completed renewal forms but having them lost by the program. Others say they never received a renewal package at all or received a renewal package in the wrong language (NASHP, 2002; Dick et al., 2002).

- **Language barriers:** In addition to the points above, NASHP (2001) reports that Spanish-speaking Latinos in California face language problems. Although the renewal forms are in Spanish, the level of Spanish is hard for them to comprehend.

B. Financial Reasons

Experts have differing opinions about the effect of cost-sharing. Many believe it is a reason for disenrollment while others assert that families prefer to pay for their coverage. Many authors put forth conflicting opinions about whether cost-sharing, specifically premium payment, helps or hinders retention. The amount of attention paid to this cost-sharing aspect and its impact on SCHIP retention is second only to the amount of attention researchers pay to the renewal process.

On the one hand, many studies show that parents find the monthly premiums "reasonable" and do not regard them as barriers to enrollment or renewal. Parents "appreciate" that SCHIP offers coverage at a "reasonable" or "fair" price, one they say is generally "affordable" (NASHP, 2002; Shenkman et al., 2002a and 2002d). The NASHP (2002) study reported that most lapsed families who paid a higher premium agree that the amount is "about right"—especially when compared with the cost of alternative private-sector options (Wooldridge et al., 2003). Studies also point out the psychological appeal of cost-sharing: paying a premium makes some families feel like they are getting "a better product;" that they are paying their own way and not "leeching" off the system; and that it buys them "peace of mind." In addition, studies concur that cost-sharing may reduce the stigma attached to public health insurance. According to Gibb et al. (2002), "Premium payments make *BadgerCare* more like private insurance and therefore may reduce the political and social stigma sometimes associated with public programs." Rather than reduce the use of services, a few studies report that cost-sharing encourages appropriate use of services (Wooldridge). Dick et al. (2002) found that in both Kansas and New York, children in families that paid premiums were substantially more likely to re-enroll after a brief disenrollment than those in families that did not pay premiums.

"I feel this premium is very reasonable. I love *RIte Care* and paying the premium makes me feel less like I am getting a free ride." In 2002, 82 percent paid their premium.

Focus Group participant, RIte Care 2002/2003

However, studies are equally as likely to argue that premiums result in higher disenrollment rates. Studies report that with economic volatility and instability common among SCHIP families, many experience occasional trouble making premium payments. Due to income fluctuations and the need to pay other bills that they perceive as more pressing, many families miss premium payments and as a result, lose coverage (NASHP, 2002; Bluestone et al., 2000). Research also shows that higher premiums depress participation rates in public insurance programs for low-income individuals and that non-payment of premiums is one of the leading causes of disenrollment in SCHIP (Ku and Cohen Ross, 2002). Some state-specific examples follow:

- Although the authors admit that more empirical research is required, they say that payment of premium was the leading cause of disenrollment in North Carolina, and that mailing the monthly premium check was reported to be "too time-consuming and costly" for both the state and for families in New Jersey (Rosenbach et al., 2001). Premium payment is also said to be a common

reason children lose coverage in California (Testa et al., 2003; Ku and Cohen Ross, 2002). Monthly premiums also limit retention in Oregon's Medicaid expansion program, the Oregon Health Plan (Ku and Cohen Ross, 2002).

- Notably, Dick et al. (2002) assert that the impact of cost-sharing varies from state to state. Data from New York indicates that children from families that paid premiums were more likely to disenroll from SCHIP (after the presumptive eligibility period), while the opposite was true in Kansas. The authors attribute this to differences in those states' policies. For example, New York disenrolls children for non-payment of premiums after a 30-day grace period, while Kansas disenrolls children for non-payment of premiums only at recertification.

- Meanwhile, the Florida Healthy Kids Program recently reduced its family premium amount to $15 (regardless of number of children). While the authors expected families to be henceforth less likely to disenroll, they admit the impact on children's disenrollment was modest, although significant (Shenkman et al., 2002d). It is worth noting, however, that the pre-SCHIP Healthy Kids Program subjected enrollees to significantly higher premiums, which were found to be barriers to enrollment and retention and subsequently dropped.

A note on measuring premium effects:

Our ability to measure the impact of premiums on SCHIP enrollment is limited by the fact that premium payment and income are closely related, making it impossible to distinguish premium effects from income effects. For example, children in higher income families (who are subject to premiums) may be more likely to have an increase in income that makes them ineligible for SCHIP or to gain private insurance; and as previously described, lower income families in Kansas (those that do not pay premiums) are more likely to be administratively disenrolled. We, therefore, do not have evidence as to whether premium requirements do or do not increase disenrollment from SCHIP. Future CHIRI studies using survey data will be able to shed some light on the impact premiums have on enrollment and disenrollment decisions.

Dick et al., 2002.

Most experts concur that while premiums may be occasionally burdensome to pay, they cannot solely account for why children are disenrolled or fail to renew. In other words, "non-payment of premium" should not be taken to mean that families "cannot afford the premium" without further investigation because there are many other reasons payments are not made or arrive late. According to

the Urban Institute's Ian Hill, "Denial of eligibility for 'failure to pay premiums' may or may not address whether SCHIP cost-sharing is affordable … it could actually reflect a number of possible outcomes—that families move out of state, and as a result, stopped paying their premiums; that families received insurance from their employers; that families were unsatisfied with their SCHIP experience; or … deemed [it] unaffordable." Another study asserts that the lack of experience on the part of caseworkers and administrative errors collecting fees may also be to blame (Rosenbach et al., 2001). In addition, Testa et al. (2003) found the following factors at play with regard to non-submittal of premiums among California's *Healthy Families* disenrollees: some families are not aware of easier methods of making payments, some do not understand or never received a billing statement, or, in a significant number of cases, the program had lost their payments.

