Briefing REPORT 2009-1

Health Care and Family Stability: Policy Decisions and Costs

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ASU School of Social and Family Dynamics
Arizona State University

Health Care and Family Stability: Policy Decisions and Costs

Overview

This is the first in a series of annual Family Impact Seminars (FIS) in Arizona. It follows a national model used in 25 other states. The Seminars connect research and state policymaking by providing state-of-the-art information in an objective, non-partisan manner. Each topical seminar includes forums, briefing reports, and follow-up activities designed specifically for legislators, key agency directors and staff. Rather than lobbying for particular policies, the Seminars provide an array of policy options and opportunities for participants to identify workable strategies and common ground.

The Family Impact Seminars, a project of Arizona State University, School for Social and Family Dynamics, seek to promote: (1) a family perspective in policy development, (2) collective discussion among policymakers and researchers, (3) an analysis of the impact public policies have on families, and (4) a connection between family-relevant research and state policymaking. The Arizona Family Impact Seminars website is www.asu.edu/ssfd/fis. For more information about national Family Impact Seminars, go to http://familyimpactseminars.org.

The Executive Summary

This report provides a written background for the FIS speakers' presentations. It includes a new way of examining public policy from the Family Impact Perspective. It contains demographic information on Arizona families, including poverty, unemployment and employment rates, parent education and nativity. In addition, the report contains information on health care access specific to Arizona families.

The presentation by Rae Jean Proeschold-Bell, PhD, of Duke University, addresses (1) the characteristics of strong, stable families and what supports them and (2) evidence-based research on the Healthy Families program as well as other effective family support programs. Laura Summer, from Georgetown University, addresses various methods to increase insurance coverage, coverage stability issues, costs to the system, and policies and procedures that can help Arizona families achieve more stable coverage.

For a full version of this report, please go to www.asu.edu/ssfd/fis/briefs.html.

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THE FAMILY IMPACT PERSPECTIVE IN POLICYMAKING

The family impact perspective in policymaking analyzes the consequences of any policy or program, regardless of whether it is explicitly aimed at families, to determine its impact on family well-being. The analyses include a consideration of the ways families contribute to the problems, how families are affected by problems, and whether families need to be involved in solutions. Just as policy makers evaluate the economic or environmental impact of policies, there are methods for examining the family impact.

A family impact perspective is different from family policy (policy that directly impacts family makeup and is designed to have specific effects on family). A family perspective examines implicit or unintended consequences policies may have on families. Policies developed at all levels can potentially affect families. Policies such as "No Child Left Behind" or "Welfare to Work" have an obvious relationship to families.

Worksite policies have a clear relationship to an employee's ability to function as a member of the family and make sure that the needs of the family are taken care of. Others, such as transportation or feedlot zoning issues may not seem to have an obvious impact on families, but if one looks beneath the surface to the intended and unintended consequences for families of all kinds, the relationships become obvious.

Although our primary goal is to make sure that families in Arizona are well served by governmental agencies and institutions, we do not engage in direct advocacy in behalf of families. Most family advocates campaign for an under-represented group or a particular policy alternative that they believe may potentially enhance family well-being. In doing this, advocates examine options in light of their own value system, using a personal interpretation of the scientific evidence, with the aim of promoting a single policy option that they deem most desirable for families.

In contrast and complement to this approach of influencing policies, policy educators do not lobby for a single policy, but rather attempt to inform policy discourse by clarifying potential consequences of several policy alternatives. They make an effort to educate by presenting research findings objectively without imposing personal biases.

Assessing the Impact of Policies on Families: The Family Impact Checklist

The first step in developing family-friendly policies is to **ask the right questions**: (1) What can government and community institutions do to enhance the family's capacity to help themselves and others? (2) What effect does (or will) this policy or program have for families? Will it help or hurt, strengthen or weaken family functioning?

The Consortium of Family Organizations developed a framework to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. Each of the six principles serves as a criterion for how sensitive to and supportive of families policies and programs are. The principles are not rank ordered and sometimes they conflict with one another, requiring trade-offs. Cost effectiveness must also be considered.

Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes questions will require rephrasing. This tool, however, reflects a broad non partisan consensus, and it can be useful to people across the political spectrum.

Policies are most beneficial to families when they:

- Foster and support rather than hinder or replace the major functions of families – family creation, economic support, childrearing, and caring for their members
- Encourage and reinforce family membership and stability
- Recognize the interdependence and strength of family relationships, even when those relationships may be conflicted
- Encourage families to be involved in addressing issues that affect them
- Recognize that there are many forms and configurations of families, and the effects of policies on diverse families may be very different
- Recognize and act on the need to support families who are vulnerable economically and/or socially

The intent of the framework is to provide individuals or groups with a tool to help think critically about a policy or a program in relation to the family. It provides the user an opportunity to formally or informally assess the possible benefits, as well as the possible negative impact, of a policy or program on families. Sometimes, it might be used to compare and contrast two or more different policy or program options. In other cases, it may be used only to identify the reasons for and reasons against one specific policy or program.

