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Medicaid and SCHIP Retention in Challenging Times: Strategies from Managed Care Organizations

By Pat Redmond

Introduction

Efforts to reduce the number of low-income uninsured children and families have focused on expanding eligibility for public insurance programs and finding ways to facilitate enrollment in these programs. Another key factor that contributes to reducing the number of uninsured is the retention of eligible beneficiaries once they are enrolled. This has become an increasing priority in recent years, with a number of states pursuing effective and cost-efficient strategies to ensure appropriate retention. Managed care organizations (MCOs) contracting with states for the delivery of health services to people enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP) are natural partners in this effort, and a number have developed projects designed to educate their members about the process of renewing eligibility and assist members with necessary paperwork. This paper profiles some of the projects undertaken by MCOs to improve retention, and discusses the obstacles to developing a successful retention project, as well as strategies for overcoming these obstacles.

The Problem of Retention

Retention is considered a problem when eligible children lose coverage after an initial period of enrollment, often due to complicated renewal procedures. Families typically must complete a renewal form and attach proof of their income in order to keep their children enrolled in coverage; in some states additional steps are also required. In response to difficult fiscal conditions and pressure to curtail enrollment in publicly funded health coverage programs, a number of states have recently changed their renewal procedures, making it more difficult for families to renew their coverage. Five states took such steps in 2004, by eliminating a guarantee of full-year coverage and making families renew their children's eligibility more frequently or by requiring families to attend a face-to-face interview at a government office when their child's

“From every point of view—family, managed care, the state—a paper heavy process is a ridiculous process. A renewal process that is rigorous to an extreme undermines the principles of managed care that we are trying to put in place.”

MCO Consortium Representative

coverage is up for renewal.¹ When states increase the procedural barriers to renewing coverage, the likelihood increases that eligible children will lose coverage.

Premium requirements may be adding to the challenges faced by families that need to renew their coverage. More than three quarters of separate SCHIP programs currently require premiums from enrolled children, generally payable monthly. Non-payment of premiums is one of the leading avoidable causes of disenrollment in SCHIP, and there is evidence to suggest that not only affordability, but the difficulty of premium payment procedures, may hamper families from keeping their children enrolled.² Complicated premium payment requirements may add to other procedural burdens families encounter in the renewal process.

Emerging Strategies from Managed Care Organizations

In the face of these challenges, some managed care organizations (MCOs) contracting with states to provide health services to Medicaid and SCHIP beneficiaries have developed and implemented strategies to improve retention. MCOs play a major role in the delivery of Medicaid and SCHIP throughout the country. A large percentage of children in SCHIP are enrolled in managed care. More than a third of Medicaid enrollees currently receive their coverage through managed care; in some states, the percentage is considerably higher, particularly among parents and children.³ MCOs are able to contribute to alleviating the retention problems in Medicaid and SCHIP, as they have both financial incentives to retain members and data systems linking their members, providers and the state Medicaid and/or SCHIP agencies.

Why MCOs Should Help Facilitate Retention

Breaks in health coverage for eligible enrollees have negative implications for families and for health plans. Recent research has shown that instability of coverage among those eligible for Medicaid unnecessarily increases the number of uninsured at any given time.⁴ Research has also shown that individuals with breaks in their coverage have poorer access to care and use of services.⁵ One study reveals that among low-income populations, those uninsured for as little as one to three months went without needed care due to costs.⁶ Even brief gaps in coverage can result in a family incurring a health care bill that it cannot afford to pay.⁷ A 2001 Commonwealth Fund survey found that many people with relatively brief periods without insurance reported serious financial consequences, such as being contacted by a collection agency for a bill that could not be paid.⁸ States have also found that it is difficult to hold MCOs accountable for care when the plans do not have access to members for a long enough period of time to deliver appropriate services.

From the MCO perspective, there are two major disadvantages to what is referred to as “churning.” “Churning” occurs when individuals lose coverage and then regain it after only a short period of time—often because of unnecessary burdens in the eligibility renewal process. Interrupted periods of eligibility make it difficult for a health plan to manage a member’s health care and to deliver effective preventive services. In addition, when

Integrating Renewal Reminders into Routine Operations: Keystone Health Plan East in Pennsylvania

Pennsylvania requires annual renewal of SCHIP coverage. Each month, approximately 1,000 to 1,500 children enrolled in SCHIP through Keystone Health Plan East, a managed care organization operating in the Southeastern region of Pennsylvania, need to renew their coverage. Keystone Health Plan East, also called Keystone CHIP, developed a renewal outreach program that implements and also expands upon the state's requirements. The state requires:

- Renewal notices that are mailed 90 days and then again 60 days prior to the child's actual renewal date. Renewal notices are always accompanied by a renewal form.
- A "last chance" notice sent to families who have not responded to previous notices or phone calls. This notice is sent 30 days prior to the renewal date, and if families respond to the notice, coverage can be maintained with no interruption.

