



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Are We Holding the Line on Health Coverage for Low-Income Families?

Briefing Charts

Washington, DC

July 29, 2003

Preserving Recent Progress for Health Coverage of Children and Parents: New Tensions Emerge

A 50 State Update on Eligibility, Enrollment,
Renewal and Cost-Sharing Practices in
Medicaid and SCHIP

Donna Cohen Ross
Center on Budget and Policy Priorities
July 29, 2003

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Figure 1

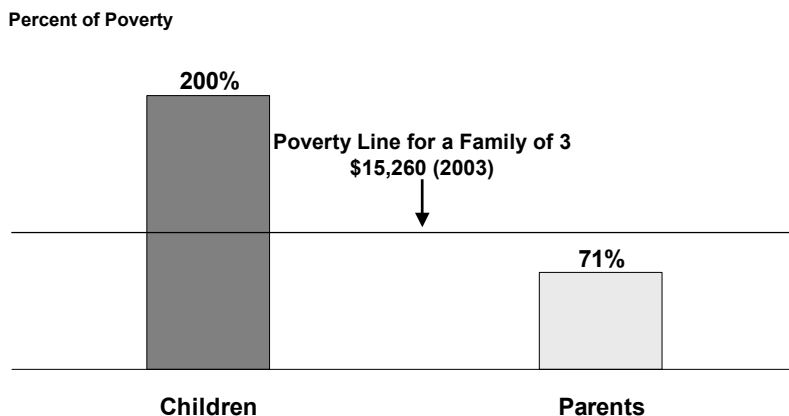
Major Themes from 2002 Survey

- **A New Dilemma**
 - Financial stress is taking its toll on state budgets and low-income families
- **Momentum has shifted: After uninterrupted progress, some states have taken steps backward**
 - Children's eligibility was largely protected, but not immune to cuts
 - Parent coverage suffered significant setbacks
- **A Cautionary Tale**
 - The full force of administrative changes may not be readily apparent
 - Continued budget problems suggests health coverage advancements are tenuous

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Figure 2

Median Medicaid/SCHIP Income Eligibility Threshold for Children and Parents, April 2003

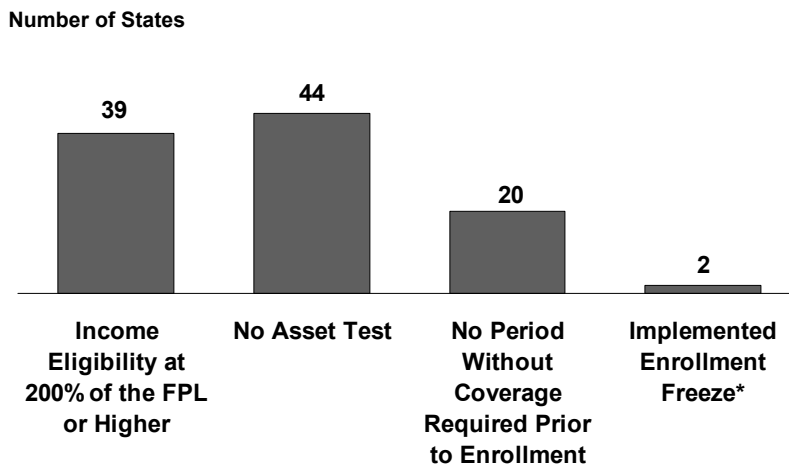


Note: Eligibility levels for parents based on the income threshold applied to a working parent in a family of 3.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 3