The framework can also be used to help in the initial stages of policy or program development as a way to encourage critical thinking about the potential policy or program and the possible impact it may have on families. The framework is not designed to be an evaluation tool in the sense of determining if the goals of a policy or program have been met. A scope of the framework, titled "Family Impact Checklist" can be found at http://www.familyimpactseminars.org.

ARIZONA FAMILIES

Basic Overview

In order to set the stage regarding families in Arizona, we reviewed several reports and sources. According to the U.S. Census (2005-2007 ACS data), there are an estimated 6.15 million people living in Arizona. There are 897,582 families with roughly 1.6 million children. The average family size is 3.33 persons, slightly larger than the U.S. average of 3.19 persons.

The median family income is $57,004, less than the U.S. average of $60, 374. There are slightly more families with children living in households below the federal poverty level in Arizona as compared to the national average, 10.3% and 9.8% respectively.

Nearly one-third (29%) of residents are Latino, compared to an overall U.S. average of 14.7%. There are 15% foreign-born Arizona residents as opposed to the national average of 12.5%.

Unemployment Rates

Since access to health care is primarily employer-based, unemployment rates are key statistics. According to the U.S. Bureau of Labor Statistics October 2008 preliminary data reports, Arizona is 3rd among states in the percentage of residents losing employment over the month at -0.7%.

Families, Children, and Poverty

Even when a parent is employed, health insurance premiums may not be affordable. Almost one-half (48%) of Arizona children live in families that are classified as low-income (less than 200% FPL).

ARIZONA HEALTH CARE ACCESS AND INSURANCE

How are Arizona residents insured? The Arizona Health Survey (AHS), conducted May 2008, specifically researched Arizona residents as opposed to national surveys. Roughly 4,000 residents were surveyed, including children; however, the data on children has not been analyzed to date. Findings on the health insurance of Arizona adults are currently available, and key points have been included here. The full report is available at www.arizonahealthsurvey.org.

About one in five adults (17%) lacked health insurance coverage in Arizona for at least some part of 2008, and roughly the same number (16%) use AHCCCS, the state's Medicaid program (Rissi et al., 2008).

Arizona residents who identify as Latino or Hispanic are more likely than non-Hispanics to report lack of insurance, which is primarily due to access to employer-based coverage (Rissi et al., 2008:11). Forty-two percent (42%) of Hispanics report employer-based coverage compared to 66% of non-Hispanic residents.

Adults who are currently looking for employment have the lowest rate of coverage at 68%. Nearly half of this group, 45%, is covered by AHCCCS, which may possibly be due to changes in social welfare benefits (Rissi et al., 2008:12).

Although AHS data are not currently available for children, several reports on Arizona children's health care coverage show that Arizona's rate of children without health insurance is one of the highest in the nation (Commonwealth Fund 2008, Children's Action Alliance 2004, Morrison Institute). Roughly 17% of Arizona children are uninsured, which ranks Arizona 48th among states in access to children's health care (Commonwealth Fund). Out of the 17% of children without insurance, half of those are eligible for KidsCare or other public health insurance programs and just need to be enrolled (CAA, 2004: 2).

Clearly there is variability in insurance coverage and access to health care in Arizona—all of which affects the ability of family members to function well in school, at work, or as members of the community.

Promoting Family Stability in a Down Economy

Rae Jean Proeschold-Bell, Ph.D.

Intuitively we know that families matter greatly. Families impact the well-being of their children and are the back-bone of society. However, it can be difficult to know what policies will best support families, especially when families can be so different in terms of culture, who heads them, the ages of the children, and the health and employment needs of each family member. Policymakers would benefit by knowing whether there are common strategies that lead to the success of most families.

How can policymakers promote family stability and family health?

There are four ways in which policymakers can promote family stability, and therefore child health, because family stability is directly related to child health.

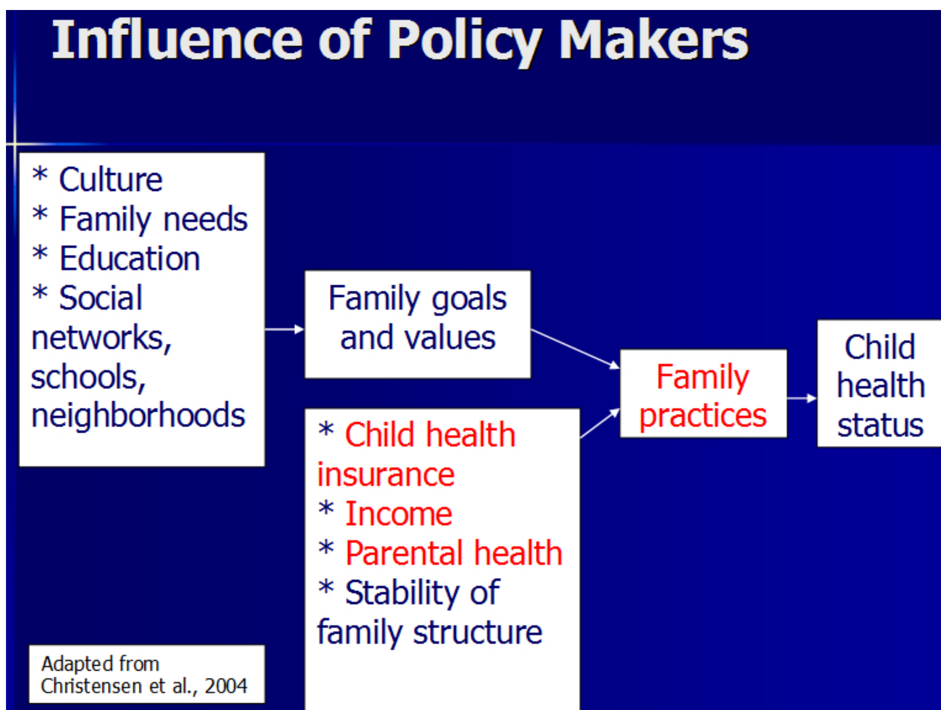
1. Provide continuous health insurance coverage for both children and parents;