Keystone CHIP has enhanced the program by adding:

- At least one, and up to three "live" (as opposed to "automated") outbound telephone calls to families who have not responded to the notice sent 60 days prior to renewal. The number of calls a family receives is dependent on whether the family responds and the amount of staff time that Keystone CHIP is able to devote to calls in a given month. No dedicated staff are assigned to this program, so calls are made by staff with other responsibilities. Approximately 500 calls are made each month.
- Reminders about annual renewal requirement in every issue of the quarterly health promotion newsletter sent to all families with children enrolled in SCHIP.

This comprehensive approach has worked well for Keystone CHIP. The response rate to the combination of letters and phone calls averages 85 percent. According to John Mancano, director of operations, "the extra work is worth it. Families keep their coverage, and from our perspective, it is much easier to keep them on than to start all over again."

Source: John Mancano, director of operations, Keystone Health Plan East:
john.mancano@ibx.com.

enrollees continually enter and exit a plan, it is difficult to maintain the stability of an MCO's membership, which is essential to its financial viability. It is important to note that reducing "churning" also has advantages for state agencies, which incur unnecessary administrative expenses when eligible children lose coverage and re-apply soon after and must be re-enrolled in the program.

Statewide Procedural Solutions Are Needed

Because of the need to promote continuity of care and stable enrollment, all of the MCO staff interviewed for this report support efforts by states to simplify and streamline the procedures families must follow when renewing coverage. As one representative of a regional consortium of MCOs explained: "From every point of view—family, managed care, the state—a paper heavy process is a ridiculous process. A renewal process that is

Shortened Recertification Period in Texas Leads Amerigroup to Develop Interventions

Shortly after the Texas legislature reduced the annual SCHIP recertification period from 12 months to six, Amerigroup Corporation, with operations in Austin and the greater Houston, Dallas and Ft. Worth areas, developed a multifaceted strategy to offset the impact of the shortened recertification period for their SCHIP members and to encourage Medicaid members to renew their coverage on time. “We were concerned that our members were not going to get the information,” Amerigroup staff explained. “Continuity of care would be harmed, and from a marketing perspective, it is less expensive to try and retain members than to get new members. We felt we had a great opportunity and responsibility.”

They began with a public awareness campaign, placing their message about renewal on billboards featuring a photo of happy mother and toddler. “Your Medicaid renewal notice is coming,” the billboards announced. “It may look different and longer, but it’s not hard.” Posters and flyers distributed throughout the community reinforced the message with specific instructions about the steps families must take to renew their coverage. (See Appendix 2.) Radio ads also promoted renewal with a “don’t lose it” message about health coverage.

Amerigroup also developed and obtained state approval for a telephone script to remind families about the importance of renewal. The state provided a computer listing of the of the renewal dates of Amerigroup members on a monthly basis, and the MCO decided to place outbound calls to members two months in advance of the member’s scheduled renewal. MCO staff checked to see if families had received the appropriate forms from the state and provided assistance to families with questions about the process.

Source: Brandi Johnson, Associate Vice President of Marketing, Amerigroup, Texas:
bjohnson@amerigroupcorp.com

rigorous to an extreme undermines the principles of managed care that we are trying to put in place.”

MCOs interviewed about retention strategies often spoke first about the need for policymakers to understand that difficult renewal procedures impede continuity of care. For example, as a result of complicated paperwork requirements, eligible children may miss out on immunizations they should be receiving at specified points in their lives. Some plan representatives spoke of having to conduct outreach to members and then provide new physical examinations for people with chronic conditions. In these cases, care had been interrupted and consequently the plan needed to “start all over” with the patient, an expense that would have been avoided if the person remained enrolled.

Implementing State Requirements

States can include requirements to improve retention in their contracts with managed care organizations. Some MCOs interviewed for this report developed retention strategies in response to requirements in their contracts with the Medicaid or SCHIP agency. (See box on page 3.)