Eligibility for Children's Health Coverage Programs, April 2003

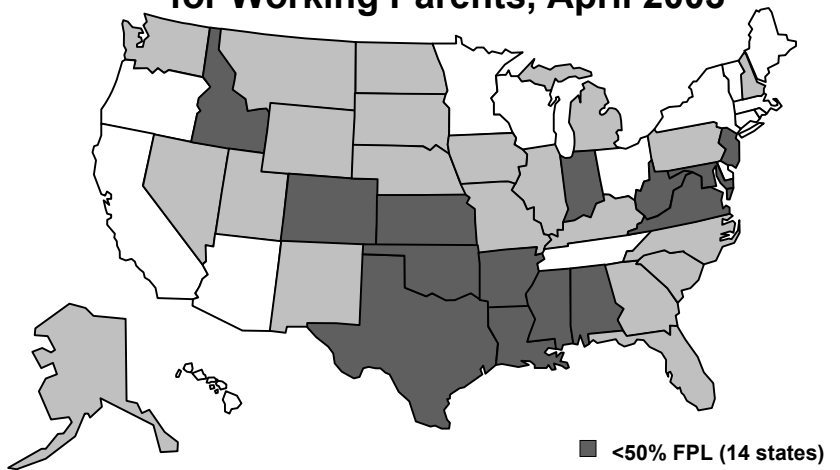


* In addition, in TN enrollment is closed to some but not all of the children eligible under the state's waiver.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 4

Medicaid Eligibility Income Thresholds for Working Parents, April 2003



Note: Eligibility levels based on the income threshold applied to a working parent in a family of 3. PA and WA have closed enrollment in state-funded programs that cover parents at higher income thresholds. UT provides primary care services to parents with income up to 150% of poverty.

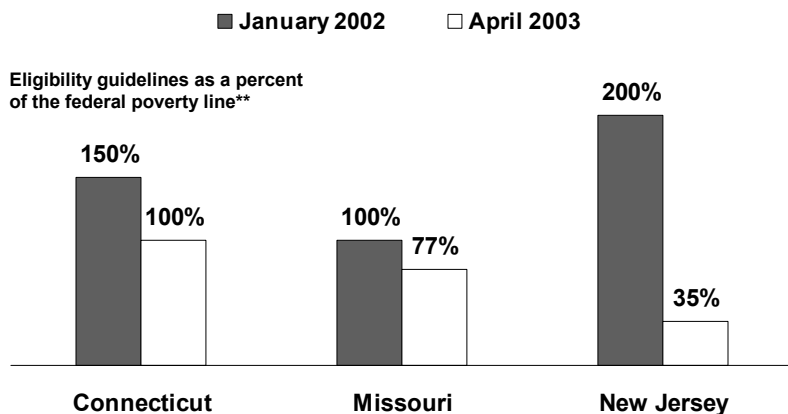
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

- <50% FPL (14 states)
- 50-99% FPL (21 states)
- 100% FPL and above (15 states + DC)

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Figure 5

Examples of States That Reduced Coverage for Parents*



* Nebraska and Tennessee also made changes that effectively reduce coverage for parents.

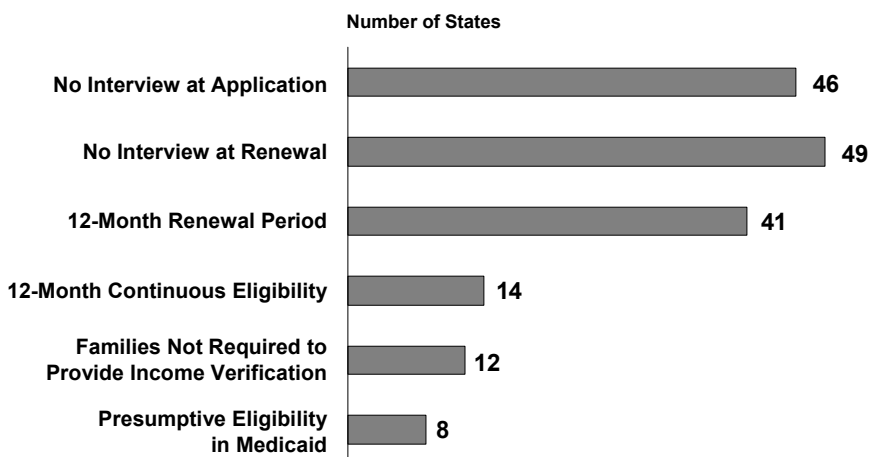
** These eligibility levels do not take earnings or other disregards into account.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 6

Simplifying Enrollment and Renewal: Strategies States are Using in Children's Health Coverage Programs, April 2003

