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**DR. DYNASAUR, MEDICAID,  
AND VERMONT'S CHILDREN**

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A  
**Vermont  
KIDS COUNT**  
Report

**Vermont Children's Forum**

*Voices for Vermont's Children*

# Vermont Children's Forum

*Voices for Vermont's Children*

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## *Dr. Dynasaur, Medicaid, and Vermont's Children*

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## Executive Summary

This report examines some key indicators of insurance stability: enrollments in all forms of insurance, participation in public health insurance and changing trends, and coverage loss and possible reasons.

There are several significant changes taking place in the health insurance arena for children in Vermont, many of which indicate that children are losing coverage unnecessarily or for reasons that are currently unexplainable.

On the positive side, the expansion of Dr. Dynasaur income limits in 1998 resulted in steady increases in the number of covered children for several years.

Between 2003 and 2006, total enrollments declined by 9.2 percent for children covered by Dr. Dynasaur (except for children enrolled in traditional Medicaid). This downward trend includes children whose families do not pay premiums.

This has occurred at the same time that the Vermont child poverty rate grew between 2004 and 2005 and as rates of children's participation in the Food Stamp and federal School Meals Programs have risen.

Meanwhile, the percent of children who are uninsured in Vermont was nearly the same in 2005 as in 2000.

## Introduction

Vermont has come a long way from 1967, when it first offered federal Medicaid health insurance to young children. Almost 40 years later, the state is close to achieving near universal health insurance coverage for children through its Dr. Dynasaur public health insurance program.

Reaching that goal may be elusive, however. Even as Dr. Dynasaur covers an increasing proportion of children as private insurance coverage declines, overall Dr. Dynasaur enrollment has fallen in recent years, and about five percent of children have no insurance.

Dependable health care access is as critical to a child's well-being as are good nutrition, safe housing, and a quality education. The impact is life-long: healthy children have the energy to participate in school and play and have more resistance to childhood illnesses and less risk of chronic and serious illness.

Maintaining affordable insurance coverage is essential to Vermont kids—they rely on public insurance more than children in most other states. More than four in ten Vermont children see their doctor and get their prescriptions paid through Dr. Dynasaur coverage.

This issue brief explores the current status of children participating in Dr. Dynasaur and looks at how children fall through the gaps—and possible causes and approaches to remedy them so we *can* reach Vermont's dream of universal health care.

*Dr. Dynasaur is both an end and a means towards improving the health of Vermont's children. Studies indicate that healthy children attend school more and then become better learners. But, Dr. Dynasaur is also a means to an end. Public Health has been able to leverage the sheer number of children on Dr. Dynasaur to set standards of care for all Vermont children.*

- Patricia Berry, Director,  
Maternal and Child Health,  
Vermont Department of  
Health

# Background

## Dr. Dynasaur :

(**dine**-ah-soar) Vermont’s public health insurance for children with incomes up to 300 percent of poverty and pregnant women with incomes up to 200 percent of poverty. Funded by Medicaid and other federal and state dollars, Dr. Dynasaur provides coverage for comprehensive prevention and medical services that set the standard for the rest of the nation.

## Health Insurance Trends

Most children in Vermont are covered by either private health insurance, through a parent’s employment, or by Dr. Dynasaur, Vermont’s public health insurance for children and pregnant women.

The health insurance picture in Vermont is undergoing changes that mirror national trends. The percent of children covered by private insurance has declined while the percent enrolled in public insurance has risen. This shift is occurring as private insurance premiums continue to rise at a rate higher than wage increases. At the same time, some employers have dropped or reduced services or eliminated health insurance entirely.

- In 2005, an estimated 52.2 percent of Vermont children under age 18 were insured by private insurance, or about 73,467, according to a state health insurance survey. That was fewer than the 55 percent, or 81,124 children, covered by private insurance in 2000.<sup>1</sup>
- During the same years, enrollment in Dr. Dynasaur represented 41 percent of children, up from about 38 percent in 2000.
- Other sources of government insurance include Medicare and the military, which cover only a small percent of children.
- Five percent of Vermont children (6,900) were uninsured.<sup>2</sup>

## What Dr. Dynasaur Does

The Vermont Department of Health (VDH) has called for every school-age child to have a “medical and dental home”—that is, a primary care physician and a family dentist who coordinates care, maintains medical history, and whom they see for their periodic needs. Dr. Dynasaur has played a major role in increasing the opportunity for child to have a medical and a dental home.