MDwise Surveys Members and Develops Collaborative Effort to Improve Retention

When Indiana first implemented its SCHIP program, Hoosier Healthwise, children were guaranteed a full year of Medicaid or SCHIP coverage from the date of enrollment, regardless of changes in their family income or other circumstances. This policy, called 12-month continuous eligibility, helped ensure that eligible children retained coverage.

However, 12-month continuous eligibility was eliminated by the legislature effective July 1, 2002. While most families continue to renew their children's coverage once a year, they are now required to report all income changes to ensure they remain below the income limit throughout the year. Families of the lowest income children—those children who are also enrolled in TANF or food stamps—are required to renew their coverage every six months, as opposed to once a year.

Concerned that this policy change was leading to eligible children losing coverage, MDwise, a nonprofit managed care organization in central Indiana, conducted a phone survey of members who had lost eligibility in the summer of 2003. Half of the members surveyed revealed that they had not been aware of the steps they needed to take to retain eligibility.

As a result of this survey, MDwise decided to partner with the Indiana statewide and local Covering Kids and Families coalitions, funded by The Robert Wood Johnson Foundation to increase participation by eligible children in Medicaid and SCHIP. With grant funding and an in-kind donation of office space, MDwise provided support for three outreach workers to be stationed at MDwise, as well as an additional worker stationed at a northwest Indiana Covering Kids and Families local coalition office. Local coalition members referred families who had recently lost eligibility to these outreach workers, who assisted them in navigating the eligibility process and becoming reenrolled.

In Indiana, Medicaid health plans are prohibited from conducting direct enrollment activities, making the enrollment and renewal work done by community organizations such as those affiliated with Covering Kids and Families all the more critical. During 2004, Covering Kids and Families assisted nearly 1,900 additional families in obtaining or retaining coverage at MDwise-supported coalition sites alone.

Source: Katherine Wentworth, Vice President of Legal Affairs, MDwise:
kwentworth@mdwise.org

MCOs Take Proactive Steps

Some MCOs began to promote renewal with their members shortly after the states in which they were located shortened the renewal period (the period of time after which a family must take steps to renew their coverage) from twelve months to six, or imposed other barriers. By working directly with their members or conducting publicity campaigns on renewal, MCOs can address the problem proactively. (See box on page 4.)

Some MCOs respond to the problem of renewal by partnering with organizations with strong roots in the communities in which they work. A formal partnership between an MCO and a community-based partner can increase awareness of the need to renew coverage

in a given community; a partnership can also provide direct assistance to families. (See box on page 5.) Some plans have also found that working directly with the community health centers that are often participating providers can provide an avenue to reach families. Neighborhood Health Plan of Massachusetts, for instance, receives information on its members' renewal dates from the state and relays this information to its community health center providers. Some of these health centers have found that it is useful to call and remind members of the upcoming renewal. A follow-up letter is sent to individuals who can't be reached by phone.

Overcoming Common Obstacles

MCOs interested in retention work often want to do more than publicize the need for renewal. But to undertake more aggressive one-on-one outreach activities, some MCOs have to overcome obstacles.

There are four common obstacles:

- Obtaining members' renewal dates ;
- Establishing effective processes for working with local eligibility offices;
- Addressing concerns about the marketing implications of providing direct assistance to members; and
- Determining whether there is a sufficient return on investment for the activities.

Each of these obstacles and the strategies that some MCOs have employed to overcome them is discussed below.

- **Obtaining members' renewal dates:** In order to reach out to members who are at risk of losing coverage at renewal, MCOs need timely information on members' scheduled renewal dates. This can be difficult to obtain. States routinely provide MCOs with the names of members and dates on which members are scheduled to lose coverage, but as one MCO staff person explained, "if you get the list July 1, and the member loses coverage as of July 1, it isn't going to do you any good. What we want is to be able to remind members to renew, not to lose them and have to go through the whole process over again."

Several MCOs interviewed for this report, including a collaborative of health plans in Washington State and a FQHC-sponsored MCO in Connecticut, described difficulties obtaining timely renewal data on their members from the state Medicaid or SCHIP agencies, and as a result, have been unable to launch projects that reach out to individual members before they lose coverage. Estimating members' renewal dates based on their entry into managed care appears to be an ineffective strategy, as the complexities of Medicaid eligibility mean not all members will have the same length of enrollment even if they became eligible at the same time.

New Law Helps MCOs Overcome Data Obstacles

The New York State Coalition of Prepaid Health Services Plans, an association of 15 health plans sponsored by public and not-for-profit hospitals and community health centers, serves the majority of Medicaid and SCHIP families in New York City and a large proportion throughout the rest of the state. Improving retention has been one of the organization's priorities for several years—ever since plans realized, according to Deborah Bachrach, counsel for the coalition, that “they were losing half of their members each year.”