More than the premium amount itself, some studies point to the inflexibility of the payment schedule and other payment rules that make it logistically challenging for families to make regular payments. Some programs offer little leniency when it comes to missed payments. Ku and Cohen Ross (2002) say that "lock-out" periods increase gaps in coverage because many of these families do not understand lock-out rules or fail to realize their children can be barred from coverage for an extended period because they miss a few payments. Moreover, non-payment of premiums is a more common problem in Medicaid and SCHIP than in employer-sponsored insurance or Medicare because Medicaid and SCHIP have no mechanism to make automatic deductions for premiums from payroll or Social Security checks. Therefore, beneficiaries might forget or be unable to make the payment each month, increasing the risk of losing coverage (McLaughlin and Crowe, forthcoming). Wooldridge et al. (2003) report that families' main problems with premiums are logistical in nature. They report having had a hard time remembering to pay their premiums every month.

C. Awareness, Attitudes and Lifestyle

"Half the families whose child's coverage had lapsed reported that they had not been told or did not recall being told that they would have to renew their child's coverage to stay in SCHIP."

NASHP, 2002

This category looks at retention from the parents' point of view and includes many significant reasons cited in numerous studies why eligible families lose Medicaid or SCHIP coverage. Many of these reasons have to do with a lack of awareness on the part of enrolled families about the rules of Medicaid and SCHIP. For example, many families are unaware that they need to renew regularly to stay enrolled; are unsure about income eligibility levels and may incorrectly assume they no longer qualify; or do not know that their premium payment amount is adjustable and can be decreased. Other reasons have to do with the busy and fluctuating lives of families enrolled in Medicaid and SCHIP, which can make it hard to maintain enrollment. There are reasons relating to perceptions of health insurance and the priority that families attach to keeping their children enrolled. And there are also reasons that have to do with the "stigma" of being enrolled in a public health program and how that affects the willingness of families to keep their children

enrolled. Finally, there are attitudes about the programs that affect retention. These issues are explored below.

Lack of Awareness

Many families are unaware that they need to renew regularly to stay enrolled. Many studies assert that a lack of awareness plays into why so many families fail to renew (NASHP, 2002; Ku and Cohen Ross, 2002; Humphries, 2003; Testa et al., 2003; Children's Health Council, 2000; Hill and Lutzky, forthcoming). According to Ku and Cohen Ross (2002), states do not generally provide renewal information on the initial application or in other promotional materials about their programs, although this strategy is being considered by some. In addition, a number of studies say that states do not always effectively inform families when it is time to renew. According to Testa et al., (2003), "Some children lose coverage because families did not receive, or understand, the [renewal] notices." In the NASHP (2001) focus groups, many parents admit they may have thrown out their renewal notices because they receive so much information from SCHIP they assumed it was not important.

Many families are unaware of income eligibility levels for Medicaid and SCHIP and so may be incorrectly assuming they no longer qualify if their incomes increase. Many studies say that self-determination is a major barrier to renewal (Love et al, 2001; NASHP, 2002; Testa et al., 2003; Humphries, 2003). Specifically, some families "self-determine" that their income is too high to continue to qualify for Medicaid or SCHIP, even though they do not know for sure what the income eligibility level is and are not contacting the programs to find out. This lack of information about income eligibility levels is a problem for many families enrolled in these programs. Data shows that these families often experience fluctuations in income, which makes them vulnerable to incorrect self-determinations.

Many families are unaware that their premium amount is adjustable. The NASHP (2002) study found that few enrolled families knew that their premium amount was adjustable and could be lowered if the family's income decreases. Without this knowledge, some families may drop coverage because they perceive the premium amount has become too burdensome.

Lifestyle Issues

"Life circumstances and attitudes" are an important factor in retention. Some experts assert that families enrolled in Medicaid and SCHIP lead especially busy and less than predictable lives. They cite "personal volatility" in addition to "economic volatility." They assert that these families tend to move in and out of employment at a higher rate than other families, which results in "failure to pay premium" and/or failure to renew (Rosenbach et al., 2001; NASHP, 2002; Bluestone et al., 2000; Hill and Lutzky, forthcoming). Their fluid lives mean that

complying with Medicaid and SCHIP rules can be more difficult. For example, in recent focus groups, many parents said they meant to return their renewal forms but became too busy or forgot to send the forms in by the deadline (Rosenbach et al., 2001). The primary reason that disenrolled parents in both Texas and states in the NASHP study give for not completing the renewal process was that they "forgot" or "did not get around to doing it" (Shenkman et al., 2002b; NASHP, 2002).

The Value of Health Coverage

There is debate over whether families "value" health coverage enough to sustain their child's enrollment. Some research asserts that many people do not see the value or benefits of having health insurance coverage. According to a 1999 National Survey of America's Families (NSAF), 22 percent of low-income uninsured children's parents said they did not enroll their children in Medicaid or SCHIP because it was not needed or wanted. This study asserts that many families are used to paying for health care services when they need or use them, not pre-paying into an insurance pool to cover services they may not even use (Wirthlin, 2002a). However, other studies disagree and argue that enrolled and disenrolled families equally feel that health coverage is important for their children. Bluestone et al. (2002) found that all respondents (100%) in every sampling group reported that health insurance for their children was "absolutely essential." In addition, one study found that obtaining health coverage for their children was the primary reason families enrolled in SCHIP in the first place (Wirthlin, 2002a). Also, NASHP (2002) and many other studies we reviewed showed that the majority of families disenrolled from SCHIP want to re-enroll, showing these families value having health coverage.

Stigma

Many studies suggest that "stigma" does not play a major role in retention. Much of the research suggests that stigma—that is, the negative association of being enrolled in a public health program for low-income families—is not a significant issue in terms of retention. Research indicates that SCHIP is a highly valued program and that the overwhelming majority of families who lose coverage want to re-enroll. For example, Wooldridge et al. (2003) found positive attitudes about both programs among enrollees. Dubay et al. (2002) found that 88 percent of parents of low-income, uninsured children who have been enrolled in Medicaid in the past have positive views about enrolling their children again. Also, a recent survey of HUSKY Part A disenrollees in Connecticut confirms that stigma was not a factor in disenrollment (Children's Health Council, 2000).

