

WRONG TARGET: Policies That Hurt Kids And Cost Us All More

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The State of Washington, as directed by the legislature, is implementing a number of policies in an attempt to decrease the state's health care costs. These policies focus on programs for low income and immigrant children. While these policies were designed to remove ineligible children from the state's public insurance programs, including Medicaid and Children's Health Insurance Program (SCHIP), they have missed the mark and have barred tens of thousands of eligible children from getting the health care they need and deserve.

As a result of these misdirected state policies, Washington's children are less healthy and less well prepared for school. These policies have created numerous hurdles for children and their families, which often result in children going without the care they need. These policies also undermine the efforts of many communities to decrease bureaucratic barriers to access to care, which are all too common in our health care system. In addition, they have increased costs for physicians, hospitals, community agencies and the state itself.

This report examines enrollment data from the State of Washington and explains the impact of these policies on our children, our schools, providers of health care, and our local communities.

What Has The State Done?

2002: Over 28,000 immigrant children were shunted from Medicaid to the Basic Health Plan (BHP). However, half of these children did not make the transition and remain uninsured.¹

2003: The state increased administrative barriers for children in the state's Medicaid and SCHIP programs, making it significantly more difficult for children to enroll in and stay in these programs. First, the state changed the certification time from twelve months to six months, which means the families of these children must now re-apply for coverage twice a year. In addition, the state now requires income verification at the time of certification, and a parent must sign all documents—eliminating the ability to re-apply on the phone or online. Finally, the state has removed continuous eligibility, which had previously allowed children to remain covered by insurance until their next eligibility determination.

"So many of our patients are not adept at dealing with systems, or don't read or write well, or don't have a stable enough address where they are going to get the mail. The thought of having to jump through those hoops every six months! The first thing I thought of when I heard about it is that a huge percentage [of our insured patients] are just going to drop off right off because they won't keep up with the hoop jumping."

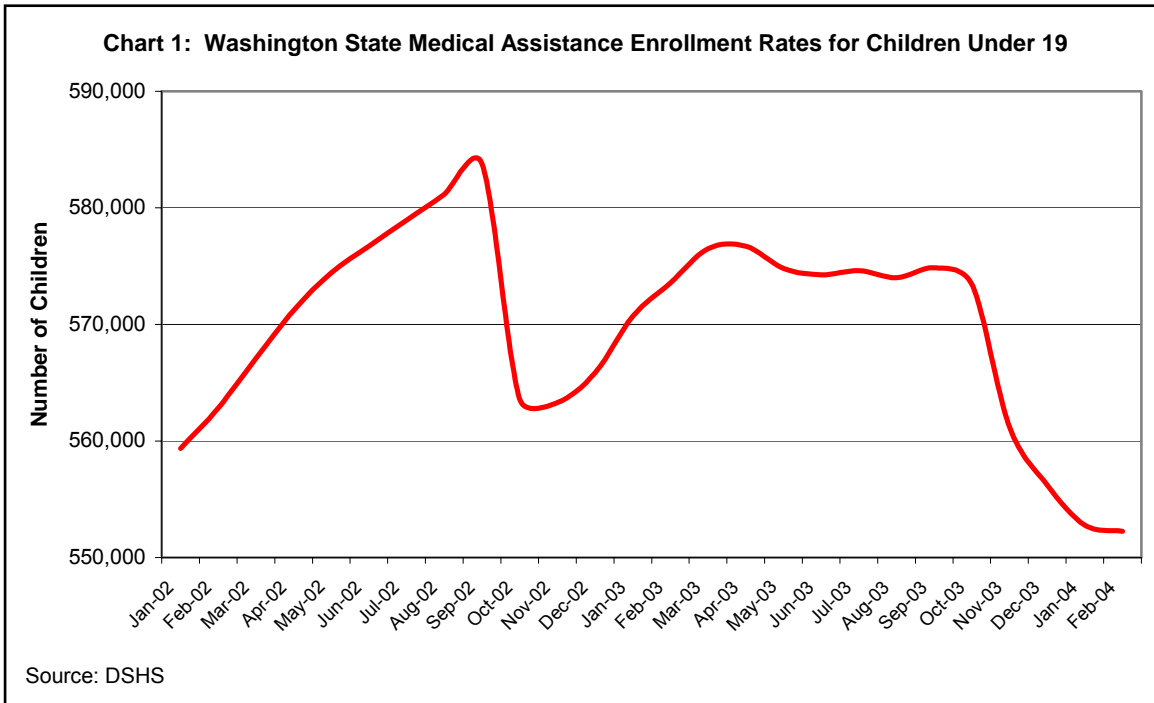
— CHC eligibility worker on how patients will handle changes