2. Reduce parental stress;

3. Promote parental monitoring through programs such as Healthy Families Arizona;

4. Address parental substance abuse and depression quickly through continuous health insurance coverage and other policies.

Policymakers can also support programs that meet family needs, such as the need for good education or housing, or programs that educate parents on healthy practices.



Why is the health of parents so important?

The health of family members is a vital resource for daily living. Parents who are healthy are able to earn a better living and give more time and energy to their children than parents who contend with poor health (Breslow, 1999). Children's health cannot be seen in isolation from their parents' health.

What is family stability and why does it matter?

Given the diversity of cultures in Arizona and elsewhere, it is worth noting that family stability has been defined consistently across cultures. Family stability is generally considered to exist in families whose parents are healthy and earning incomes; whose members experience housing changes only infrequently; and whose family members stay together with infrequent divorce and remarriage, or few separations due to immigration and job-seeking reasons (Patterson & Yoerger, 2002).

The benefits of family stability on children are numerous. Family stability results in more effective child supervision and parental monitoring, less family conflict, and more family cohesion (Robertson et al., 2008). Good parental monitoring, in particular, results in better child physical and mental health.

Supporting child health through promoting parental monitoring

Early research on families mapped out broad-strokes relationships between child health and poverty, between child health and parental depression, between child health and parental substance abuse, and so on. One key family practice that has been elucidated is parental monitoring. Parental monitoring has to do with the degree of supervision parents provide their children. Good parental monitoring has consistently been found to promote successful academic and social experiences in children. Conversely, poor parental monitoring has been found to result in high family stress; child abuse; child neglect; juvenile delinquency; and academic failure (Robertson et al., 2008).

Given the dire outcomes of poor parental monitoring, it is logical to ask what promotes good parental monitoring. Parents free from serious illness, that is, healthy parents, make good parental monitors (Ashiabi & O'Neal, 2007). Good mental health, in the form of not being depressed and not being addicted to substances, also enables parents to be good monitors

(Forgatch & DeGarmo, 2002, Johnson, 1996; Johnson et al., 1995; Patterson & Yoerger, 2002). Continuous health insurance for parents is therefore key in promoting parental monitoring, which in turn supports children.

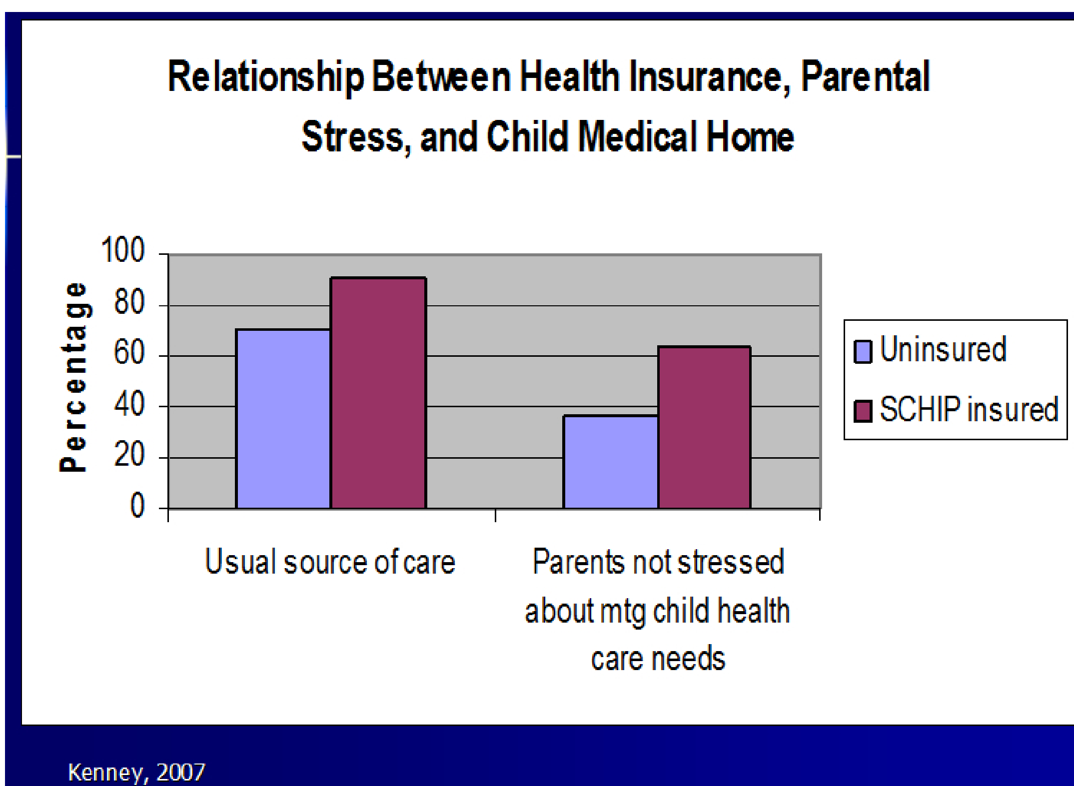
Surprisingly, almost anyone can be taught to be good at parental monitoring. The bad news is that people are not born knowing how to parent. Programs such as Healthy Families Arizona include education on parental monitoring.