However, a few studies do show that some enrollees attach a certain stigma to SCHIP, linking it with welfare or Medicaid, according to a study by Rosenbach et al. (2001). Stigma may be more of an issue with Medicaid. While most studies find that enrollees report high satisfaction with Medicaid, a few studies assert that

negative attitudes are *slightly* more likely to be reported about Medicaid than SCHIP (Bluestone et al., 2000; Rosenbach et al., 2001).

Perceptions of the Programs

Most studies agree that there is high satisfaction with Medicaid and SCHIP. Most studies (Testa et al., 2003; Humphries, 2003; Shenkman, 2002d; Children's Health Council, 2000; NASHP, 2002) agree that satisfaction with SCHIP is quite high, with most participants stating that they wanted to remain enrolled, or to re-enroll if they had been dropped from the program. NASHP (2002) found that 83 percent of parents of enrolled children say SCHIP is an "excellent" or "very good" program, while 63 percent of parents of children no longer enrolled say it is an "excellent" or "very good" program. Parents report high levels of satisfaction with most aspects of the programs, including benefits, providers and services. Medicaid also receives high satisfaction rates. In a study for the Kaiser Commission on Medicaid and the Uninsured, Perry and Kannel (2000) report that 94 percent of current Medicaid enrollees rate the program as "good." These high satisfaction rates suggest that perceptions of the program do not lead to disenrollment. However, it should be noted that many studies do identify the enrollment process (i.e., complex application forms, too much documentation required, poor treatment by eligibility workers, etc.) as a reason why some families choose not to enroll their children in Medicaid.

D. Systems Reasons

There is evidence that some states have yet to work out the problems stemming from delinking Medicaid from public assistance programs. Some studies assert that eligible children may be wrongly losing Medicaid coverage when their parents lose public assistance. Some experts believe that an effective delinking of the welfare, Medicaid and food stamp procedures has not been a priority for states (NHPF, 1999). According to Mann (2001), "Nationwide, hundreds of thousands of individuals have lost Medicaid eligibility as a consequence of welfare reform." According to Gresenz et al. (2002), 51 percent of children lose Medi-Cal coverage each year after leaving cash aid.

E. Health Status, Socioeconomics and Third Parties

Although few in number, we found studies that address health and socioeconomic factors that may influence retention in Medicaid and SCHIP. This is clearly an emerging area of study in which much of the data is not yet conclusive, and sometimes contradictory, about the role these factors play in retention. These factors include the health status of children, and specifically, if healthier children are more likely to leave the programs than children who have greater health needs. Closely-related is the issue of utilization of health services while enrolled—that is,

the degree to which children who use more health services are more likely to stay enrolled than those children who do not use health services.

There are also a few new studies that examine the role of gender, race and income in retention. These studies seem to suggest that certain racial groups are more likely to become disenrolled, namely African-Americans, and that lower income families are also more likely to lose coverage than those over 200 percent of the Federal Poverty Level. There also are some initial findings that boys are more likely to retain coverage than girls. However, most authors working on these issues assert that more research is needed on these factors.

Finally, there are some interesting insights about the role of third parties, such as health plans and employers, in helping families stay enrolled, although there is still not much data on these topics. In addition, there are a few findings about the role of caseworkers in retention, but once again, this comes from one or two studies and is a topic that needs more exploration.

Health Status

There is disagreement about the role of health status in retention. Many experts believe that families with more health needs would be more likely to retain their Medicaid and SCHIP coverage because they see a greater *value* in keeping their child enrolled. According to this logic, families with healthier children would see less value in staying enrolled because they would be using services less. Not all studies we reviewed found this to be true, however. The NASHP (2002) study, for example, did *not* find that currently enrolled children had greater health needs than those who had lost coverage. Indeed, that study found that parents of disenrolled children were more likely to report their child to be in poorer health than those still enrolled. However, the authors of this study believe the data are too vague to draw firm conclusions on this issue.

Other studies do support the experts' logic, though. Shenkman et al.'s, (2002a, 2002b, and 2002c) studies in Florida, New Hampshire and Texas indicate that children with physical special health care needs are less likely to disenroll than other children. In fact, in Texas, children with physical special health care needs were 20 percent less likely to disenroll than their healthy counterparts, and children with mental health care needs were 30 percent less likely to disenroll. Shenkman et al. admit that further study is warranted in terms of children's health status as a factor for enrollment, disenrollment and re-enrollment.

Similarly, experts agree there are not yet enough data to show a correlation between use of health services and staying enrolled—although it looks likely. On a related point, some surveys show that children who use more health services are more likely to keep their SCHIP coverage (Shenkman, 2002c). In Florida, children were slightly more likely to stay covered under the *KidCare* program longer when the program encouraged parents to seek preventive care, compared to

when the program did not promote preventive care (Shenkman, 2002c). Testa et al. (2003) report: "Families may be more likely to jump through the programs' hurdles and renew their children's coverage if they have benefited from the insurance coverage by receiving care. Children who remain insured are more likely, albeit slightly, to have received care compared to children who lost coverage." However, the authors admit that this correlation is based largely on anecdotal evidence and concur that further research is needed. Currently, there is not much in the way of in-depth research on the correlation between using services and the likelihood of keeping coverage.

Race, Gender and Income

Although race in regards to retention is a new area of research, some studies are beginning to find that African-American children are more likely to lose coverage. Miller and Phillips (2002) suggest that "family characteristics, SCHIP program attributes, and sociodemographic factors all play a role in explaining variation in rates of SCHIP program retention." Their study of disenrollment from New Jersey *KidCare* found that disenrollment was higher among African-American families and those with only one child enrolled in *KidCare*. Wooldridge et al. (2003) also examined the role of race in their Louisiana study and found that African-American children are less likely to remain enrolled in *LaCHIP* than Hispanic or non-Hispanic white children, even after controlling for income. The authors go on to suggest that, "These findings suggest that re-enrollment and retention policies might need to be targeted to specific groups of children. For instance, state efforts to follow up children who do not return their [renewal] forms may need to take into account language and other cultural differences across racial and ethnic groups." Finally, the NASHP (2002) study found that both African-American and Hispanic families had generally higher disenrollment rates than non-Hispanic whites, although these findings varied by state.