One of the most noteworthy elements of Dr. Dynasaur is its emphasis on and quality of prevention services—which equal or exceed those available through private insurance. The federal government ensures that children who receive Medicaid have access to EPSDT (Early Periodic Screening, Diagnosis, and Treatment). Vermont has extended this guarantee to all children enrolled in Dr. Dynasaur, regardless of Medicaid status. EPSDT services offer the most thorough access to the crucial barometers of health, enabling a child’s primary care physician to address symptoms and health risks before they become acute or chronic. Dr. Dynasaur also covers dental and vision care, unlike many private insurance plans.

In the years since Dr. Dynasaur was first implemented, Vermont children have been able to rely on more consistent and affordable care. This access, coupled with VDH efforts to increase awareness of the need for prenatal care, health education, and greater outreach, are likely related to improvements in indicators of child health and well-being.

## Dr. Dynasaur History

### Medicaid

Vermont first offered public health insurance through the federal Medicaid program, which has been periodically expanded since 1967. This program covers children and pregnant women who meet narrow categorical, financial asset, and income criteria. These enrollments represented an average of about 58 percent of all children covered by Dr. Dynasaur in 2005. (This group of Dr. Dynasaur enrollees will be referred to as “Dr. Dynasaur-Medicaid.”)

### Dr. Dynasaur

In 1989, the Vermont Legislature created a new state-funded health insurance program, called Dr. Dynasaur, to expand coverage to uninsured pregnant women, and children through age six, who were ineligible for Medicaid. It covered children with family incomes up to 225 percent of the federal poverty level, and pregnant women with incomes up to 200 percent of poverty. Cost-sharing was instituted in the form of co-payments for some services.<sup>3</sup>

In 1992, Dr. Dynasaur was incorporated into the Medicaid program, which resulted in several significant changes. Coverage was expanded to children up to age 18 and a financial asset test was no longer required. In addition, Medicaid rules now applied to children enrolled in Dr. Dynasaur, resulting in the elimination of co-pays, as well as access to Dr. Dynasaur as supplemental insurance for insured children who did not have comprehensive coverage.

Eventually, the program name, “Dr. Dynasaur,” came to represent all forms of Vermont public health insurance for children and pregnant women. It operates as a seamless program for consumers, and all children

enrolled in Dr. Dynasaur can access the same comprehensive services.

In 1998, a new federal program to reduce the number of uninsured children—the State Child Health Insurance Program—helped expand Dr. Dynasaur to children with incomes from 225 to 300 percent of poverty. Additional funds also provided insured children at that same income level with supplemental Dr. Dynasaur coverage.

### Premiums

In Vermont, premiums are charged to Dr. Dynasaur beneficiaries whose incomes are above 185 percent of poverty. The legislature first established these payments as part of the fiscal year 1997 budget, and has increased premiums periodically.

In 2003, the Vermont Legislature responded to rapidly rising Medicaid costs and increased enrollments by both raising premiums and significantly changing the premium billing system. Dr. Dynasaur premiums increased by more than 40 percent for the higher-income children. Previously, Dr. Dynasaur invoices had been sent out quarterly, billing for the past three months’ premiums. Under the new billing system, premiums are paid monthly, in advance.

In 2005, premiums were raised again. As part of 2006 health care legislation, premiums will be reduced by half in July 2007.

### Premiums: National Trends

Growth in Medicaid use has led strapped state Legislatures to impose premiums to share in costs. However, national data show that even though children account for 48 percent of Medicaid (including SCHIP) enrollees, they represent only 19 percent of expenditures on services.<sup>4</sup>

