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12-Month Continuous Eligibility in Medicaid: Impact on Service Utilization

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INTRODUCTION

Under the 1997 Balanced Budget Act (BBA), states were granted latitude by the federal government regarding the administrative and enrollment processes for their Medicaid programs. This latitude allows states to implement strategies intended to reduce barriers for enrolling and retaining eligible children. One method for reducing these barriers is to decrease the burdensome administrative requirements for enrollees to maintain coverage. This can be achieved by, among other approaches, adopting a presumption of continuous 12-month eligibility, which allows enrollees to remain in Medicaid without reapplying for the next twelve months.

In January 2001, California implemented a presumption of continuous eligibility for a full year following enrollment in California's Medicaid program for children, called Medi-Cal. After the first year, enrollment increased by 13.5%, and by December 2002, enrollment had increased an additional 20.3%.

This brief moves beyond an investigation of the link between 12-month continuous eligibility policies and increased enrollment, looking at the connection between these policies and children's continuity of care. Specifically, this brief explores whether instituting 12-month continuous eligibility for Medi-Cal has directly benefited Medi-Cal enrollees by improving their process of care.

DATA AND METHODS

Using a "difference-in-differences" approach, the authors analyzed monthly Medi-Cal eligibility files and claims data from 2000 and 2001—the year prior to and following the 12-month continuous coverage policy—to determine the following:

1. The changes in health care utilization for children who had continuous Medi-Cal coverage before and after the implementation of 12-month continuous eligibility.
2. The changes in utilization for children who had discontinuous coverage before and after the policy change.
3. The magnitude of the difference in the change in utilization rates over time for children with continuous coverage compared to those with discontinuous coverage.

Although the authors hypothesized that discontinuity of coverage would reduce to near zero after implementation, the data showed that this was not the case. Originally, the authors intended to use a propensity scores regression model to predict the likelihood of having future breaks in Medi-Cal coverage among enrolled children. Instead,

sizeable populations existed of children with either continuous or discontinuous coverage both prior to and following implementation of 12-month eligibility. With this finding, the authors used a multivariate logistic regression difference-in-differences approach to carry out a pre-post intervention analysis: They compared health services utilization rates *before* the implementation of continuous eligibility (using data from 2000) with utilization rates *after* the policy implementation (using data from 2001) for both the continuous and discontinuous groups, and looked at differences between these within-group changes.

FINDINGS

If the continuous eligibility policy had its desired effect of giving continuous coverage to all enrollees in Medi-Cal, then the number of children with discontinuous coverage in 2001 would have been close to zero. Unfortunately, this proved to not be the case. In 2001, over 477,000 children still had discontinuous Medi-Cal coverage, although this did represent a reduction in the number of children with discontinuous Medi-Cal by about one-fourth as compared to 2000. In light of this surprisingly large population of children who had discontinuous coverage, evaluation of the impact of the policy intervention on health services utilization became a measurement of the actual differences in utilization before and after the intervention, keeping in mind that one-quarter of a million children who had discontinuous coverage in 2000 gained continuous coverage in 2001.

Emergency Room Visits

As seen in Table 1, children with continuous coverage had higher rates of ER visits ("Asthma or Diabetes" or "Any") than children with breaks in their coverage, both before and after the implementation of continuous eligibility. The rate of ER utilization for asthma or diabetes-related conditions, i.e. visits that would be considered preventable with good primary care and disease management, showed no post-intervention change for participants with breaks in coverage, and the utilization rate for these visits among the continuous group slightly decreased. However, these rates of usage (0.71% in 2000 and 0.64% in 2001) were unexpectedly nearly double that of the usage rates for children with discontinuous coverage (0.38% for both 2000 and 2001). For all ER visits, a similar decrease among children with continuous coverage was observed (15.01% in 2000 and 14.16% in 2001), but again the usage rate was nearly double that of children with discontinuous coverage (8.17% in 2000 and 8.61% in 20001). There was also a slight increase in all ER visits among children with discontinuous coverage as compared to 2000.

Table 1. Rates of ER and Doctor Visit by Continuity of Coverage Among Children With Medi-Cal, 2000 and 2001

	2000		2001			
	Continuous Coverage N=2,487,475	Discontinuous Coverage N=731,309	Continuous Coverage N=2,781,664	Discontinuous Coverage N=477,044	Total	Difference in Differences
ER, Asthma or Diabetes	0.71%	0.38%	0.64%	0.38%	40,138	0.001
Any ER Visit	15.01%	8.17%	14.16%	8.61%	868,047	0.013
Any Doctor Visit	58.23%	28.67%	55.93%	29.53%	3,354,787	0.032
Child Well Check	11.26%	4.33%	12.80%	5.41%	693,540	-0.005

*2000 data represent pre-intervention utilization rates, and 2001 data represent post-intervention rates.