> "Little is known about the family, programmatic or contextual factors that are associated with high program retention. Most studies do not examine variation across demographic or geographic subgroups, or across different plan designs… Few studies examine disenrollment for reasons other than non-renewal."
>
> *Miller and Phillips, 2002*

Initial studies suggest that income, age and gender may play a role too. Shenkman et al. (2002a, 2002b and 2002c) have done the most extensive work on socioeconomic variables in retention to date. Their Florida study (2002c) reported that lower-income (below 133% of the Federal Poverty Level versus those between 185 and 200%) families were more likely to lose *KidCare* coverage. In Texas, several socioeconomic variables were "significantly related to the odds of a child disenrolling from SCHIP for any reason, including age (older children were less likely to disenroll), gender (boys were slightly less likely than girls to disenroll) and race (non-Hispanic black families were more likely to disenroll) (2002b). Similar patterns were related to *non-renewal* as well.

Third Parties

Many experts believe third parties—community-based organizations, counties, employers, schools, health plans and providers—play a key role in retention. Testa et al. (2003) discuss "the vital role of partners" and how

California relies heavily on counties, community groups, schools and health plans to enroll and maintain children in Medi-Cal and *Healthy Families*. Humphries (2003) argues for expanding the involvement of health providers in the renewal process: "Washington [state] already has a strong coalition of workers from different backgrounds working to improve retention, but campaigns encouraging providers to support Medicaid renewals would be worth while." Ellwood (1999) talks about the important role of most welfare staff in educating families about Medicaid. Ku and Cohen Ross (2002) suggest that firms employing low-wage workers could make it easier for their employees and their dependents to join or stay on Medicaid or SCHIP. For example, employers could keep application materials in their personnel offices or help employees collect pay stubs if income verification is required.

Caseworkers may play an important role in retaining families, but little research has been done with this vital group. According to NASHP (2001) the role of caseworkers in retention is "vital." Focus group participants said, "Those who are helpful, polite and knowledgeable can substantially facilitate retention," [while] "those who are insensitive, ill-informed or disrespectful [can make retention difficult]." A particular complaint of parents in these focus groups was with caseworkers' lack of knowledge about SCHIP. Many report being given incorrect information. A focus group study reviewed for this project (IHPS, 2001) found that some caseworkers make extra efforts to reach out to families who fail to renew and who are in danger of losing their coverage. Indeed, this study revealed that taking extra steps to keep a child enrolled—such as keeping their file open longer before closing it, making phone calls to the family, helping them complete the renewal forms and gather the needed information—was often an individual decision of the caseworker and not required by the program. This insight suggests that the personal commitment of the caseworker to retention may affect retention rates.

V. Ideas for Improvement

Most studies we reviewed include a section with ideas for improving retention in Medicaid and SCHIP. Once again, there is much agreement among experts about the kinds of changes they recommend. Much of the focus is on making the renewal process easier for families, and experts offer many changes that could ease the process. There are also many ideas that have to do with reaching out to families in danger of losing coverage as well as suggestions about using third parties to assist with renewals. Many experts suggest improving and standardizing data exchange and data systems so that families can move seamlessly between programs and plans without fear of being dropped from one program or another. Some also recommend that premium payment rules be relaxed to assist families who occasionally cannot pay their premiums. Finally, there are some specific ideas that are found in a few studies about improving retention. Although the data are sparse, we include information about successful implementation of improvement ideas where possible. It should be noted that this section does not address communications ideas for improving retention other than brief references. (Communications is the focus of the following section.)

A. Simplifying the Renewal Process

Many studies and experts believe that the renewal process itself is a barrier to retention. Research shows that the renewal process and paperwork requirements are burdensome for many families. Data shows that roughly half of all enrolled families drop off the program during the renewal period (Dick et al., 2002). Their improvement ideas for making the renewal process easier include:

> "Our results clearly show that there is a strong and large association between disenrollment and recertification. At each recertification in the three States that did not have passive re-enrollment, approximately one-half of those enrolled at the time dropped out of SCHIP."
>
> *Dick et al., 2002*

- **Passive renewal:** Many experts believe that passive renewal decreases disenrollment. Passive renewal is the process in which families must only provide information if their income or other family circumstances have changed, otherwise they are assumed still eligible. Florida's system of passive renewal receives a great deal of attention in the literature, most likely because it has been successful in lowering disenrollment rates (Rosenbach et al., 2001; Dick et al., 2002; Shenkman et al., 2002d).

- **Annual renewal:** Research suggests that quarterly renewal or renewal every six months will lead to higher disenrollment rates. Experts say the fewer times families must complete forms the better for retention (CHIRI, 2002).

- **Limit face-to-face interviews:** Data shows that families find in-person interviews to be burdensome and can cause logistical problems since they may require time off from work, babysitters, etc. Forty-eight states for children and 35 states for parents now use mail-in forms in order to limit face-to-face interviews (Cohen Ross and Cox, 2002). However, when adults are enrolled in

the same program as children, which can occur with Medicaid, many states still require face-to-face interviews for the entire family.

- **Self-declaration of income:** Many families complain that providing pay stubs can be difficult due to inconsistent and fluid employment. Some families do not even receive pay stubs from their jobs. When Michigan allowed families to self-declare their income rather than provide extensive paper documentation, caseworker productivity increased by 25 percent (Holmes, 2001).

> "States processes for conducting SCHIP eligibility redetermination have not undergone the same level of reform in the interest of simplification as have initial enrollment processes …much less attention appears to have been paid, to date, to exploring strategies for simplifying or streamlining the SCHIP redetermination process…"
>
> *Hill and Lutzky, Forthcoming*

- **Pre-filled renewal forms:** Some states have renewal forms already completed with the previous year's information inserted. Families only need to add information if there have been changes in their incomes or other circumstances.