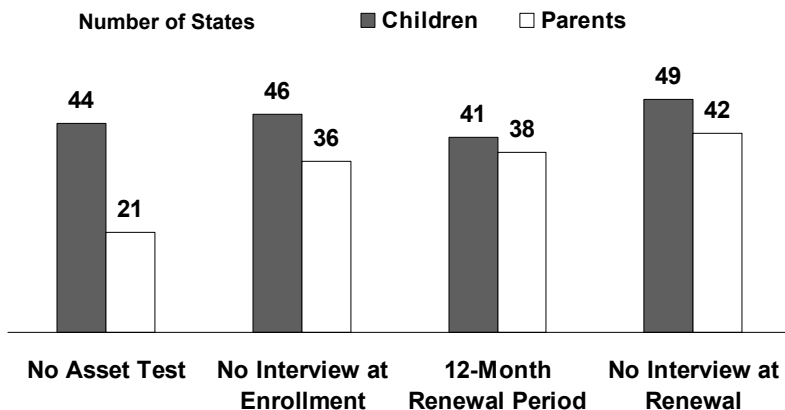


SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 7

States Have Not Simplified Health Coverage for Parents to the Extent They Have for Children, April 2003



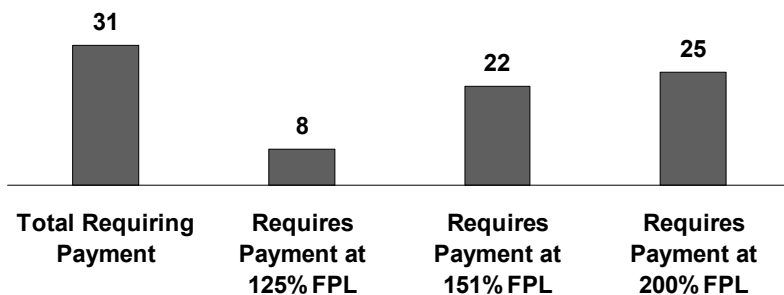
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 8

Premiums or Enrollment Fees in Children's Health Coverage Programs, April 2003

Number of States



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

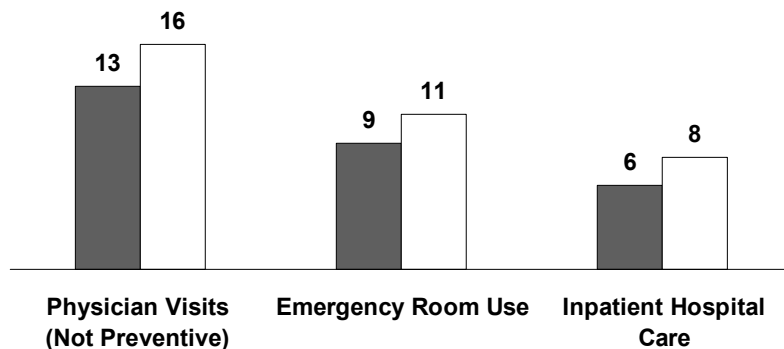
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Figure 9

Co-payments for Selected Services in Children's Health Coverage Programs, April 2003

Number of States

■ Family Income at 151% FPL □ Family Income at 200% FPL



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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What Does the Future Hold?

- Continued budget concerns are likely to heighten states' quest for cost savings
- States have the opportunity to protect health coverage, at least temporarily

Louisiana: Increasing Health Coverage for Children

Ruth Kennedy
Deputy Director, Medicaid
State of Louisiana
July 29, 2003

Figure 1

Children's Health Coverage in Louisiana

- Children covered up to 200% of poverty through an SCHIP-funded Medicaid expansion (LaCHIP)
- No asset test
- No premiums or cost-sharing
- Enrollment/Renewal Simplification
 - No waiting period
 - No face-to-face interview
 - 12 month continuous eligibility
 - State assistance with income verification
- Aggressive Outreach