Physician Visits

As shown in Table 1, the authors found that children with past and predicted breaks in their coverage had fewer doctor visits (both for well-checks and for any visit) than children with continuous coverage, both before and after the implementation of continuous eligibility.

Upon closer inspection, however, the numbers reveal more nuanced results: The utilization of doctor visits ("any") did increase for children with discontinuous coverage (28.67% to 29.53%), but this utilization decreased for children with continuous coverage between the pre- and post- intervention periods (58.23% to 55.93%). However, a decrease in doctor visits ("any") for the continuous care group would not be expected as an effect of the intervention. Well-check visits, on the other hand, increased for both the continuous and discontinuous coverage groups–from 11.26% to 12.80% for continuous coverage, and from 4.33% to 5.41% for discontinuous coverage. This would indicate that the intervention may have encouraged improved outcomes on this measure for the discontinuous group. However, the outcome for the continuous care group is once again surprising.

DISCUSSION

The above findings are largely unexpected, and the potential reasons for this are multiple:

- It is possible that the intervention somehow had an unintended effect on the utilization patterns of Medi-Cal enrollees with continuous coverage, among whom we would expect to otherwise see no change in utilization as a result of the intervention.
- There could be other, unmeasured, factors influencing the utilization patterns of both the intervention and comparison groups.
- It is possible that the intervention was simply not entirely successful in influencing all four utilization measures used to assess its impact. An analysis of other measures might yield different results.
- There might have been a lag time in seeing the full effect of the intervention with respect to utilization by enrollees with discontinuous coverage. In this case, an analysis of utilization in the years subsequent to 2001 would yield different utilization patterns.

In addition to these possibilities, it is important to note potential methodological limitations. Namely, the Medi-Cal claims data used for this analysis does not include data about healthcare provided to enrollees that was not paid for by Medi-Cal. Research literatures indicates that people who lose their public coverage continue to use care and simply use free providers or pay for care out-of-pocket (Nolan et al. 2002; Zlotnick and Soman 2004). (However, the authors would point out that preventable emergency room visits ("Asthma or Diabetes") would not have occurred if appropriate care had been provided elsewhere.)

The findings above point to a reality that has been explored by other studies (Bindman et al. 2009), namely that increasing continuous coverage among children is unfortunately not likely to provide cost savings to a state's Medicaid program.

CONCLUSION

While the findings of this analysis were not entirely anticipated, the mixed results indicate that additional research is needed to assess the impact of implementing continuous eligibility policies. In general, researchers concerned with access to care have found that any kind of discontinuous coverage breaks the link that insurance provides between the enrollee and healthcare services (Davidoff et al. 2000; Dubay and Kenney 2001; Kasper, Giovanni, and Hoffman 2000; Keane and Lave 1999; Lave et al. 1998; Olson, Tang and Newacheck 2005; Sudano and Baker 2003). Showing the opposite effect—i.e., that continuous coverage facilitates continuity of care—would strengthen the case of the implementation of continuous eligibility policies, which are fairly simple, low-cost administrative methods by which states can improve their retention and boost enrollment.

The 2010 Patient Protection and Affordable Care Act (PPACA) mandates that, effective January 1, 2014, states implement an expansion of the Medicaid program to include everyone with household incomes at or below 133% of the Federal Poverty Level (FPL), both those with and those without dependent children in the home. This expansion is estimated to increase the population in Medicaid by nearly 16 million people by 2019 (Congressional Budget Office

2010). As of December 2009, only 22 states used 12-month continuous eligibility in their Medicaid programs (Kaiser Family Foundation 2010), which has historically been a state decision. However, the PPACA overlaps eligibility determination for Medi-Cal into the new web-based Exchanges, and the detailed requirements for these new portals have been left up to the Secretary of the U.S. Department of Health and Human Services (HHS). Whether or not HHS regulations will include 12-month continuous eligibility as a new requirement for states remains unclear.

The findings above demonstrate a clear public health benefit of 12-month continuous eligibility—through this administrative method, more children gain continuous coverage and have a higher likelihood of seeing a doctor during the year as per recommended guidelines from the American Academy of Pediatrics. That continuously enrolled children also tend to use emergency rooms more often may indicate avoidance of any medical care by discontinuously insured children. It also represents an avenue for improvement in Medicaid, as parents will use emergency departments less when there is adequate access to a doctor's office.

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The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues, specifically as they relate to the state implementation of the Affordable Care Act (ACA). The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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