Many states also have established premiums

## Premiums by Income Levels

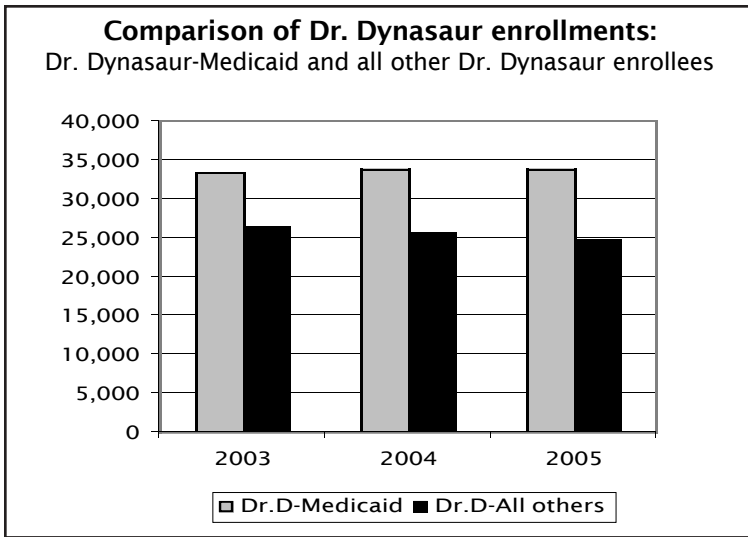
<b>Income:</b>	0-185 % of Federal Poverty Level* (FPL) (Income of under \$2,424 per month)
<b>Who:</b>	Uninsured pregnant women, children under age 18
<b>Premium:</b>	None
<b>Income:</b>	185-225 % of FPL* (\$2,425 to \$2,948 per month)
<b>Who:</b>	Uninsured children under age 18 Pregnant women with incomes of 185-200 percent FPL* (\$2,425-\$2,620 per month)
<b>Premium:</b>	\$30/month (Changes to \$15/month July 2007)
<b>Income:</b>	225-300 % of FPL* (\$2,949 to \$3,930 per month)
<b>Who:</b>	Under-insured children (Privately insured, but without comprehensive insurance) Dr. Dynasaur serves as secondary insurance.
<b>Premium:</b>	\$40/month (Changes to \$20/month July 2007)
<b>Income:</b>	225-300 % of FPL* (\$2,949 to \$3,930 per month)
<b>Who:</b>	Uninsured children under 18. (Also known as SCHIP coverage.)
<b>Premium:</b>	\$80/month (Changes to \$40/month July 2007)

\*2005 Federal Poverty Level (FPL) for a family of 3 (with 2 adults). Poverty income = \$1,310 per month (also referred to as 100% of poverty). Many benefit programs set income eligibility above the FPL. That higher income level is shown as its percentage above the official poverty level, or 185%, 225%, etc. Note: Families pay only one Dr. Dynasaur premium regardless of number of family members enrolled in the program.

Note: Enrollment and disenrollment data in this report are based on actual counts of children covered by Vermont’s public health insurance. They are not directly comparable to data on page 2 (percent and number of children insured by private, public and other insurance, and uninsured children), which are estimates based on a 2005 survey.

and other forms of cost-sharing in the belief that when beneficiaries must pay a portion of health care costs, they will use benefits more responsibly and reduce unnecessary use of service. Studies have shown that those enrolled in public health insurance use health care services at the same rate as the rest of the population. When more services are used, they are used for preventive care, such as EPSDT.<sup>5</sup>

# The State of Insurance for Children



Dr. Dynasaur enrollments split into traditional Medicaid and all other Dr. Dynasaur enrollees. Enrollments increased by 1.5 percent for the first group and declined by 6 percent for the second group.

**Dr. Dynasaur annual enrollments\***  
(All except traditional Medicaid beneficiaries)

Income Level*	2003	2004	2005	2006	Difference between 2003-2006	
					#	%
0-185	16,284	15,530	14,968	14,772	-1,512	-9.3
185-225	4,710	5,134	5,219	4,653	-57	-1.2
225-300 w/insurance	2,034	1,810	1,559	1,249	-785	-38.6
225-300 w/o insurance	3,090	2,952	3,027	2,992	-98	-3.2
All: 0-300%	26,344	25,686	24,773	23,932	-2,412	-9.2

\*Average of monthly enrollments. 2006 is the average of January-October.<sup>6</sup>  
Income levels refer to percent of federal poverty level. See note in box on page 3.

## Enrollments

In 1998, when Dr. Dynasaur was expanded to cover children with incomes up to three times the poverty level, overall enrollments grew each year for several succeeding years. However, between 2003 and 2005, enrollments dropped by 1,087 children, to 58,632. During this period, premiums had increased twice.

The picture is more complex when breaking down enrollments between children covered by traditional Medicaid and all other children covered by Dr. Dynasaur. Enrollments of children in Dr. Dynasaur-Medicaid gained by 1.5 percent, or 485 children, between 2003 to 2005, but enrollments of all other recipients dropped by 6 percent, or by 1,570 children. Enrollments have continued to decline overall from 2005 and 2006, bringing the total drop from 2003, to 2,412 (or 9 percent).

The second table breaks down enrollments even further, by income levels (for all recipients other than those with traditional Medicaid). This shows even more distinct patterns.

Of concern is the fact that enrollments of children at the lowest income levels for Dr. Dynasaur—those living below 185 percent of poverty—also declined. Families of children at this income level do not pay premiums.

Similar shifts at the higher-income end of Dr. Dynasaur also have occurred. Since 2003, there has been a steady decline in the number of privately insured children who use Dr. Dynasaur for supplemental insurance and whose family income is between 225-300% of poverty.

The only enrollment group to show consistent increases during 2003 to 2005 is children with incomes between 185-225% of poverty. In 2006, numbers also are down in this group.