Figure 2

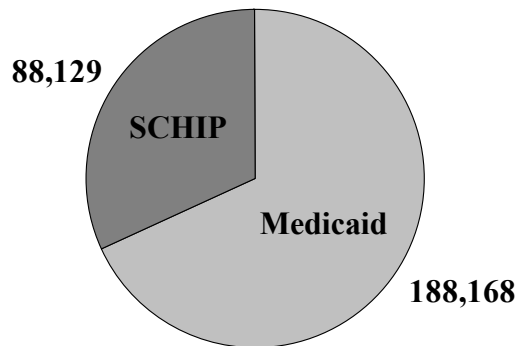
Prerequisites for Increasing Enrollment



Figure 3

Growth in Louisiana Public Coverage SCHIP & Medicaid

11/98 to Present



Total = 276,297 Additional Children

Figure 4

Progressive Simplification Three Major “Waves” in Louisiana

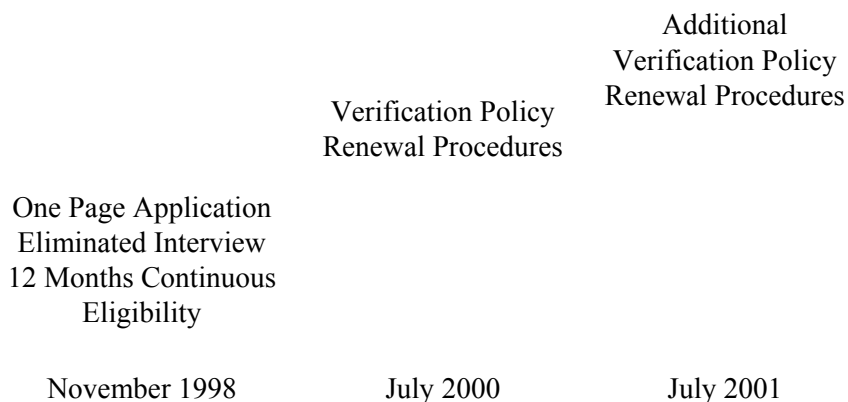


Figure 5

Medicaid Children in Louisiana Monthly Enrollment Net Change

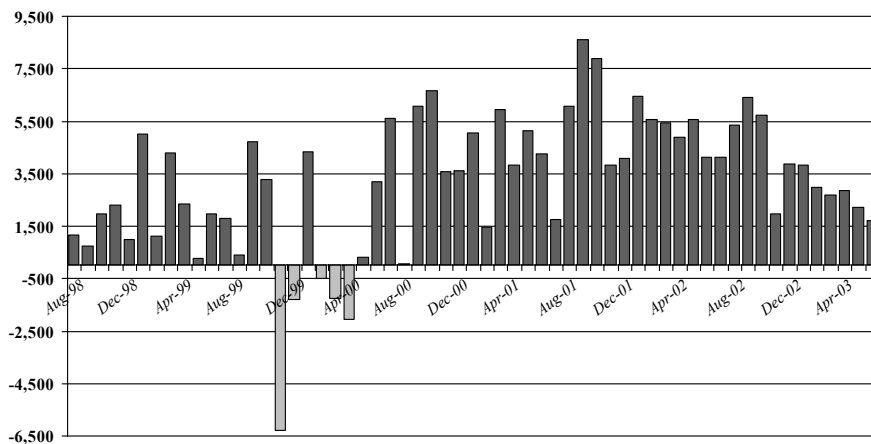


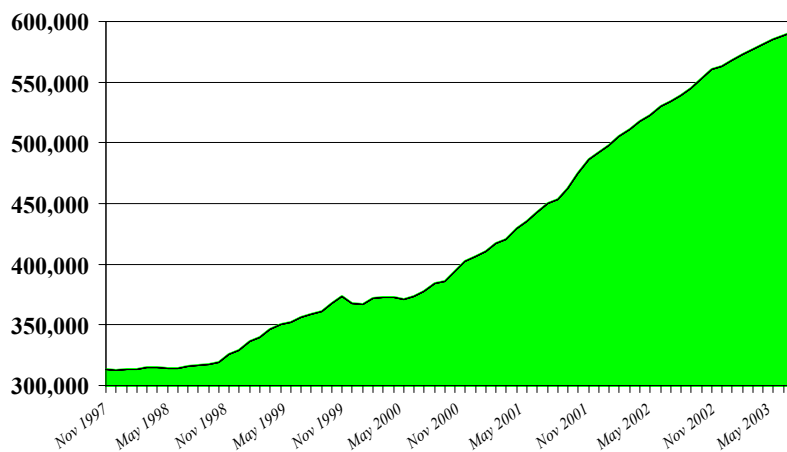
Figure 6

Simplification Impact on Louisiana Enrollment & Renewal Outcomes

- SCHIP application denials for procedural reasons = .04%--
less than ½ %
- Medicaid (Title 19) renewal closures for procedural reasons = **8% statewide average**
- *Ex parte* renewals (passive renewal) for **60%** of Medicaid children
- Net increases in enrollment for both Title 19 Medicaid **and** Title 21 Medicaid children **every month** since May 2000

Figure 7

Enrollment in Children's Health Coverage in Louisiana



Menu of Strategies Improves Retention in Louisiana

In Louisiana, improving retention started with the development of systems to track the reasons children were losing coverage. Computer codes were initially vague, indicating that cases were closed for “failure to cooperate.” New codes were established to provide more explicit information, such as “failed to return form,” “failed to return verification,” or “mail not delivered.” Another beginning step was to change the vocabulary used on forms, in manuals and in conversation with program participants. “The word ‘redetermination’ is welfare-speak,” said one state official. “The term, ‘renewal’ makes more sense to families and is a lot friendlier.”