Supporting child health through continuous health insurance for parents and children

Health insurance coverage in Arizona has significant gaps; only five states have higher proportions of uninsured residents than Arizona (Rissi et al., 2008). In 2008, among working adults ages 18-64 in Arizona, 25% or 950,000 people lacked health insurance for at least part of the year (Rissi et al., 2008). Having health insurance directly translates into receiving needed medical care. In Arizona in the past year, over 30% of people without health insurance put off needed medical care, compared to 10% of people with insurance (Rissi et al., 2008).

Health insurance for adults is critical to child health 1) because healthy adults are better parental monitors and 2) because health insurance allows parents to quickly treat their own depression or addiction when they experience it. However, as one might imagine, health insurance for children is also critical (Ashiabi & Neal, 2007; Ettner, 1996; Newacheck, 1992; Paul et al., 1998; Perrin et al., 1989; Stoddard et al., 1994; Wood et al., 1990). Uninsured children are more likely to:

- Have fewer doctor visits;
- Go a year without any doctor contact;
- Lack a medical home;
- Receive inadequate preventive care;
- Not go to the doctor when they have symptoms; and
- Have higher rates of hospitalization for illness or injuries due to lack of primary care.



Health insurance for children is also needed to prevent child illness and physical disorders. Health insurance also helps in reducing complications and additional adverse consequences when illnesses and injuries do occur. A large number of children--10-20% of children in developed countries--have chronic physical disorders (Cadman et al., 1987). Having a chronic health condition greatly impacts children, making them twice as likely to have a psychiatric disorder or maladjustment problems, and threatening their academic success (Cadman et al., 1987).

How can policymakers decrease parental stress in order to support child health?

Parental stress is a problem for children in two important ways. First, highly stressed parents do a poor job of monitoring their children, leading to the negative outcomes described above, including child abuse and neglect, academic problems, and juvenile delinquency. Second, highly stressed parents may become depressed or attempt to cope through substance abuse, both of which have negative consequences for children.

Policymakers can decrease parental stress by supporting policies that provide continuous health insurance for children. Lack of health insurance for their children is a stressor for parents. For example, data show that parents whose children became enrolled in SCHIP reported significant decreases in their stress (Kenney, 2007). In addition, chronic health problems in their children also create parental stress and strap parents' financial and emotional resources (King et al., 2005). Continuous health insurance enables parents to seek early treatment for their children and prevent health problems.

How does having a depressed parent affect children?

Having a depressed parent negatively affects families in several ways. These families experience more conflict, less cohesion, less expressiveness, less organization, less child supervision, and more harsh and non-contingent discipline. Together, these elements serve as child health risk factors. Children with a depressed parent are twice as likely to have mental health problems and are more likely to have physical, social, and academic problems (Ofsun et al., 2003; Billings & Moos, 1983; Kern et al., 2004; Murray et al., 1999). Children of depressed parents are also more likely to use alcohol and drugs (Billings & Moos, 1983), possibly due to decreased parental monitoring.

How can policymakers decrease parental depression?