## Disenrollment for Nonpayment of Premiums

Legislators and advocates were concerned that the 2003 Dr. Dynasaur premium increases and billing policy change could send financially precarious families over the edge, unable to afford premiums. Any insurance loss is a potential risk to children's continued access to health care. Research nationally and in other states has shown that premiums may result in children losing coverage due to family inability to pay.<sup>7</sup>

To monitor the impact of premiums in Vermont, the 2004 legislature required the state Department of Children and Families to provide quarterly reports on people who lose coverage as a result of not paying premiums ("disenrollment for nonpayment of premium.") The reports show the number of people who are disenrolled immediately after their bill is not paid, and the number who remain disenrolled continuously for the fol-

lowing three months. Data are not available beyond that period. We do not know if those who were without insurance for three months later re-enrolled in Dr. Dynasaur or were covered by private insurance, or continued to be uninsured.

- In 2005, of children who were disenrolled each month, an average of 125 children were continuously without coverage for the following three months. For January to October 2006, the average was 130 children.<sup>8</sup>
- Disenrollment as a percent of premium-based enrollment has varied slightly between 2005 and 2006. In January 2005 and 2006, the rates were 1.24 percent and 1.46 percent respectively. In July 2005 and 2006, they were 1.69 percent and 1.61 percent.

## Uninsured Kids

In 2005, 4.9 percent of Vermont children under age 18, or 6,900, were without insurance, a slight increase from 4.2 percent, or 6,191, in 2000.<sup>9</sup>

- About 80 percent of uninsured children are eligible for Dr. Dynasaur, or 5,490.
- Dr. Dynasaur previously insured 69 percent of uninsured children who lost coverage during the past 12 months. This compares to about 47 percent in 2000. About 17 percent of uninsured children previously were enrolled in private insurance within the past 12 months, compared to 23 percent in 2000.
- 55 percent of uninsured children had

been without health care coverage for over 12 months.

- Over half of uninsured children live in low-income families, with incomes below \$2,682/month for a family of three. (<200 percent of the federal poverty level). Slightly less than one-third of uninsured children live in families with income between \$2,682 and \$3,930 (200%-299% of poverty), and more than one-fifth live below the poverty line.
- Older children and youth were more likely to be uninsured—60 percent of those without coverage were ages 10-17. In addition, boys are more likely to be uninsured.

Dr. Dynasaur Disenrollment for nonpayment of premiums

	185-225%	225-300 Underinsured	225-300 Uninsured	Total
January 2004	NA	NA	NA	270
April 2004	NA	NA	NA	77
October 2004	NA	NA	NA	138
November 2004	NA	NA	NA	233
December 2004	NA	NA	NA	214
January 2005	NA	NA	NA	126
February 2005	NA	NA	NA	102
March 2005	45	21	51	117
April 2005	69	18	62	149
May 2005	96	27	52	175
June 2005	50	17	40	107
July 2005	74	31	56	161
August 2005	45	43	61	149
September 2005	50	17	39	106
October 2005	45	18	29	92
November 2005	46	17	28	91
December 2005	56	27	40	123
January 2006	61	14	52	127
February 2006	57	18	42	117
March 2006	49	14	32	95
April 2006	75	20	35	130
May 2006	69	16	47	132
June 2006	76	28	56	160
July 2006	72	18	56	146
August 2006*	132	27	88	247
September 2006*	151	30	74	255
October 2006*	127	23	79	229

Data from Disenrollment reports, Vt. Department of Children and Families. \*Preliminary reports.

## Impact of Losing Coverage

Even a short-term loss of insurance can wreak havoc on a child's getting adequate preventive or regular medical care; health problems that occur during this period also add to economic burdens of already-struggling families.

- Children may have to stop medications, forgo immediate treatment for common problems such as ear infections, or ongoing treatment for more serious illnesses. They miss check-ups and needed preventive care.
- Lack of insurance can set back a child's progress in recovering from an illness or dampen their resistance to illness. In the interim, they are at risk of having minor problems develop into more urgent problems. Families may hold back on treatment until the illness becomes much worse. Increased emergency room use has been linked to loss of insurance.<sup>10</sup>
- 45 percent of uninsured Vermont children did not have a regular check-up due to cost. And more than four times as many uninsured children as insured children did not see a doctor within the last 12 months—30 percent compared to 7 percent.

The child isn't the only person affected by loss of health care coverage. Without insurance, medical expenditures can mount, adding to the family's existing economic woes and stress.