The state piloted a host of new strategies, which now have become part of the renewal process:

- Caseworkers first search the computer to see if the child is receiving another benefit, such as food stamps. If so, the family’s income is automatically verified and health coverage is continued.
- For families whose health coverage cannot be continued automatically, the state created a new, simple renewal form. Although families are asked to return proof of income with the form, if the form is returned without it, coverage will not be terminated if the wage information of the Department of Labor database verifies that the child still qualifies.
- Finally, the state is taking steps to track the performance of local Medicaid offices to ensure caseworkers understand and follow the new procedures.

This concerted effort to assure children retain health coverage for as long as they remain eligible is showing success. In 2001, the state began tracking the outcomes of these changes in renewal procedures for children. The percent of children losing coverage declined from 25 percent, in March 2001, to less than 10 percent today.

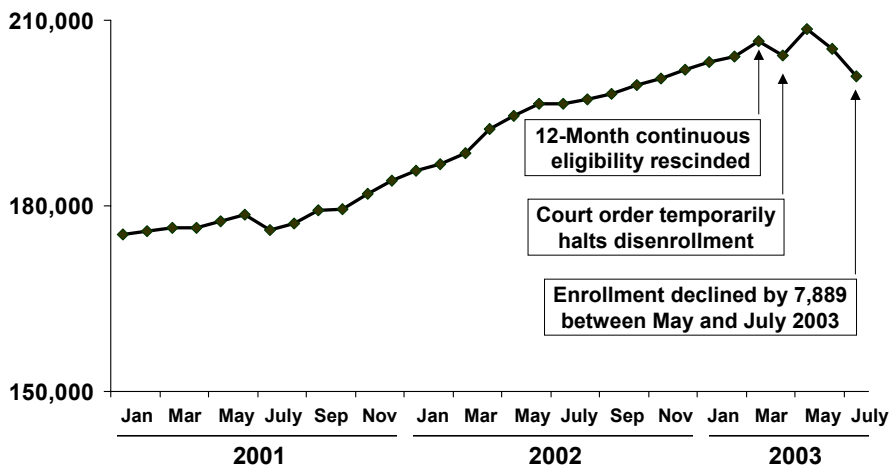
Source: Updated from *Enrolling Children and Families in Health Coverage: The Promise of Doing More*, Center on Budget and Policy Priorities, 2002.

Judy Solomon Children's Health Council State of Connecticut

Data on Medicaid Enrollment Trends in Connecticut

July 29, 2003

Children Enrolled in Connecticut's Medicaid Program (HUSKY A)



SOURCE: Children's Health Council, State of Connecticut, based on monthly enrollment data