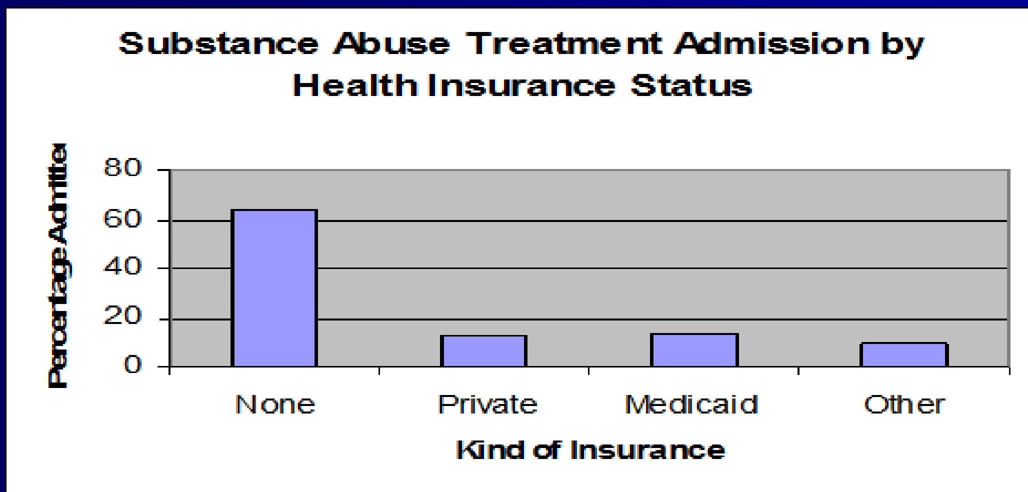
Depression can be prevented through fewer life stressors for parents. In particular, stable employment, housing, and health insurance can decrease parental stress. When parental depression does occur, early treatment can minimize the impact on families. Highly effective treatments for depression exist, and these work whether one is genetically predisposed to depression or not.

How does having a parent who abuses substances affect children?

Although it will come as no surprise that parental substance abuse is bad for children, the effects on children tends to be far more severe than is generally understood. Parents who abuse substances, including alcohol, provide their children with less parental monitoring. The effect is that their children are more likely to use substances, engage in sexual risk behavior, experience traumatic events, consort with deviant peers, and commit crimes (Richards et al., 2004; Robertson et al., 2008; Grellla, 2005; Robertson & Hussain, 2001). Children whose parents abuse substances are also at greater risk of child abuse and neglect (Ammerman et al., 1999; Dunn et al., 2002); 40%-80% of child welfare cases involve parental substance abuse. Child abuse and neglect result in numerous delinquent behaviors, including drug and alcohol use, risky sexual behaviors, minor crime, and violent crime (Semidei et al., 2001; Young et al., 1998; Bensley et al., 2000; Robertson et al., 2008; Young et al., 2007).

How can policymakers decrease parental substance abuse?

Substance abuse policy has a long history in the United States, and it is not possible to repeat it here. However, continual access of parents to health insurance is an important component of substance abuse treatment. Parents need help to be able to afford substance abuse treatment and access it quickly for minimal impact on the family. Very effective substance abuse treatments exist, and recent advances in pharmaceutical treatments have only improved treatment efficacy. Unfortunately, country-wide, over 60% of people who were admitted to the hospital for substance abuse treatment had no health insurance (SAMHSA, 1999).



What happens to families during economic downturns?

Family stress increases when they face job insecurity or loss. Job loss, or even just the stress related to job insecurity, can lead to greater parental depression and substance abuse. As outlined above, parental stress, depression, and substance abuse lead to less parental monitoring and put children at risk.

What policies should be considered to support families during economic downturns?

Unfortunately, during times of economic stress, parental stress increases and threats to parental monitoring increase, too. Financial strain has been shown to increase both depression and substance use (for a review, see Peirce, et al., 1994). Evidenced-based ways to decrease parental stress and increase parental monitoring include:

- Providing uninterrupted health insurance to parents and their children;
- Making sure health insurance includes mental health and substance abuse treatment;
- Supporting programs that teach parents problem-solving strategies to decrease their stress, and that teach parents how to monitor their children. Example programs with strong research support are Healthy Families Arizona and Early Head Start.

Programs currently in place in Arizona that improve child health

Two programs that improve child health and increase parental monitoring are Healthy Families Arizona and Early Head Start.

Healthy Families Arizona

Healthy Families Arizona began in 1991 and is now in over 150 communities in Arizona. Families are enrolled during pregnancy or during the first 3 months after birth of a child; this child need not be their first child. In order to qualify for Healthy Families Arizona, families must have significant life stressors, such as poverty, unemployment, lack of education, history of abuse or neglect as a child, substance abuse, depression, or domestic violence. Families may receive services for up to 5 years, although the average length of services is 2 years. The service intensity is based on family need. Initially, families receive weekly 1-hour visits from a family support specialist who works to promote:

- Positive parent-child interaction;
- Home safety;
- Parental monitoring;
- Problem-solving and coping skills;
- Child development;
- Health and nutrition; and
- Parent education and work goals (Krysik & LeCroy, 2007).

In addition, a strong component of Healthy Families Arizona is regular screening for child developmental milestones, in order to facilitate early intervention when needed. Family support workers also work with parents to make sure that children get regular medical check-ups and any other medical care that they need (Krysik & LeCroy, 2007). Prenatal care is also an emphasis of Healthy Families Arizona.

Evaluation research results on Healthy Families programs throughout the United States, and on Healthy Families Arizona in particular, have been positive. For Healthy Families Arizona, an independent evaluation found that the program had high quality assurance standards and good participant retention in which only 4% of families had terminated by 3 months, and 63% of families participated for more than 1 year (Krysik & LeCroy, 2007). Practically no program participants had substantiated CPS reports (only .3% did), despite weekly visits from family support specialists who are obligated to report any signs of abuse. Improvements were found in parental attachment, social support, sense of parenting competence, and parental depression (Krysik & LeCroy, 2007).