*Families that have uninsured children were also more likely than families with insured children to have problems paying for medical bills, to have been contacted by a collection agency about unpaid medical bills, or have had to alter their lives significantly in order to pay medical bills.*

- 2005 Vermont Household Health Insurance Survey

## Uninsured Children, *continued*

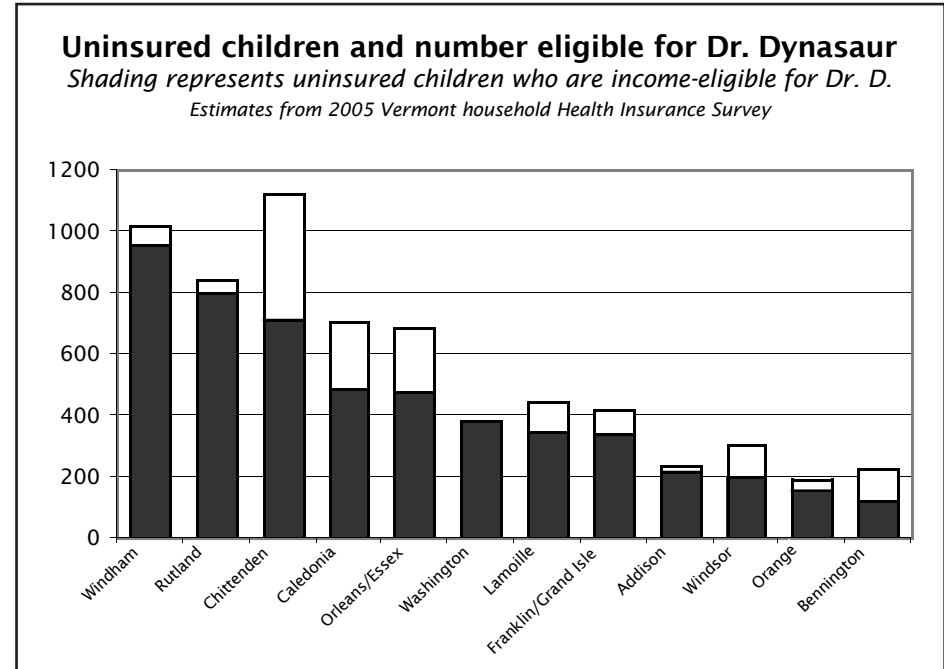
- Although the majority of children without insurance are estimated to be eligible for Dr. Dynasaur, one out of two parents responding to the 2005 survey said they did not think their child would be eligible. One parent in seven was unaware of the publicly funded health insurance.

### Churning

Some children temporarily lose Dr. Dynasaur coverage for short periods and later regain coverage. This pattern of short-term inconsistent coverage is what policy-makers call "churning." If we look at the

reports on disenrollment for nonpayment of premiums, we can estimate the number of children churning—those who initially were disenrolled and then regained coverage within the report's three-month period. In 2005, the average was 70 children per month, compared to 85 per month in 2006 (January through July).<sup>11</sup>

The total number of children churning may be higher; these estimates do not include the number of children who lose coverage for other reasons, such as incomplete applications or recertification problems.



# Analysis of Enrollment

Enrollment declines present a perplexing dilemma because it can be difficult to identify the causes responsible for these changes. Various factors—an improved economy or a decline in population—might explain some of the trends. This section looks at possible reasons for downturns in enrollment and disenrollments.

## Family economic security

Judging from recent poverty data and benefit programs participation, it doesn't appear as though fewer children are in need.

- The 2005 U.S. Census American Community Survey found that Vermont child poverty increased between 2004 and 2005—from 10.9 percent of the population under age 18, to 14.5 percent.<sup>12</sup>
- Participation in low-income nutrition benefit programs show no significant decline. The percent of children approved for free and reduced-cost federal School Meals continued to increase and Food Stamp enrollments also have grown during recent years.

## Population changes

- Between 2000 and 2004, the estimated number of children under age 18 declined by over 7 percent, or by 11,000.<sup>13</sup>
- This change in population may not be related to declines in Dr. Dynasaur enrollment, however. Even though the child population is smaller, the percent of newborns enrolled in the Women, Infant,

and Children's Supplemental Nutrition Program (WIC) has actually increased in recent years.<sup>14</sup> WIC serves children under age five and pregnant and postpartum mothers with a medical or nutritional condition, whose family incomes are up to 185 percent of poverty or who are enrolled in Dr. Dynasaur or Medicaid (up to 300 percent of poverty).

## Fewer older children insured

In its 2005 Household Health Insurance Survey, the report's authors speculate that families may not continue health insurance coverage for older children because their medical needs are not as frequent.