What Is The Impact Of These Policies?

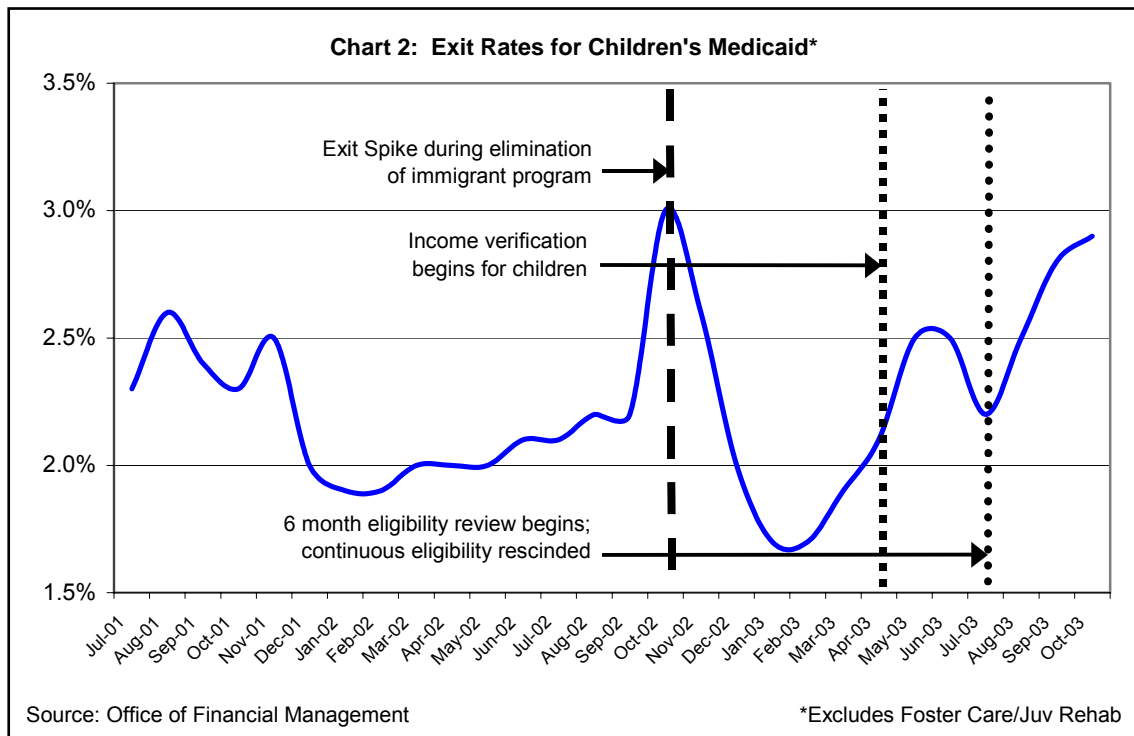
Between October 2002 and February 2004, more than 45,000 children in the state lost coverage and became uninsured (See Chart 1).² Given recent policy decisions, many more will continue to drop out of the Medicaid program. As more children come up for recertification over the next months, the same rate of decline is expected to continue for most of 2004.

¹ "Status Report About Immigrant Children's Health Coverage Via Basic Health." Children's Alliance, September 2003.

² Washington State Department of Social and Health Services.



The fall in enrollment in state programs is directly related to the policies described above.³ Exit rates from Medicaid spiked in October 2002 and have steadily increased since January 2003 (See Chart 2).