In terms of direct medical outcomes, significantly higher percentages of Healthy Families Arizona children had received full immunization than the overall population of children in Arizona (Krysik & LeCroy, 2007). Higher immunization rates have also been found in all Healthy Families programs in the United States combined, compared to the population averages in their areas (Harding et al., 2007). In addition, numerous Healthy Families programs have significantly fewer low birth weight babies than control groups (Harding et al., 2007).

Risks of cutting back on Healthy Families Arizona funding

During difficult budget times, one option of policymakers is to maintain programs but cut their budgets. It is important to note that multi-site evaluations suggest that Healthy Families programs are only effective when instituted with optimal service delivery (Harding et al., 2007). Cutting back on services, increasing the caseloads of family support specialists, or decreasing the education level of family support specialists is likely to seriously compromise program effectiveness. The kinds of results that Healthy Families Arizona has achieved are difficult to achieve, and work with complex families requires resources.

Healthy Families can be cost-saving

Healthy Families programs address the root causes of problems that take years to surface; it therefore often takes a long time to see improvements in child health and the subsequent financial benefits to society. However, cost savings have been documented in cities that have given substantial funding to Healthy Families over a long period of time. For example, the city of Hampton, Virginia, attributes $11.2 million in savings between 1994 and 2004 to their Healthy Families program (Galano & Huntington, 2002).

Early Head Start

Another program with strong research documentation of success in the areas of child and family health is Early Head Start. Early Head Start differs from Healthy Families in that the enrolled families must have a teenage parent having a child for the first time. Families are served from the birth of the child until the child is 3 years old. Families receive weekly home visits from family support specialists who do many of the same things as Healthy Families support specialists. Because teen parents can be isolated and because peer needs are so strong during adolescent years, Early Head Start includes group socialization activities. Early Head Start also has a strong emphasis on interdisciplinary teams working toward the health of the child and family. Teams include social workers, nurses, psychologists, and psychiatrists. Regular nursing visits are made to check on the health of the child.

There is a strong evidence base for Early Head Start that includes randomized controlled trials, the gold standard of research, for 17 programs. In this multi-site study, Early Head Start children did better than control children in cognitive development, language development, sustained attention, engaging with parents, and aggressive behavior (Love et al., 2005). Early Head Start parents did better than control parents in being more emotionally supportive, providing more learning stimulation, and spanking less. Immunization rates and child health status were similar for both Early Head Start and control group children, with trends toward better outcomes for Early Head Start children. It is possible that it takes more than 3 years to see substantial differences in child health status between groups. Regardless, the family environment fostered by Early Head Start increases parental monitoring, which is key to child health.

Programming policy summary

In sum, intervening with families is difficult and requires resources and well-trained staff. Programs with strong evidence bases currently exist in Arizona, most notably, Healthy Families Arizona and Early Head Start. Support for such programs is critical with the current economy, which is likely to increase family stress, depression, and substance abuse. Support for parents and their children is especially important now.

Conclusion

There are a number of things that policymakers can do to support family stability and child health. The adoption or support of multiple policies is likely to be more effective than any single policy alone. Policymakers can examine proposed programs and policies to see if they: provide continuous health insurance coverage for both children and parents; reduce parental stress; promote parental monitoring; and address parental substance abuse and depression.

The Impact of Policy Decicions on Access and Cost

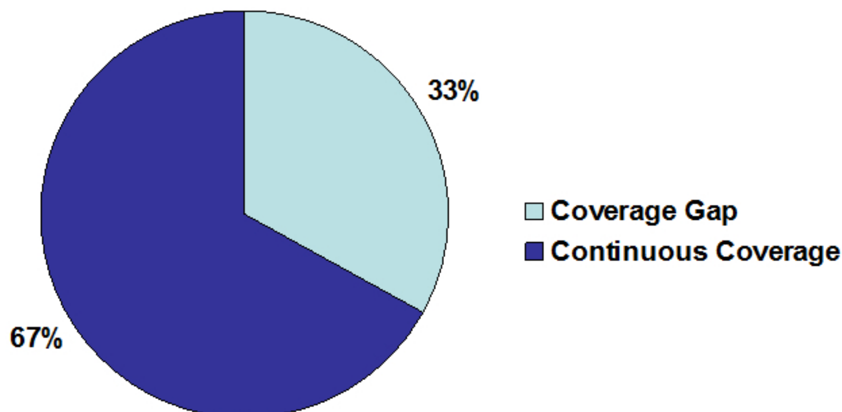
Laura Summer

Although there is general agreement that broad health insurance coverage is desirable, there is less agreement about how to achieve it and all policymakers have concerns about the costs associated with broadening coverage, particularly during difficult economic times. However, the need to provide health care coverage and services to vulnerable individuals persists and is likely to grow. One achievable goal for public insurance programs is to ensure that individuals who already are eligible have stable coverage. Achieving coverage stability in public programs is an important goal, not only because stable coverage is associated with the provision of optimal health care services and outcomes, but also because it is associated with efficiency in program administration. This report examines methods can be used to increase access to public health insurance; discusses the advantages of more stable coverage; and shows how states have achieved and can achieve more stable coverage.