- **Shorter, simpler renewal forms:** Experts say that many states have long and complicated renewal forms. Those states that have streamlined the forms seem to believe it has added to higher return rates.

- **Self-addressed, stamped envelopes:** This removes one more barrier for parents to return their completed renewal forms.

- **Multiple sites collecting renewal forms:** This would allow families to submit renewal forms at a number of locations to add to the convenience of completing the renewal process.

- **"Express renewal":** Currently in use in Massachusetts, this process allows some families to renew their eligibility "off-cycle" when they visit a community clinic, provider's office or other community location before the renewal date if they have no change in income to report. According to Humphries (2003), express renewal has proven "successful as 42 percent of requests led to extension of the members' eligibility."

> ***Washington is taking many steps to improve the renewal process…***
>
> Washington state has implemented a number of measures to ease the renewal process such as automatic Medicaid renewal through the food stamps program – i.e., that is when information used to enroll in one state program is considered sufficient for another. They have also done the following: passed 12-month continuous eligibility; printed translated applications in over six languages (most states only provide Spanish and English); allowed self-declaration of income since 1998; created mail-in renewal forms and enabled enrollees to renew over the telephone; and printed the Healthy Kids Now logo on the eligibility review form to promote parent recognition of the Medicaid and SCHIP programs.
>
> ***Jane Humphries, 2003***

B. Outreach

Many experts and studies recommend that states reach out more effectively to families in danger of disenrollment and offer personal assistance to help them through the renewal process. Their ideas include:

- **Contact families due for renewal:** New York City's recent "Medicaid Recertification Assistance Demonstration Project" proved that contacting beneficiaries two months before their renewal date can retain more families. The project hired and trained 23 people to call and send letters to families, resulting in a significant drop in disenrollment rates (Tassi and Bachrach, 2002).

- **Follow up with families who have not returned their renewal forms:** Some states follow up with families when they fail to return their renewal forms to try and encourage them to return the forms and offer assistance if they are having problems.

- **Improve communication notices reminding families it is time to renew:** Most experts and studies agree that making notices clearer and more noticeable (so that families do not throw them away) could positively help retention. The next section has more information about communications notices.

- **Keep addresses up-to-date:** Many states report that they have a large number of renewal notices returned because of incorrect addresses. This means that families are not aware that it is time to renew and so may be losing coverage. Part of the problem is that annual renewal has meant that Medicaid and SCHIP do not have the regular contact with families that they used to have with more frequent renewal.

- **Increase reminder letters prior to renewal deadline:** Some experts believe that families need to see multiple notices to ensure they understand it is time to renew.

- **Provide toll-free information lines in appropriate languages:** Some families who do not speak English will resist calling toll-free numbers and seeking assistance because they think they must speak English, or perhaps Spanish, to obtain help. However, California, for example, has addressed this by offering toll-free assistance through 11 different language lines.

- **Provide renewal reminders in multiple languages:** Similarly, experts assert that renewal notices need to be in appropriate languages.

Retention Efforts in Medicaid:
San Bernardino and Los Angeles Counties, California

At the county level, both San Bernardino and Los Angeles are currently conducting efforts to retain both children and adults in Medi-Cal (California's Medicaid program). Part of The Robert Wood Johnson Foundation's "Supporting Families After Welfare Reform" project, these efforts are described briefly below.

Los Angeles County:

- The county created a **participant glossary** as part of its application and information packets that identifies words beneficiaries find hard to understand and provides simpler definitions. This has been translated into seven languages.

- Due to high employee turnover in county offices and because of frequent changes to program regulations, Los Angeles County created a **verification guide** to assist eligibility workers in determining when verification is required.

- The county assembled various **telephone transcripts** based on the most common reasons individuals request case closures. Retention workers are charged with educating these individuals and convincing them to remain enrolled in Medi-Cal.

San Bernardino County:

- San Bernardino County uses a **verification checklist** (similar to the one mentioned above) listing types of verification and whether proof of the item is mandatory, or if the customer statement is acceptable in order to speed up the renewal process.

- The county is **examining renewal procedures** in order to determine the best way to renew eligibility with the least effort on the part of the family and caseworker. Part of this effort requires gathering information about alternative, simplified processes for renewal.

- The county is **gathering data** on the number of enrollees who are discontinued and subsequently reapply.

- In the near future, San Bernardino County plans to develop **customer surveys** to: assist individuals with renewal as well as to question them after discontinuance; develop a **video for Medi-Cal office staff** explaining the eligibility process; include **information about eligibility on return envelopes;** and conduct **caseworker and consumer focus groups** around best retention methods, most frequent reasons for discontinuance and misconceptions families have about eligibility.

- **Provide additional training and support for caseworkers and other program representatives:** The emphasis of the training, according to experts, should be on helping families successfully complete the renewal process.

C. Renewal Assistance and Third Parties

- **Provide renewal assistance to first-timers:** Studies show that families who are renewing for the first time need and want assistance in filling out the forms (National Governors Association, 2000).

- **Use "community-based application assistors" to help with renewals:** While many states have set up community-based application assistors to assist with enrollment, they do not have a similar program for renewals.

- **Reach out to community-based partners:** Most experts agree that third party organizations can play a key role in retention. These include community-based organizations, managed care plans, health clinics and doctors (National Governors Association, 2000). Rhode Island, for example, created "Medicaid Self-Help Areas" in hospitals and doctor's offices that offer renewal forms, a free copy machine and a drop box in the main waiting areas.

- **Pay for renewals:** Some experts suggest paying community-based organizations (CBOs) for every renewal they assist. For example, this could mean providing assistance to families in filling out forms (National Governors Association, 2000; Testa et al., 2003).

- **Target employers:** Some experts suggest using employers to encourage workers to renew by providing forms at work sites, time off for renewing or help with income information (Ku and Cohen Ross, 2002).

New York's Facilitated Enrollers

Many families receive assistance from community or clinic outreach workers when they enroll in SCHIP or Medicaid, but such help may be missing when they renew. To fill this need, New York permits community-based outreach workers (state-funded "facilitated enrollers") to help families complete renewal paperwork. A family may receive assistance in filling out either an original application or a renewal form, and the worker can also track the success of the application or renewal. Some facilitated enrollers also maintain lists of families that are due for renewal, conduct outreach and provide renewal assistance.