To develop an effective retention effort, it was necessary for the plans to find out well in advance of members' losing coverage. At the request of the plans, the New York State legislature amended the State Social Services Law to require the state Department of Health to provide each member's end-of-coverage date on MCO's monthly rosters. With financial and technical support from the Center for Health Care Strategies, an organization dedicated to quality improvement in health care services for Medicaid beneficiaries, the coalition was able to launch a demonstration project to help members to renew their coverage, staffing the effort with participants in a welfare-to-work training program that provided job coaching and supervision.

Staff contacted members by phone two months in advance of their renewal dates to encourage members to renew their eligibility and answer questions about the process. The results of the initial project were mixed, largely, the coalition believes, because of built-in barriers to recertification: even individualized assistance cannot compensate for a burdensome recertification process. In the end, however, Bachrach says, “the New York City plans, as businesses, just ran with this. A number of them now devote enormous resources to renewal efforts on their own.”

Source: Deborah Bachrach, Manatt, Phelps and Phillips, LLP: (212) 830-7233 and Tassi, Bachrach, Kalkines, Arky, Zall, and Bernstein, LLP, Center for Health Care Strategies, *The Medicaid Recertification Assistance Demonstration*:

http://www.chcs.org/usr_doc/medicaidrecertification.pdf

When information on renewal dates is not available from the state, it seems to reflect not a lack of interest or willingness, but deficiencies in information technology. Correcting these deficiencies can be expensive. “The state wants to do this,” staff from the Connecticut plan noted, “but the data element we need isn't available in the right place in the computer. The state would need to invest in a systems change in order to make this happen, and this change is lower on the priority list than a number of other changes.”

Now that they have renewal dates, plans in New York (See box on page 7.) can use the facilitated enrollment process to assist with renewal. Facilitated enrollment allows designated community workers, including staff members from MCOs, to serve as the official state representative for the required Medicaid face-to-face interviews, thereby bringing the enrollment — and renewal — process directly into communities. Facilitated enrollers assist applicants in completing applications, assembling documentation and selecting a managed care plan and primary care provider.

Health Plus Dedicates 50 FTE Staff to Renewal Efforts

With over 265,000 Medicaid and SCHIP enrollees, and some 22,000 members who need to renew their coverage each month, Health Plus, a nonprofit Medicaid and SCHIP MCO serving the five boroughs of New York, is well positioned to observe the importance of promoting renewal among membership. Until Health Plus began a comprehensive renewal outreach program in 1999, the drain of members every month was significant. The reason, according to Tom Early, chief executive officer, was simply “that eligible people couldn’t make it through the process, so they were dropping off.”

In response, the plan designed a multifaceted approach. Dedicating 50 FTE staff to the effort, Health Plus put together “recertification teams” located in each of the City’s five boroughs. These teams, using the renewal dates provided well in advance by the state, contact members by phone, and if necessary, make home visits, to encourage members to renew their coverage and assist them with the process. Recertification teams start the process early: two months prior to the member’s scheduled renewal date, Health Plus sends a reminder postcard and begins the process of calling individual members.

The process is effective: on the average, 84 percent of SCHIP members renew their coverage each month, as do 70 percent of Medicaid members. Health Plus is in the process of a return on investment analysis of this effort. “We hadn’t sat down to quantify this and determine if it’s worth it,” Early explains. “Our hope is that we can continue to afford to do this, as it clearly makes a difference for our membership.”

Source: Tom Early, chief executive officer, Health Plus: tearly@healthplus-ny.org

- **Establishing effective processes for working with local eligibility offices:** Although federal rules allow MCOs to enroll eligible children in SCHIP, only the state Medicaid agency can determine eligibility for Medicaid.⁹ MCOs are limited to performing the initial processing of paperwork associated with Medicaid eligibility. As a result, MCOs that intend to develop individualized assistance to members on renewal will need to develop an understanding of the specific steps and timeline in the eligibility process.
- **Addressing concerns about the marketing implications of providing direct assistance to members:** Federal rules require that beneficiaries have a choice in the selection of a Medicaid managed care plan and limit the marketing activities that plans can conduct.¹⁰ In response to these regulations, and also in part because of overly aggressive marketing in the early days of Medicaid managed care, states have established a variety of safeguards designed to protect choice and provide accurate information about health plans, once an applicant is enrolled in Medicaid. For instance, many states contract with an independent enrollment broker, which is typically responsible for providing new Medicaid beneficiaries with information about their options and assistance in selecting and enrolling in a plan.