*[F]amilies may not be renewing coverage for... [older] children as they become teenagers. One reason may be less frequent trips to health care providers. Younger children tend to visit doctors and other health care providers frequently for immunizations, well care visits, and for common conditions like colds. As children age, these visits may become less frequent, and the perceived need for health insurance coverage may decrease as well.<sup>15</sup>*

## Failure to recertify

By statute, Dr. Dynasaur review is every 12 months. But, in practice, children enrolled in Vermont's welfare program, known as Reach-Up, and/or Food Stamps, are reviewed every six months. As long ago as 2001, a review by the U.S. Department of Health and Human Services, Health Care Finance Agency, pointed out the following disparity in the redetermination process:

*Dr. Dynasaur has been a foundation for improvement projects such as the Vermont Child Health Improvement Program at the University of Vermont, Tooth Tutor Program which assists school aged children in obtaining a dental home, and the partnership with the Women Infant and Children's Program (WIC) which provides both medical services, care coordination and food for pregnant women and children (under age 5). The Dr. Dynasaur program is a foundation of public health for Vermont's children."*

- Patricia Berry,  
Vt. Department of Health

## Insuring parents helps kids

Parents' health and their participation in health care coverage influence children's health and coverage. Expanding public health insurance to cover parents has been associated with increased enrollments of their children. Urban Institute researcher, Genevieve Kenney, found this relationship in her research.

*Expanding public coverage to parents gets more kids covered, we've found, which in turn may lead to better access for both parents and children. There's also evidence that the mental health status of parents affects whether children get the health care they need. So even if the ultimate goal is to improve the lives of children, what's going on with the parents needs to be taken into account too.<sup>16</sup>*

Vermont offers public health insurance to low-income parents and caretakers with incomes above the standard Medicaid cut-off, through the Vermont Health Access Program (VHAP). In the past three and a half years, average enrollment has fallen by over 35 percent, from 2,754 in 2003, to 1,779 in 2006 (January-October). These parents have incomes between 150% to 185% of the federal poverty line, or \$1,965 to \$2,423 per month for a family of two adults and one child.

*We are... concerned that the State links the Medicaid redetermination process to that of ANFC [Aid to Needy Families with Children, now known as Reach-Up], and note that most joint ANFC/Medicaid cases were closed due to failure to attend the required face-to-face interview. While Medicaid-only cases are redetermined annually by mail, joint cases are redetermined every six months, and require an interview.<sup>17</sup>*

### Disenrollments and premiums

The Office of Vermont Health Access monitored the outcomes following the 2003 premium and billing changes, and issued periodic updates in 2004 and early 2005. In April 2004, it released the results of a survey of people who were disenrolled due to nonpayment of the premium.

The survey found that 43 percent of disenrolled children had switched to private insurance. In addition, 27 percent of families reported that premium cost was a problem, and the remaining 30 percent reported they were confused or dissatisfied about the payment period or premium amount. Half of those who had lost coverage and were uninsured expected to reenroll.<sup>18</sup>

The last update, issued in January 2005, showed a 2.5 percent overall decline for all Dr. Dynasaur enrollments, from January 2003 to December 2004. Premium-based enrollments had increased by 5.9 percent during the same period.<sup>19</sup>

2006 trends show a significant change between 2003 and 2006: a 9.2 percent drop for all Dr. Dynasaur programs and a 8.9 percent decline for premium-based enrollments.

The Vermont Legislature's Joint Fiscal Office, which provides independent fiscal analysis, issued its own report in 2004. It generally concurred with the results of the April 2004 Office of Vermont Health Access report, but also urged state government to continue analysis of the impact of premiums on enrollment. Among its conclusions:

*To understand the final consequences of this policy change, it is essential that the Department of PATH [Prevention, Assistance, Transition and Health Access, now known as Department of Children and Families] continue its current efforts to monitor and report disenrollment, with particular focus on reasons for disenrollment and transition to other coverage.<sup>20</sup>*

Unfortunately, the disenrollment reports are limited in their scope. Because of that, it is difficult to observe trends or understand the full extent of loss of coverage related to nonpayment of premiums.

### Reasons for nonpayment

Data are not collected on the reasons why premiums were not paid, so it is not possible to determine the full impact of premiums on affordability. The reasons for not paying premiums can range from inability to pay, to change to private insurance, loss of eligibility when child turns 18, loss of eligibility when income increases beyond the limit, family moves out of state, or problems with recertification—the parent may have been confused about the process or forgotten to pay the premium, or encountered other obstacles.

## Conclusion

**W**hat we don't know can hurt us. With limitations to the data we can access, there are more questions than answers about the status of children and others who lose health coverage:

We don't know how long children remain without insurance once they are disenrolled for nonpayment of the premium.