³ "The Costs of Enrollment Instability in Washington States Medicaid Program." Health Policy Analysis Program, March 2004.

Every Part Of The State Is Affected:

Nearly all counties across the state have been affected by these policy changes. As Table 1 shows, few counties are spared the loss of coverage for their kids. Now more than ever, thousands of children in every part of the state are not getting the preventive services they need and are coming to school unprepared to learn. The counties with the highest percentage losses since October 2002 are in rural areas and Eastern Washington—the communities with the fewest resources to address these shortfalls.

We Are Mostly Removing Eligible Children From Public Programs:

A recent study by the University of Washington Health Policy Analysis Program using Medical Assistance Administration information shows that most children leaving Medicaid are leaving for reasons other than being ineligible.⁴ In fact, only about 20 to 30% of the children removed are ineligible for Medicaid. Most are eligible but are inhibited from getting coverage because of the administrative barriers and hurdles described above. These roadblocks are affecting the families that need the most help. Research has shown that the families with lower incomes have significantly lower rates of recertification due to the complicated processes they must navigate to keep their child covered.⁵ The very families that need the coverage the most are most liable to being inappropriately excluded even though they are eligible.

Kids Are Not Getting Needed Services:

Kids who have lost coverage, even if they are eligible, are less healthy than those with coverage. Access to health services is decreased and illness intensity is increased.⁶ This is

Table 1. Fall in Enrollment Rates Between September 2002 and December 2003

COUNTY	Sep-02	Dec-03	Change	Percent Change
Adams	4,029	3,376	(653)	-16.2%
Asotin	2,481	2,564	83	3.3%
Benton	15,591	14,866	(725)	-4.7%
Chelan	10,696	10,684	(12)	-0.1%
Clallam	6,634	6,466	(168)	-2.5%
Clark	36,559	35,079	(1,480)	-4.0%
Columbia	261	194	(67)	-25.7%
Cowlitz	11,540	11,467	(73)	-0.6%
Douglas	3,321	1,871	(1,450)	-43.7%
Ferry	1,633	1,619	(14)	-0.9%
Franklin	12,845	10,946	(1,899)	-14.8%
Garfield	79	63	(16)	-20.3%
Grant	14,751	13,576	(1,175)	-8.0%
Grays Harbor	9,103	8,258	(845)	-9.3%
Island	3,557	3,339	(218)	-6.1%
Jefferson	2,190	2,100	(90)	-4.1%
King	119,564	116,549	(3,015)	-2.5%
Kitsap	16,551	16,004	(547)	-3.3%
Kittitas	2,953	2,824	(129)	-4.4%
Klickitat	2,730	2,535	(195)	-7.1%
Lewis	9,417	9,767	350	3.7%
Lincoln	819	1,015	196	23.9%
Mason	5,650	5,641	(9)	-0.2%
Okanogan	7,467	6,895	(572)	-7.7%
Pacific	2,332	2,181	(151)	-6.5%
Pend Oreille	1,650	1,678	28	1.7%
Pierce	67,389	64,516	(2,873)	-4.3%
San Juan	977	745	(232)	-23.7%
Skagit	13,918	13,166	(752)	-5.4%
Skamania	853	1,018	165	19.3%
Snohomish	46,984	44,788	(2,196)	-4.7%
Spokane	48,040	46,805	(1,235)	-2.6%
Stevens	5,803	5,526	(277)	-4.8%
Thurston	17,180	16,017	(1,163)	-6.8%
Wahkiakum	264	151	(113)	-42.8%
Walla Walla	6,787	6,405	(382)	-5.6%
Whatcom	17,159	16,185	(974)	-5.7%
Whitman	2,478	2,515	37	1.5%
Yakima	49,420	45,039	(4,381)	-8.9%
Unidentified	2,120	439	(1,681)	-79.3%
STATEWIDE	583,775	554,872	(28,903)	-5.0%

Source: DSHS

⁴ "The Costs of Enrollment Instability in Washington States Medicaid Program." Health Policy Analysis Program, March 2004.