Ku and Cohen Ross, 2002

D. Coordination between Programs

- **Coordinate databases of different public programs.** Many studies cite the problems caused by incompatible databases between Medicaid and SCHIP and how that can make it impossible to track the movement of families between programs. Better data coordination can also reduce the number of renewals families will have to participate in since state programs will be able to share information among themselves. For example, Maryland recently established an electronic database system that interfaces with the TANF, food stamps and Medicaid programs. This interface automatically updates a household's changes for Medicaid when a change is reported for TANF or food stamps. This automated coordination of programs ensures that case information is current, extends Medicaid for the family, and reduces the number of renewals in which the family must participate (The Centers for Medicare and Medicaid Services, 2001).

E. Relaxing Premium Payment Rules (for SCHIP)

- **Help families who miss payments:** For example, states could set up payment plans, allow for grace periods, allow hardship waivers or discount premiums. NASHP (2002) found that one-third of families with children losing coverage for not paying premiums reported having trouble paying premiums some months. To address this issue, some states have already established grace periods and also offer families the opportunity to lower their premium amount if their income decreases.

- **Create a universal premium amount:** To reduce confusion and make the premium amount affordable, Florida charges a flat fee of $15 per family per month.

- **Automatic paycheck deductions:** Some experts believe this will cut down on families missing payments and therefore being dropped from SCHIP.

- **Shift from monthly to one annual, affordable payment:** This would reduce the number of families who fall behind in payments. Some states have already instituted this option. However, Ku and Cohen Ross (2002) note that annual fees that are too high could pose an even greater barrier for some families, in which case they suggest an annual enrollment fee that is heavily discounted.

Covering Kids & Families: State and Local Retention Efforts

Many state and local grantees of The Robert Wood Johnson Foundation's *Covering Kids & Families* (CKF) program are currently working on retaining eligible children in their respective Medicaid and SCHIP programs. A handful of these efforts are described below.

Local grantees:

- In Florida, the **Human Services Coalition (HSC)** of Miami/Dade County, one of four separate CKF efforts in Florida currently working on retention, plans to engage in the following activities: working with the Department of Children and Families (DCF) to further the discussion about passive re-enrollment as well as to develop a system to ensure that individuals receive a letter and *Kidcare* application as soon as they lose Medicaid; and using outreach staff who speak English, Spanish and Creole to provide one-on-one assistance with clients to help them better navigate the program.

- ***MaineCare*** plans to hold nine CKF spring workshops to educate eligibility workers and update their information about *MaineCare*. Topics will include: services covered, cost, eligibility guidelines and the application process. As part of this effort, CKF developed a training handbook which includes a section on policies regarding re-enrollment to be reviewed during the sessions. Participants are asked to remind their clients about the importance of completing the review form if they want to retain their MaineCare benefits.

- **Washington Health Foundation**, working in tandem with coalition partners, is focused on improving the renewal process. WHF analyzes statewide data about families who drop off the program during renewal, later converting this to county-level data in order to help local CKF sites improve retention strategies. In addition, WHF efforts include testing the effect of phone assistance on the renewal process, as well as fielding a survey among 60 families about the renewal process.

Nationwide:

- In addition to these state-specific efforts, The Robert Wood Johnson Foundation's ***Covering Kids & Families* Access Initiative** (CKF-AI) is being managed by the Center for Health Care Strategies. A nationwide initiative, CKF-AI aims to reduce the problems encountered by enrolled beneficiaries, specifically in terms of gaining access to care, which appear to be related to retention problems. The Urban Institute intends to work with as many as 25 local grantees of CKF-AI to try to document access/retention connections on the local level.

F. Other Improvement Ideas

- **Measure and evaluate effectiveness of renewal strategies:** Experts recommend that states need to evaluate the effectiveness of various retention strategies.

- **Evaluate reasons for disenrollment:** Because state data and families often give different reasons for the loss of coverage, some states follow up with families that either failed to renew or did not pay premiums to better understand their reasons for leaving the program.

- **Encourage use of necessary preventive health services once insured, especially preventive care:** Given their finding about "adverse selection" in the Texas SCHIP program, Shenkman et al. (2002b) suggest that "Texas may want to consider, as part of its outreach activities, educating families about the importance of insuring their children for preventive and routine care, not just care when their children get sick or have chronic conditions."

- **Complete the delinking of TANF and food stamp procedures from Medicaid:** The Centers for Medicare and Medicaid Services (2001) suggests the following remedies: "States must ensure that low-income families have access to Medicaid, *regardless of their connection to the cash assistance system.* That is, families must have the ability to learn about and enroll in Medicaid even if they are not seeking cash assistance. Furthermore, families who no longer receive cash assistance need to be informed that they may remain eligible for Medicaid, and state systems must be in place to ensure that eligible families retain their health care coverage." Ku and Cohen Ross (2002) note that the federal government has already developed a variety of processes to improve Medicaid retention on this front, including reinforcing the requirement that an individual's Medicaid eligibility should not be discontinued until caseworkers have determined that no Medicaid eligibility criterion still applies. California places individuals into a "pending" category until this review is completed.

- **Discontinue the practice of including families who have not been approved through presumptive eligibility in retention figures.** Since their status is temporary and including these families inflates disenrollment figures, it has been suggested that states remove families who fail to qualify for SCHIP from their retention figures.

Insights from Frank Thompson's
"Managing Medicaid Take-Up:
Children and the Take-Up Challenge:
Renewal Processes in Medicaid and CHIP"

According to Thompson's evaluation of renewal processes in 18 states, "One of the best ways to reduce the burdens of renewal for children is to do less of it." His study makes the following points:

- **States have eased renewal burdens for Medicaid and SCHIP beneficiaries by increasing the enrollment spans for children, but most have *not* adopted continuous eligibility.** Of the 18 states in the sample, 13 provide one year of eligibility for children enrolled in both their Medicaid and SCHIP programs. But most states have not opted for "continuous eligibility," whereby a child can remain enrolled for a year regardless of changes in the financial circumstances of the family. In the case of Medicaid, less than a quarter of the states provide continuous eligibility for 12 months; in the case of SCHIP, just over half do.