Although neither federal regulations nor state safeguards should inhibit MCOs from assisting their members with the renewal process, some plans have never considered providing renewal assistance because of historic concerns about marketing. In New Jersey, for example, the state encourages MCOs with SCHIP members to conduct outreach and promote the renewal issue to individual members. Medicaid HMOs are

encouraged to do general membership mailings that promote renewal, but do not conduct individual outreach in order, one official explains, to avoid raising marketing issues. MCOs that have not considered providing individual renewal assistance should be aware that it is not prohibited by federal rules.

- **Measuring the return on investment:** The business case for promoting timely renewal is self-evident: loss of eligible members is a drain on revenues and undermines financial and operational stability. Research is needed, however, to determine to what degree a significant investment in improving renewal rates can pay off for MCOs. The MCOs interviewed for this report either were unwilling to share their analyses of the return on financial investment or were just beginning to undertake such analyses. Others were satisfied from other indicators—such as responses to mailings or website hits—that their efforts were worthwhile.

Non-profit organizations interviewed for this report noted that, while they must maintain financial viability, their priorities may differ from for-profit companies. As one non-profit executive explained, nonprofit plans have “a lower profit margin — just one or two percent, in contrast to commercial plans which need to make five or ten percent. This allows us more of a mission focus.”

The recognition that without some investment in renewal, health plans might find themselves with a higher-cost patient mix has been important to some of the MCOs interviewed for this report. These organizations are concerned that if they do not work to assist members with retention, they will face “adverse selection,” a term used in the industry to describe a patient population disproportionately composed of people with serious health risks. Although there is research to indicate that adverse selection at the point of renewal may be a risk for plans, most experts seem to agree that there are not enough data to show a correlation between staying enrolled in Medicaid or SCHIP and increased utilization of health care services.¹¹

Despite the absence of definitive research, concern about adverse selection did, in part, motivate some of the plans interviewed for this report to engage in work on renewal. None of the plans, however, appear to have designed approaches that would target only healthy members: a phenomenon known as “cherry picking” that was documented in the early days of Medicaid managed care, and remains a concern among advocates. The interventions described in this report appear to target the membership bases broadly and do not raise concerns about cherry picking.

A comprehensive approach to retention may help plans maintain a workable mix of members. A study conducted in 2003 by Colorado Access, a nonprofit health plan with Medicaid and SCHIP members in 37 counties, illustrates how retention issues may play a role in adverse selection. The study examined the financial impact on the plan when members do not renew their coverage and “new” members do not take their place. “What we learned is that — in the absence of other factors — our members who have the highest health care needs, the ones who really need care, ended up with their eligibility determination taken care of faster than the ones who were healthier,” stated Sherry Rolfing, vice president for market and business development. Rolfing explained

Rhode Island MCOs Invest in a Multifaceted Approach

A collaborative of managed care plans in Rhode Island, working closely with the Rhode Island Department of Human Services and the statewide Covering Kids and Families Coalition, developed a multifaceted, ongoing quality improvement approach to improving renewal.

The three managed care organizations contracting with Medicaid in Rhode Island — Blue Cross and Blue Shield of Rhode Island's Blue Chip Program, Neighborhood Health Plan of Rhode Island and United Health Care — made commitments to contact families individually after the state had sent the families two renewal notices. The first state notice is 60 days prior to coverage expiring and the second is sent approximately 20 days prior to the end of coverage. Approximately 50 percent of members respond sometime between the first and second renewal notice. The remaining members require more outreach. Each month, the Department of Human Services sends the three managed care plans a list of their members who have not responded by the time the second renewal notice is sent. The managed care plans are then able to send a postcard and call members to remind them about renewal and assist them with the form if they need help.

The plans also work closely with the state to minimize the number of outdated addresses, a problem that has proved difficult to solve. Health plans currently work with local eligibility offices to ensure that any change of address information (which the health plans often obtain themselves) is quickly processed so that members can receive their renewal notices at their current residence.

Measuring the impact of this work is complicated. “We know this makes a big difference for individual members,” Brenda Whittle, vice president for marketing at the Neighborhood Health Plan of Rhode Island, explains. “It’s really awful for the members if they lose their eligibility and can’t see the doctor or fill a prescription for their child.” But determining which interventions are most effective has proved more difficult. Neighborhood Health Plan of Rhode Island is currently conducting a study in which 70 percent of the members whose names are sent to the plan by the state will receive the additional outreach and renewal assistance; 30 percent of members will not. Data from this study will help the health plan to determine to what extent its intervention is making a difference.