We don't know how these children get health care and preventive care in the interim.

We don't know how many children have lost coverage due to lack of money to pay premiums.

We don't know why enrollments are down for children whose families are not required to pay premiums.

We don't know why families of the uninsured children who are eligible for Dr. Dynasaur thought their children didn't qualify, or were unaware of or averse to enrolling their children in Dr. Dynasaur.

Until we have the answers to these and other questions, we're operating in the dark. Although premiums will be reduced by 50 percent for Dr. Dynasaur participants in July 2007, we don't know what the future will bring. Future cost pressures on federal funds and Vermont's Medicaid budget could potentially result in policy changes limiting access to or breadth of services, premiums could increase again or be imposed on even lower-income beneficiaries.

These issues call for expedited strategies to address missing pieces in outreach, recertification, enrollment and data collection. They require a serious commitment to remove impediments to covering eligible children and families and maintain those who are already enrolled.

*Dr. Dynasaur has made my life as a pediatrician immensely more satisfying, because I know people are not looking in their wallet or checking account before they decide to bring their kids in for care. I can provide care without wondering whether they are making decisions between food and health care. Probably 50 percent of the kids that I see are covered by Dr. Dynasaur. Dr. Dynasaur pays less than private insurance, but that's fine with me. It has helped me give better care. I can say to people, 'You know what? Maybe your kid doesn't need an antibiotic. Why don't I see you back in two days and see how things are going?' Before, people would be thinking, 'That's another \$60. I can't do that.'*

- Dr. Jack Mayer,  
from *Communities of Caring*<sup>21</sup>

# Recommendations

*At the state level, the findings present a strong word of caution to would-be budget cutters who hope to save money by cutting provider reimbursement rates. The evidence strongly suggests that this policy will increase the rate of children leaving Medicaid and [State] Children's Health Insurance Program to become uninsured.*

- Benjamin Sommers,  
From Medicaid to Uninsured: Drop-Out among children in public insurance programs.<sup>22</sup>

## Improve Continuity of Insurance Coverage

Because so much of the preventable loss of insurance has been linked to problems with recertification of eligibility, many states have simplified the process and materials. Some of these measures take into consideration literacy challenges, and focus on improving convenience of renewal. Others address more systemic changes.

Adopt the Continuum Approach recommended by the Report on Medicaid and Catamount Outreach prepared by Bi-State Primary Care Association.<sup>23</sup> This approach calls for designing a system that prevents no eligible individual from “falling between the cracks,” by recognizing the complexity of matching appropriate coverage to eligible residents who may experience a wide range of fluctuating income, family size, financial resources and other factors.

- Create simplified renewal forms, with user-friendly reading level for those with low literacy.
- Mail renewal notices well in advance -by as much as 60-90 days.
- Consider “out-stationing.” In rural areas where transportation is limited, locate some eligibility workers in out-of-office, non-traditional settings, available after hours to 9-5 workers. Known as “out-stationing,” this practice has made a difference in other states’ urban areas, and

could address access challenges in Vermont’s rural areas.

- Improve visibility of information about Dr. Dynasaur and Medicaid on School Meals enrollment forms. Enlarge and make section easier to read.

### Systemic changes

- Develop a system to contact individuals and families that have not paid premiums to determine why they did not pay, and to offer assistance in recertifying or reenrolling, if applicable.
- Change the practice of six-month face-to-face reviews for Medicaid beneficiaries who are also enrolled in Reach-Up and/or Food Stamps. In its 2001 report on Vermont Medicaid/TANF, the U.S. Department of Health and Human Services recommended the following change:

*The State should consider establishing an annual redetermination schedule and mail-in procedure for all categories of Medicaid, including ANFC-related Medicaid, to promote continued Medicaid coverage for all beneficiaries.<sup>24</sup>*

- The 2001 Vermont Medicaid/TANF Review also recommended:

*The State should also streamline the redetermination form and eliminate the requirement for submission of a new application at redetermination.*

- Consider presumptive continued eligibili-

ty for children at risk of losing coverage due to a parent's missed appointment for ANFC and/or Medicaid review.

- Consider pre-completed forms, which can reduce renewal problems. Explore the costs and benefits of establishing a pilot run of “passive reviews,” a process in which the state fills out and sends the renewal forms with all of the known family information. The family then corrects the application if needed, or does nothing if no income or other changes have occurred.

For example:

- States that have introduced “passive reviews” have greatly reduced the problem of children “churning” in and out of coverage, by retaining their coverage. It also has helped families with limited literacy skills for whom filling out a form is a difficult process. Concerns about abuse of this system could be addressed through periodic monitoring of the program.