What methods can be used to increase access to public health insurance?

Three methods can be used to increase access to coverage:

- Expand eligibility.
- Make efforts to reach and enroll those already eligible.
- Ensure stable coverage for eligible individuals which can increase families' access to coverage.



Source: Arizona Health Care Cost Containment System (AHCCCS), 2007.

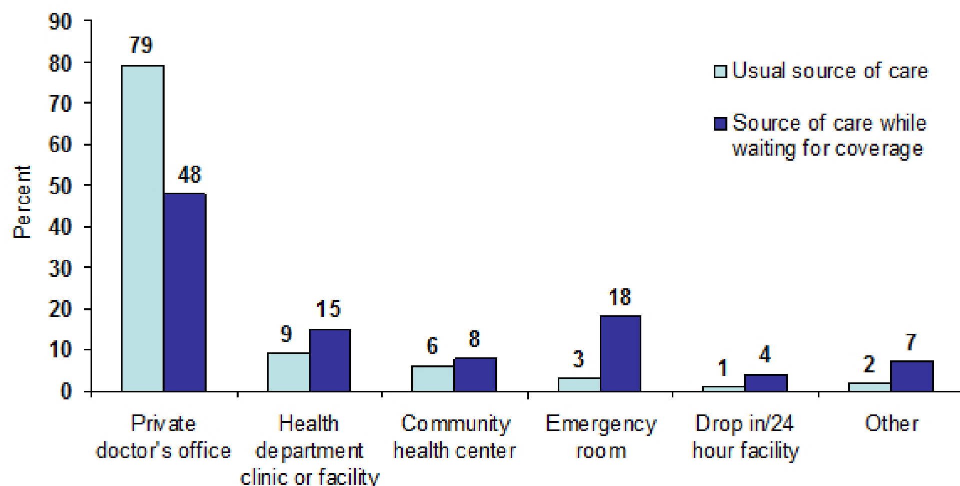
Data from Arizona show that the great majority of children who leave and return to coverage over a two-year period have gaps of three months or less. The term "churning" refers to the phenomenon of losing and regaining coverage over a short period of time.

Experience across states suggests that relatively short gaps tend to occur for administrative reasons rather than because an individual is not eligible for coverage during the gap period. Thus, the data indicate that there is an opportunity to make some administrative changes to promote more stable coverage. One practical reason to emphasize coverage stability now is that it is possible to make progress even in difficult economic times. Instability is a problem that has been identified and can be corrected with changes in policies and practices that are not expensive to implement. In fact, experience from other states indicates that practices to promote more stable coverage can generate some administrative savings.

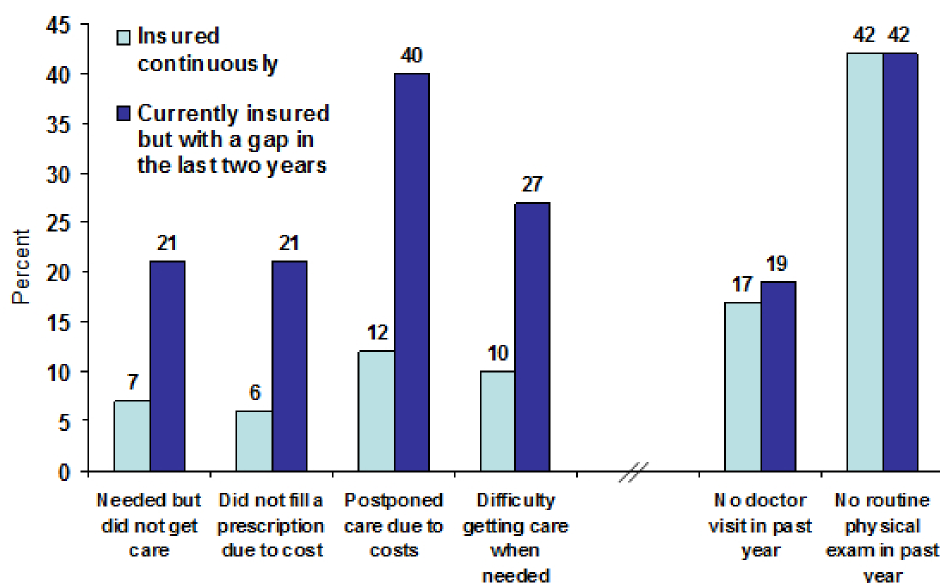
What are the advantages of more stable coverage?

More stable coverage promotes the efficient and cost-effective delivery of care and the receipt of comprehensive coordinated care.