Source: Brenda Whittle, Vice President for Marketing, Neighborhood Health Plan of Rhode Island, bwhittle@nhpri.org

that this does not mean the other members don't want health care, rather, it seems that many people do not understand the process, and members with serious health conditions may simply be more aware of the status of their coverage because they visit the doctor more frequently or fill prescriptions on a regular basis. Without an influx of new members to even out costs, and no program to encourage all members to renew, the plan becomes increasingly composed of people with very high health care costs—a financially unsustainable mix.¹²

Conclusion

Managed care organizations can play an important role in promoting retention of coverage among families with children enrolled in Medicaid or SCHIP. There is a need for additional work on retention in many states, as eligible families often lose coverage at the point when they need to renew eligibility, and in some states, the paperwork required for renewal is difficult for families to complete. Families often see their MCO as the “face” of public coverage. MCOs can capitalize on this identity and work in partnership with state agencies to improve retention rates among their members. Although eligibility systems are often separate from the operations of the health plan, it is possible for health plans to obtain the tools they need to assist with eligibility renewal, and plans that have taken on this task report promising results.

Appendix 1

Recommended Steps to Involve Managed Care Organizations in Efforts to Improve Retention of Eligible Children in Medicaid and SCHIP

Steps States Should Consider

1. Collaborate with managed care organizations to create guidelines on appropriate and effective retention strategies.

- States should clarify how any state safeguards to protect beneficiaries' free choice of plans might affect renewal activities that managed care organizations may wish to undertake. States should explicitly describe activities that managed care organizations are free to conduct to encourage members to renew.

Contracts with managed care organizations should require that MCOs implement basic renewal activities (such as communicating with members about the need to renew and the renewal process) and can encourage MCOs to pursue and track the success of more intensive renewal strategies.

- States should provide managed care organizations with information on members' renewal dates well in advance so that managed care organizations can take steps to assist members.

2. Assist managed care organizations in developing relationships with local Medicaid/SCHIP eligibility offices to facilitate processing of members' renewal forms.

- States should encourage local eligibility offices to collaborate with managed care organizations working to improve renewal rates.
- States should consider providing managed care organizations with a liaison to eligibility offices so that problems can be resolved.

Steps Managed Care Organizations Should Consider

1. Promote the importance of renewal and provide one-on-one assistance to their members.

2. Track the cost and effectiveness of renewal activities.

- Managed care organizations should document the impact of brief enrollment periods on the health of individuals enrolled in their plans, focusing particularly on breaks in enrollment of members who later re-enroll.
- To the extent possible, managed care organizations should analyze which retention activities significantly improve renewal rates among members.

- To the extent possible, managed care organizations should develop methods of measuring the return of investment for renewal activities.

2. Share best practices with trade groups, states, and community organizations.

- Managed care organizations should build support for this work by sharing successes and developing partnerships with groups, such as community organizations, that might be able to expand the reach of their activities.

End Notes:

¹ Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

² Forthcoming, Center on Budget and Policy Priorities.

³ Centers for Medicare and Medicaid Services, Managed Care Enrollment Summary 2005: [http: www.cms.hhs.gov/medicaid/managedcare/regbrout.pdf](http://www.cms.hhs.gov/medicaid/managedcare/regbrout.pdf)

⁴ Pamela Farley Short, Deborah R. Graefe and Cathy Shoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, The Commonwealth Foundation, 2003.

⁵ Ferry Fairbrother and Arfana Haidery, *How Health Insurance Stability Impacts the Quality of Health Care*, New America, July 2005.

⁶ Short, Grafe and Shoen, 2003.

⁷ Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, The Commonwealth Foundation, 2002.

⁸ Ku and Cohen Ross, 2002.

⁹ 42 CFR 4310.10

¹⁰ For a summary of the marketing rules that apply to managed care organizations under the Balanced Budget Act of 1997, see: [http: www.familiesusa.org/site/DocServer/MMCSept2002.pdf](http://www.familiesusa.org/site/DocServer/MMCSept2002.pdf).

¹¹ Lake, Snell, Perry and Associates, *Retaining Eligible Families in Medicaid and SCHIP: What We Know So Far*, 2003.

¹² Communication with Sherry Rolfing, vice president for market and business development, Colorado Access: sherry.rolfing@coaccess.com