- This approach may appear to be costly, but proper safeguards have lead to very little abuse, according to some research. Researcher Benjamin Sommers acknowledged states’ legitimate concerns, but found that,

*Passive re-enrollment would not keep children covered if their circumstances improve significantly, but it would prevent children in need from dropping out simply because their parents failed to recertify.*<sup>25</sup>

- Vermont should consider conditionally covering children who are approved for the Federal School Meals Program, pending confirmation of eligibility. School Meals’ income eligibility for reduced-price meals is below 185 percent of poverty, which is within Dr. Dynasaur income guidelines.

- In Ohio, an addendum to the School Meals application encourages parents to apply for health insurance for their children. After the state receives the forms, eligible families are sent applications for the children’s state health insurance program. The city of Cincinnati took the program a step further, with follow-up calls to assist parents.<sup>26</sup>

### **Involve health professionals in renewal process**

- Consider adopting Massachusetts’ “Member Express Renewal” process, which allows families to renew enrollment prior to the annual date, in a doctor’s or clinic office. This reduces stress, possibly also transportation problems, as well as administrative paperwork.<sup>27</sup>
- One study found that frequency of family visits to health care providers was associated with maintaining coverage of the children. Health professionals served as a good connection to encourage parents to enroll or renew insurance. The study suggested that reimbursement “be made possible for the physician and staff to assist in helping with the public insurance renewal process.”<sup>28</sup>
- 2006 health care legislation included funding to increase Medicaid reimbursement rates for physicians. It will be essential to maintain adequate Medicaid reimbursement rates in future years, to prevent limitations to health care access. If rates decline, fewer providers will accept Medicaid clients, thus limiting options for children covered by Dr. Dynasaur, and others dependent on public health insurance.

*If states are to make informed improvements in their eligibility renewal policies, then they will need either to make investments to improve their administrative data systems, or periodically conduct disenrollee surveys, parent focus groups, or other research to better understand what happens to children once they lose their State Children’s Health Insurance Program eligibility.*

- The Urban Institute<sup>29</sup>

*Information on whether disenrollees are successfully moving to private health insurance, moving to Medicaid in a timely and efficient way, or becoming uninsured, may help determine how concerned to be about disenrollment and what to do about it.*

- Packard Foundation<sup>30</sup>

## Improve Data Collection and Reporting

### Data limitations

When it comes to understanding trends and measuring the causes of reduced enrollments, or results of premium implementation, few data resources are available. Data limitations plague research on the impact of changes to Medicaid policy in most states. The Urban Institute, in its report, “Is There a Hole in the Bucket? Understanding SCHIP Retention,” found that “State SCHIP and Medicaid data systems are highly variable in their capacity to report eligibility and redetermination data.” They recommended that states must invest in more effective administrative data systems, or turn to conducting more targeted research, such as parent focus groups, disenrollment surveys, or other measures to better analyze the status of people who have lost coverage.<sup>31</sup>

- The state data system does not track whether children who have been disenrolled for three months later reenroll in Dr. Dynasaur or obtain other health insurance coverage.
- Disenrollment reports cannot be tallied with others, so there is no cumulative count of children who remain uninsured due to nonpayment of premiums.
- Similarly, we do not know the number of children who lose and regain Dr. Dynasaur coverage more than once a year.

### Gather more qualitative data

Qualitative research collects information from consumers and others in the form of surveys, focus groups, in-depth interviews, and other approaches. This form of research fulfills an important need, by answering the questions that cannot be provided by data

systems, such as “why are children losing health care coverage.”

- For example, the state of Michigan collects samples each month from its administrative database, and then follows the insurance usage and transition of each of the children in this sample. This also allows them to discover what conditions have resulted in changes to insurance status.<sup>32</sup>
- Vermont could take a similar approach, with follow-up interviews or surveys with these individuals.
- Appropriate funds to add staff capacity to the Economic Services Division. This would allow it to produce more data analyses, without adding to its increased workload related to analysis of Medicare Part D, Catamount Health, and Employer Supported Insurance programs.
- Conduct more frequent Vermont Household Insurance Surveys. Administered by the Vermont Department of Health Care Administration, these surveys provide valuable, up-to-date information on health insurance status of Vermonters. They are far more accurate than the Census Current Population Survey results. The previous Vermont Household Insurance Surveys were conducted in 2005 and 2000. More frequent updates could alert policy makers to unmet needs or enrollment problems.

These are just a sampling of some successful efforts to stabilize children’s enrollment in public health insurance. Some will cost money—but those funds are better spent to improve coverage rather than to react to the higher costs of not taking care of kids.

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