Continuous coverage promotes continuity of care, more appropriate service use, and the provision of services in less costly settings. Continuous coverage contributes to the goal of providing a "medical home," a term that generally refers to care that is accessible, continuous, comprehensive and coordinated, and delivered in the context of family and community. Studies of children with public coverage show that those with continuous coverage are much less likely to report difficulty getting medical care than those with intermittent coverage, and are less likely to seek care at emergency rooms (Summer & Mann, 2006). This phenomenon was evident in the results of a telephone survey of Virginia families whose eligibility determinations for Medicaid were delayed or whose applications were still pending after implementation of Medicaid citizenship-documentation rules. Some 40 percent of parents whose children needed health care while waiting for coverage determinations reported that their children did not get all the care they needed. These results suggest that continuity of care was compromised, and that at least some children received care in places that were more costly than their usual care setting.



A national study that measured access to care for insured adults with continuous coverage and with coverage gaps shows that those with continuous coverage had better access to care.



According to an analysis of data from the Medical Expenditure Panel Survey, average monthly Medicaid expenditures decline as people remain enrolled for longer periods. Each month of Medicaid enrollment reduced Medicaid expenditures for individuals with incomes below 200 percent of the federal poverty level an additional $6.49 per month (Bindman, Chattopadhyay, & Auerback, 2008).

Continuous coverage also contributes to higher quality care. For example, many health plans have developed disease management programs to improve care and contain costs. The programs are more likely to be effective when participants have continuous coverage (Birnbaum & Holahan, 2003). Also, efforts to measure and improve the quality of care are more likely to be effective when individuals can be included in quality measures that require enrollment for continuous periods of time (Dick, Allison, Haber, Brach, & Shenkman, 2002).

Reducing administrative costs

Another advantage of achieving more stable coverage among eligible individuals is the potential to reduce administrative costs and keep them low for states and localities, health plans and providers. Some of the reasons that costs are higher when coverage is unstable are presented below (Summer & Mann, 2006).

Administrative Costs Associated with Coverage Gaps

	States and Localities	Health Plans	Providers
Enrolling, disenrolling, reenrolling – extra paperwork, system updates, mailings.	✓	✓	✓
Delivering new member services multiple times		✓	✓
Researching and reconciling billing problems	✓	✓	✓
Verifying enrollment status and assisting with enrollment	✓	✓	✓
Managing and monitoring care		✓	✓

Source: Summer and Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies." The Commonwealth Fund, June 2006.

With more stable coverage, state programs realize some of the administrative savings directly; lower operating costs for plans and providers may also help contain overall program costs. State officials consistently report that when large numbers of people disenroll from public health insurance programs and subsequently re-enroll, the cost of running their public coverage programs is higher than it would be with more stable enrollment (Summers & Mann, 2006).

There is a general consensus among health plan administrators that costs to plans related to churning are substantial. Plans spend considerable time on disenrollment and reinstatement tasks and on resolving billing issues, reconciling claims, and determining the coverage status of plan members who lose and regain coverage. The costs of these extra functions are reflected in the plans' charges. Another indication of the cost of churning to plans is that many have made a business decision to be proactive in promoting stability of coverage for their members to avoid or lessen the costs associated with churning.

How can states achieve more stable coverage?

There are a number of policies states can adopt to promote more stable coverage. Each deserves consideration, but it is important to note that the adoption of multiple policies is more likely to promote stable coverage.

- Require annual, rather than more frequent, eligibility determinations
- Use a passive renewal process
- Ensure smooth transitions
- Make technological improvements
  - Use electronic applications
  - The Virtual Office pilot project in Arizona
- Provide assistance
- Consider the impact of all policies on coverage stability
  - Policies that do not appear to be directly related to coverage dynamics may actually affect stability. There is evidence, for example, that the provision of public coverage for parents as well as children contributes to more stable coverage in families. There is considerable evidence that charging insurance premiums in public health programs can have a negative impact on coverage stability and churning. Some states have switched from monthly premiums to annual enrollment fees, a change that reduces administrative costs associated with premium collections.

States also are considering systems to permit families to pay premiums in different ways: in cash at various locations, including convenience stores or electronically.

Conclusions

A number of the policies in Arizona are designed to promote coverage stability, but as in all states, there is the potential for policy changes to promote greater stability. For example:

- Most individuals are enrolled for a one-year period, but it would be helpful to apply this policy to all adults. Continuous coverage, which ensures that coverage for children remains uninterrupted between renewals regardless of changes in family circumstances, would also help. Finally, it would be helpful to consider a policy that allows for "opportunistic" renewals.
- The expanded use of Health-E applications and renewals, which will likely incorporate what the state learns from the current pilot, should help eligible individuals get and keep coverage.
- All states that operate separate Medicaid and SCHIP programs face challenges related to aligning program rules and procedures. Arizona has taken important steps towards alignment, for example, by removing the requirement for face-to-face interviews in some instances, but there is more that can be done to assure that in practice the application and renewal processes cannot be differentiated and movement between the programs is seamless. An inventory of current procedures with the goal of better aligning them could prove useful.
- Current efforts to improve administrative efficiency and to "troubleshoot" when eligibility problems arise can also help improve stability particularly if data on enrollment patterns are routinely collected, analyzed, and used to show if and where attention to certain aspects of the enrollment and renewal process are needed.

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