⁵ Lipson, K., Fishman, E., Boozang, P. & Bachrach, D. "Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Health Insurance Programs." Commonwealth Fund, 2003.

⁶ *Coverage Matters*. Board on Health Care Services, Institute of Medicine, 2001 and *Care Without Coverage: Too Little, Too Late*. Board on Health Care Services, Institute of Medicine (2002).

because parents of uninsured children are more likely to postpone health care needed for their child (41% versus 16% of Medicaid enrolled) and to leave prescriptions unfilled (26% versus 13% of Medicaid enrolled).⁷ Uninsured children who drop out of Medicaid do not benefit from disease management programs that are proven to benefit children with illnesses.⁸ Insurance and managed care plans have little incentive to invest in preventive care for Medicaid children if there is a good possibility that they may be disenrolled.⁹ Keeping children in a stable relationship with health insurance coverage is critical to ensuring a stable medical home, adequate preventive care, disease management, reduction of avoidable hospitalizations, and decreased intensity of illness.¹⁰ These uninsured kids come to school sicker, often spread communicable diseases, and are not able to learn if they have preventable health conditions.

Costs Are Not Saved:

While direct Medicaid costs have been reduced, actual Medicaid costs have only partially decreased and costs have been shifted to other parts of the state budget and onto the budgets of schools, local providers, and local hospitals and clinics.

State: Children who do not get their preventive care are twice as likely to be admitted to a hospital for an avoidable hospitalization.¹¹ Since most of the disenrolled children are eligible for Medicaid, when they get sick and are hospitalized, they are re-enrolled on Medicaid and those costs are borne by the state. Unfortunately, since twice as many avoidable hospitalizations occur, state costs increase substantially.

Schools: School nurses are finding more children turning to them for regular health care. Teachers are finding that the number of kids coming to school with inadequate prevention and care is increasing. This means that teachers, nurses and administrators have to find resources for these children, resulting in more expenses for the educational system that is increasingly burdened with society's ills—but this time it was the decision of policy makers to shift this burden to others that has caused the social problem. Moreover, these children are falling behind—they miss more days of school due to untreated illnesses and they can lack the necessary immunizations required to begin school.

Medical Groups: Practices that try to maintain continuity and provide high quality health

“A few months ago [my kids] didn’t get their coupons for like a month. Because I got the paper sent to me, I filled it out and sent it back but I also had to call them and I didn’t know that. Before they were just doing all calls and not the paperwork. It had changed. So I filled it out and then called when I hadn’t gotten the coupons. And they said I should have called. But there was nothing saying you had to call too. So, they lost coverage for a month and was able to get them back on. And then I realized that I hadn’t gotten them and I called in again.”

— Annabelle, a mother with two children on SCHIP, experienced a lapse in coverage for her children because of confusion around the new eligibility rules

⁷ Perry, M. & Kannel, S. “Medicaid and Children: Overcoming Barriers to Enrollment, Commission on Medicaid and the Uninsured.” Kaiser Family Foundation, 2000.

⁸ Birnbaum, M. & Holahan, D. “Renewing Coverage in New York’s Child Health Plus B Program: Retention Rates and Enrollee Experiences.” United Hospital Fund, 2003.

⁹ “Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far.” Lake, Snell, Perry & Associates, June 2003.

¹⁰ Hakim, R. & Bye B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, *Pediatrics*, 108(1), July 2001.

¹¹ Ibid.

services for Medicaid recipients provide services for children when they are not covered, even if they are eligible. They lose in direct care and in increased paper work by staff who must spend more time trying to get children enrolled. Overhead in practices has increased significantly in the past few years (approximately 30% more administrative staff).¹² This change does not improve care, but rather increases the cost of care for everyone, since those costs are absorbed by the practice and passed on to other people coming to the clinic. Many practices are now

“...the sick part is we are still seeing [patients who lose their coverage] during those months their coverage lapses. We end up eating the cost for those two months. It’s hard when we are an open clinic like this. We end up eating the difficulty of the system, that patients don’t understand. We will end up still seeing them in hopes that [insurance] comes through – we’ll see them even if it doesn’t come through instead of denying people their diabetes medication. We’ll see them as we sink, but we’ll see them. Because it’s a human right and that’s part of what the clinic stands for. But it’s hard when it happens. It hurts someone somewhere.”