- **Most states do *not* engage in aggressive retention activities to contact and keep children enrolled, but a majority has simplified renewal processes.** Only four of the states in the sample have emphasized following up and assisting enrollees who fail to meet the requirements to renew their eligibility, what Thompson calls "active inreach." But most states have opted for other practices (more passive approaches) that reduce the transaction costs of renewal, such as less paperwork and emphasizing proof of income, which is easier to obtain than proof of assets.

- **Over half of the states have made significant progress toward establishing seamless referral between Medicaid and SCHIP in the case of renewal.** Children who lose eligibility for either Medicaid or SCHIP may qualify to become enrolled in the other program. More seamless referral facilitates continuation of health insurance coverage. Four states in the sample avoid this referral challenge by making SCHIP a Medicaid extension; eight have adopted joint renewal forms for Medicaid and SCHIP.

- **Reviewing a range of renewal factors, about one-third of the states rank relatively high in promoting greater ease of renewal for children enrolled in Medicaid and SCHIP.** Six of the states have developed a portfolio of renewal practices that substantially reduce the transaction costs of renewal for beneficiaries. Seven states, however, fall at the opposite end of the continuum, having adopted relatively few practices that ease renewal. The remaining five states emerge as hybrids, having eliminated some barriers while sustaining others.

VI. Communications Strategies on Retention

Medicaid and SCHIP communications efforts historically tend to focus on enrollment. In the years following the creation of SCHIP, all states engaged in promotional activities to raise awareness about their programs and to encourage families to apply. These included television, print and radio ads and promotional events in many states. There were also billboards, posters, PSAs, giveaways like Frisbees and rulers with the program logo, and a number of grassroots outreach efforts largely through daycare centers, faith communities, schools, health care providers and community-based organizations.

There has been much less focus on retention in terms of communications—that is, until recently. Many states are experimenting with and making changes to the way they communicate with families about renewal and paying premiums (for SCHIP). This section highlights some of these communications ideas.

This section also briefly addresses the current environment in terms of statewide media campaigns on retention. Interviews with experts suggest that the current budget crisis in many states is resulting in cutbacks in the degree to which states are marketing their SCHIP programs, let alone developing new campaigns around retention. These issues are explored later in this section.

Communications Ideas

Following are some ideas from states on how to communicate about retention. This list of ideas is not meant to be comprehensive—it only represents the efforts of a few states encountered in the literature search and in interviews with experts.

- One state mails postcards in advance announcing that the renewal packet is coming soon and that families need to complete the packet to stay enrolled in the program. Some states also send reminder postcards two weeks after the renewal packet has been sent to urge families to complete the packet.

- One state has redesigned its renewal notice so that it is now a checklist of items that families need to complete to successfully renew. The prior format was a paragraph of information about the renewal steps. The hope is that the checklist will be clearer to families and make it easier for them to comply.

- Some states have developed two-sided renewal forms—one side in English and the other side in Spanish—to ease language barriers.

- Some states use self-addressed, postage-paid envelopes for the return of renewal forms.

- One state printed its renewal forms on blue paper to distinguish it from the other materials sent by the program to families, and reminds families that it is time to renew by using the tagline, "If it's blue, it is time to renew."

- One state has a semi-annual SCHIP newsletter informing families of changes in the program. The newsletter also enables the program to repeat messages about retention and the importance of renewing. The newsletter has the added advantage of keeping addresses current by reminding families to contact SCHIP if they are planning to move.

- One state uses bright yellow stickers that say "Important Insurance Information" and attaches them to renewal packet envelopes to make sure families understand this material is important and not just a regular mailing from the program.

- One state has developed refrigerator magnets reminding parents to renew in SCHIP. The magnets provide the toll-free SCHIP phone number, as well as space for parents to write their SCHIP renewal date and their doctor's and dentist's phone numbers.

- One state mails renewal packets in envelopes with the SCHIP logo and address instead of the Department of Health and Human Services (DHHS) return address. The reason for this is to reduce any stigma that families may feel in receiving mail from DHHS, which also administers cash assistance programs.

- One state includes information about how to use insurance and contact information for the SCHIP office in the renewal packet.

- One state gives families stickers with their renewal deadline date on it.

- One state has developed training videos for outreach workers that include tips about renewal and how to keep eligible families enrolled in Medicaid and SCHIP.

- One state uses premium payment coupons (similar to car payments) and prints reminders and useful information on them. For example, they include a message about the families' ability to adjust their premium amount if their income goes down and reminders about renewal.

Media Campaigns

In our review of research and interviews with experts we could find little evidence that states are developing statewide media campaigns specifically designed to promote retention as they did with enrollment. There seems to be a number of

reasons for this. Perhaps the most significant reason, according to experts, is that the budget shortfalls in many states mean that states are less interested in promoting enrollment, or retention, in Medicaid and SCHIP. There are also some experts who believe that a media campaign on the scale of the initial SCHIP awareness campaign is not as useful with retention. Rather, they suggest that grassroots communications efforts and focusing on renewal notices and other program materials are perhaps the best ways to increase retention. These and other issues are explored below.

A. State Budget Crisis

An interview with one expert gives insight into how many other states are struggling with depleted state budgets for Medicaid and SCHIP. This expert said, “Right now, retention is not that big of an issue for the state.” He goes on to report that his state recently cut almost all of the money given to the local public health departments for outreach and has even eliminated the "bounty" or the $25 application assistance fee that the health departments received for each successful enrollment. He said, “Media campaigns for [Medicaid and SCHIP] have been cut significantly…I haven't seen one in months. It appears as though the state is not trying to get the word out on these programs.” In addition, he asserts that promoting Medicaid specifically has always been a low priority. He said, “There has notoriously been little money for outreach and retention for the Medicaid program.”

B. Still a Focus on Enrollment

Those media campaigns that still continue, in spite of budget concerns, tend to use original messages about the need to sign up children for Medicaid and SCHIP and do not explicitly address retention, according to some experts. One expert we interviewed described her state’s media campaign as having been “extensive in terms of outreach and enrollment and minimal in terms of retention.”

However, a few experts disagree and say that these ads not only work for enrollment but can also help with retention. They point to messages about “low-cost or free health coverage” for “working families” that covers important medical services like “doctor visits and prescription medicine” and that provides parents with “peace of mind” knowing that their children are covered. They say these kinds of messages can work to remind parents why having health coverage is important and, therefore, help with retention.

C. Less Is Known About What Messages Work for Retention

Despite some overlap in enrollment and retention messages, there are still some aspects of retention that may be distinct. Experts say that, overall, there is less known about the kinds of messages that work to keep families enrolled in Medicaid and SCHIP other than those developed for enrollment. While states do seem to be learning about the best ways to communicate about renewal through changes to their renewal notices and other materials, there is much less known about the underlying causes of why some families "forget to make premium payments or return renewal packets." The NASHP (2002) study found that many families admit they just did not get around to completing the forms or sending in the premium payments.

These kinds of reasons for loss of coverage suggest some families may lack the motivation needed to comply with the renewal and premium-payment rules of Medicaid and SCHIP, and may not be sufficiently concerned about what the lack of health coverage could mean for their children and themselves. If confirmed, these *attitudinal* reasons for loss of coverage would suggest that new kinds of messages and communications ideas would be needed to keep these families enrolled. Little is known about what kinds of messages would address these types of barriers to interaction.

D. The Emphasis in Retention Is on Community Outreach

One expert we interviewed explained that the emphasis of states in regard to retention has been focused on community-based and local efforts to keep families enrolled. In fact, he questioned if a statewide media campaign is really the most effective way to increase retention. He recommended that we look instead to community-based efforts where local organizations, providers and others conduct outreach at the ground level, convincing families to sign up for and stay enrolled in programs. He believes this is the most promising strategy.

Part of this strategy involves "community-based applications assistors," who once assisted only with enrollment but are slowly moving to assist with renewal efforts as well. His feeling is that states are moving in the direction of finding ways to assist families on the grassroots level to keep their coverage and that some are looking to community-based organizations, schools, providers and others who were so effective with enrollment to convey assistance and messages about retention.

Insights from Market Research for the Florida *Covering Kids* Social Marketing Campaign (2000)

This was a study sponsored by *Covering Kids* to evaluate ads and messages designed to promote enrollment and retention in Florida's *KidCare* program (SCHIP). Since we could find almost no market research about retention messages, the insights from this study are particularly helpful. The key findings are as follows:

- *KidCare* participants felt that a premium of $15 per month is affordable and co-payments are reasonable for check-ups and prescriptions.
- People appreciated it when the advertising showed the monthly cost. They want to know how much they will need to pay if they enroll in *KidCare*.
- Respondents reacted negatively to the message encouraging people not to "cancel" or "drop" coverage. These appeals made people wonder if there is some problem with the program since people are dropping out.
- People said the tagline that gives the phone number needs to be up long enough for people to write the number down.
- People felt it would be good to demonstrate the cost savings of paying insurance and going to a doctor's office versus going to the emergency room. Their point is that *KidCare* can save families money, which is not always how people think about insurance. The cost-savings theme is not explicit in the ads.
- They also felt the message of "peace of mind" is good and they like the phrase "It's one less worry." They point out that families without insurance worry about accidents or needing urgent medical care, but not being able to obtain it because they lack health coverage. Thus, health insurance provides peace of mind.

VII. Gaps in Knowledge

In our review of research on Medicaid and SCHIP retention and in the interviews with leading experts, it became clear that certain issues still need additional research. In some cases, there are only one or two studies on the topic. In other cases, we could find no existing data. These topics include:

Retention in Medicaid vs. SCHIP: The data we could find on retention overwhelmingly focuses on SCHIP, not Medicaid. There seems to be little research specifically on Medicaid retention. Yet there are features of Medicaid that make it distinct from SCHIP and suggest there may be unique factors involved in retention. Specifically, Medicaid is free for most enrollees, whereas SCHIP enrollees usually pay a premium and co-payments. In addition, Medicaid has a much longer association with public assistance programs and welfare, which could mean more stigma. Data collection systems, administration, participating health plans, eligibility criteria, enrollment and renewal processes, and other features of Medicaid are also usually distinct from SCHIP and have not been fully researched in terms of their role in retention.

Adults vs. children: There are very little data about the retention of adults in public health programs. Since the primary focus in regard to retention has been SCHIP, which is a program for children, there has not been a focus on adult retention. Yet adults may face unique barriers to retention (i.e., busy lives, less urgency for their own coverage, hopes of obtaining coverage through an employer) that may be different from the kinds of barriers affecting children's retention.

The demographics of who loses coverage: This report includes some new data about race, gender and income in terms of retention, but this is still a new topic. Even the reports we reviewed that address this topic suggest that more study is needed to draw conclusions about whether some groups of enrollees are more likely to lose coverage than others.

Health status and retention: Although there are slightly more data on this issue, there is still not conclusive evidence that the health status of the individual matters in terms of retention. Currently, the bulk of the data suggests that children with more health needs tend to stay enrolled while healthier children are more likely to lose coverage. However, more research is needed to prove this point. Likewise, there are not yet enough data about the utilization of health services and how that affects retention. Some studies suggest that the more a family uses health services while enrolled in Medicaid or SCHIP, the more likely they are to value the program and stay enrolled. Once again, however, more study of this issue is needed before this point can be made with confidence.

Sources

This section lists the studies cited in this literature review in alphabetical order. Studies marked with an asterisk (*) indicate ones we relied most heavily upon in writing this report. Where available, Internet links to the study are also provided.

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