— CHC staff member on how changes will affect safety net health centers

tightening up on the children they will serve and turn away non-enrolled children. These children have decreased preventive care, decreased continuity and disease management, and present more to the emergency rooms.

Community Health Centers: Community health centers must devote a large portion of their resources to helping patients understand, troubleshoot and complete paperwork and recertification forms. For example, one health center has five staff people whose time is entirely devoted to helping Basic Health Plan and Medicaid patients complete their paperwork on time. In addition, CHC staff must work closely with patients to ensure they remain covered. Patients who do lose coverage continue to seek care at the centers on a sliding fee basis, but their contribution covers only a small portion of the cost, or about 18 cents on the dollar, and they generally lose access to specialty care.¹³

Hospitals: Hospitals care for the uninsured through their emergency rooms and in-patient hospital rooms, and either absorb the loss or invest more in people to assist in completing forms. Administrative costs have increased for hospitals and charity care has doubled for many in recent

years.¹⁴ Many communities support their hospitals through public hospital districts. Residents in those local hospital districts are now being asked to tax themselves to pay for these services.

The State Is Planning To Make This Problem Worse:

The administration and the legislature have plans to worsen these problems by imposing premiums on children’s health care for low-income families. While these premiums may seem small, these families have very few resources. They often have to choose between paying for housing, food or health expenses. However, housing and food are necessary and because most children appear well, parents often forego insurance and hope their children do not get ill. It is estimated that 4,000 children will drop off insurance with the imposition of premiums.¹⁵ Moreover, the premium amounts being charged are so small that the revenue the state expects from them (\$2.8 million) are essentially negated by the costs associated with collecting the

¹² Phillips, W. “Impact of Managed Care on Practices” (unpublished report). University of Washington, 1999.

¹³ Average visit cost calculated from data collected by the Washington Association of Community and Migrant Health Centers. Average patient contribution per visit calculated at \$20 based on interviews with four community health centers and data collected from a sample of centers by the Community Health Network of Washington.

¹⁴ Washington State Department of Health, Center for Health Statistics.

¹⁵ “2004 Washington State Legislative Summary. Children Weren’t The Top Priority.” Children’s Alliance, March 2004.

premiums (\$2.9 million). The only revenue the state will earn (\$2.5 million) is a result of eligible children dropping off the program.

Local Programs Are Made Less Effective:

Many communities around the state have tried to overcome the hurdles described above and to increase their children's access to care, to treat developmental, physical, mental and oral health problems, and to work with the schools and other community organizations in order to truly improve the care of children. These programs are being undermined by the poorly thought through policies noted above. The Kids Get Care program in King County is a primary example of the negative affects these policies. This very successful program focuses on getting all children care. However, all of the added bureaucratic barriers now make their task much more difficult.¹⁶ A premium will make the promise of care hollow.

Choices For The State:

These policy changes have failed our children. The goal of these policy changes was to save state funds. However, evidence to the contrary indicates that these policies are penny wise and pound foolish. While they save some funds in one account, the costs end up in other parts of the budget and shift many costs to local communities. The health care costs saved by Medicaid for these poorly conceived plans are way less than one percent of the Medicaid budget. People in Washington State have repeatedly registered their support for covering kids in polls and through the ballot box. People of all political stripes and in all parts of the state support spending state money on children's health care. It is a small investment with a large benefit.

Changing these policies is inexpensive and can make a big difference. Changes that should be made are:

1. Postpone or eliminate any premiums on children in low-income families.
2. Return recertification to a yearly basis.
3. Leave children on Medicaid until their next recertification.
4. Use minimum federal standards for form completion in order to decrease unnecessary paperwork for families.
5. In the long run, make all children below 250% of the federal poverty level (FPL) eligible for one of the public programs, and simplify their enrollment requirements so they can get the care they need.

¹⁶ Wysesn, K. "Evaluation of Kids Get Care." Public Health of Seattle and King County, 2004.