Expanding HUSKY Coverage for Children in Connecticut

Estimating the Costs of Expanding HUSKY A and HUSKY B to Undocumented Children

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FINDINGS

Expanding Connecticut's Medicaid and Children's Health Insurance Program (CHIP) coverage (HUSKY A and HUSKY B) to children and youth under age 19 who are not in the country with legal status would help the state reach universal health care coverage for all children. Lawmakers considered such a coverage expansion, but were deterred by concerns about the cost. This policy memo outlines the key factors that should be considered when estimating the costs of expanding HUSKY coverage to children who are undocumented, a portion of which would not be eligible for federal matching funds. **Based on the factors outlined below, the total estimated costs to the state are approximately $25.3 million over a two-year period.**

BACKGROUND

Medicaid and CHIP Coverage Expansions

Medicaid and CHIP coverage for noncitizens is limited to certain lawfully present immigrants, such as legal permanent residents, refugees, and asylees, and such coverage is subject to restrictions.[1] Health care costs for individuals who meet all of the eligibility requirements for Medicaid except for those related to immigration status are eligible for federal matching payments only for the treatment of life-threatening emergency conditions (known as emergency Medicaid).[2] There is no such option for federal matching payments under CHIP. All other costs related to coverage of noncitizens must be paid for with state-only funds.

As of 2020, six states (CA, IL, MA, NY, OR, and WA) and DC cover income-eligible children in Medicaid/CHIP who are otherwise ineligible due to immigration status.[3] These states have children's coverage rates well above the national average, ranging from 96.4 percent to 98.8 percent in 2018.[4] Connecticut's children's coverage rate of 97.4 percent also surpassed the national average, but is in the middle compared to other states in the northeast.[5] Medicaid and CHIP improve health from prenatal development to adolescence to adulthood, and are linked to improvements in educational outcomes at the elementary, high school, and college levels. These gains produce economic benefits in adulthood, including increased employment, higher tax payments, and returns on public investment in Medicaid.[6]

Estimating the Costs of Expanding Coverage to All Children Regardless of Citizenship Status

There are three key factors to estimating the costs of covering all children regardless of citizenship status: (1) the total number of undocumented children, (2) the participation rate, and (3) the cost per child.

1   **Total Number of Undocumented Children**

To understand the fiscal impact of expanding HUSKY A and B to cover all children regardless of citizenship status, it is important to begin with an estimate of the number of undocumented children living in Connecticut, rather than the number of uninsured children. While an estimated 20,000 children were uninsured in Connecticut in 2018,[7] research shows that most uninsured children are eligible for but unenrolled in Medicaid/CHIP. Nationwide, 56.5 percent of uninsured children are Medicaid/CHIP eligible, 32.8 percent have family income that exceeds the eligibility thresholds, and just 10.7 percent meet the income requirements but are ineligible because of immigration status.[8]

Estimating the number of undocumented children living in Connecticut comes with some considerable uncertainty. The Migration Policy Institute (MPI), a nonpartisan research center based in Washington, DC, is the leading source of state-level estimates of the undocumented population.[9] According to MPI's most recent estimates, the number of undocumented children under age 19 in Connecticut is about 13,000 (MPI does not publish estimates for all children and youth under age 19, but the totals can be derived from the published data; see note on page 6).[10]

Income estimates from MPI can help identify how many undocumented children would qualify for HUSKY A or B based on family income. The income limit for children and youth in HUSKY A is 196 percent of the federal poverty level (FPL), while coverage in HUSKY B is available to children and youth with family incomes up to 318 percent of the FPL. According to estimates from MPI, approximately 46 percent of the undocumented population in Connecticut has family income below 200 percent of the FPL and 54 percent have income at or above 200 percent of the FPL.[11] While this does not align precisely with the HUSKY A and B eligibility levels and income counting rules, it is reasonable to assume that of the approximately 13,000 undocumented children living in Connecticut, roughly 46 percent would be income-eligible for HUSKY A and roughly 54 percent would be income-eligible for HUSKY B, though a small share may be over the 318 percent of the FPL income limit for HUSKY B (see Table 1).

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Table 1: Distribution of Undocumented Children Above/Below 200% of the FPL

Family Income below 200% of the FPL	5,980
Family Income at or above 200% of the FPL	7,020
Total	**13,000**

2 Rate of Participation in Medicaid and CHIP

Not everyone who is eligible enrolls in Medicaid and CHIP, and enrollment rates are influenced by multiple factors. Nationally, participation rates in Medicaid/CHIP (the share of eligible people enrolled) was 93.1 percent in 2017.[12] In Connecticut, the participation rate is higher, at 95.7 percent in 2017.[13] Historically, factors that impact participation rates include the perceived benefits of enrolling, information and transaction costs associated with enrollment, and stigma.[14] Sustained, cooperative efforts by states, the federal government, and stakeholders can maximize enrollment,[15] but fear of negative immigration enforcement action can drive enrollment in the opposite direction.[16] Robust outreach efforts could also increase enrollment among currently eligible groups.[17] For new programs, it typically takes a few years to achieve substantial enrollment.

Of the 13,000 undocumented children in Connecticut, some share would be expected to enroll in expanded HUSKY A or B right away, while others may never enroll. For example, in Oregon (the most recent state to expand Medicaid/CHIP coverage to undocumented children), only about one-third of eligible children enrolled in the first year.[18] Of the approximately 5,200 children who enrolled in year one in Oregon, 3,600 were enrolled automatically from Oregon's emergency Medicaid program. The remaining children were reached through a comprehensive, community-based outreach program netting about 100 new enrollees per month.[19] By the end of year one, 35 percent of the total eligible population enrolled.[20] After 18 months, program enrollment reached 5,865, and if the same enrollment trend continued, about 43 percent of the total eligible population would have enrolled by the end of year two.

It is reasonable to assume the Connecticut will have a similar experience to Oregon, with 4,550 children enrolled by the end of year one and 5,590 enrolled by the end of year two. Both states have lower-than-average child uninsured rates,[21] higher-than-average Medicaid/CHIP participation rates,[22] and similarly sized undocumented child populations.[23] However, Connecticut could have more or less success depending on the state's outreach and enrollment efforts. If Connecticut is unable to automatically enroll children currently using emergency Medicaid services, it would take longer to reach Oregon's participation rate. Even if Connecticut is able to enroll some children automatically and works very hard to reach and enroll other eligible children, the anti-immigrant climate created by the current federal administration makes it unlikely that the state can achieve high participation rates. See Table 2 for estimated participation rates based on the Oregon model (base scenario with 35 percent enrollment in year one and 43 percent enrollment in year two) and plus 15 or minus 10 percentage points (high and low scenarios), split 46 percent to HUSKY A and 54 percent to HUSKY B for the first two years of program implementation.

A sizeable share of eligible children will never enroll. Though enrollment data as a share of the eligible population is not uniformly available in the states that have expanded Medicaid/CHIP to cover undocumented children, estimates show enrollment levels ranging from 33 percent to 63 percent over time.[24]

Table 2: Estimated Enrollment in Expanded HUSKY A and B

SCENARIO	YEAR 1			YEAR 2		
	HUSKY A	HUSKY B	TOTAL	HUSKY A	HUSKY B	TOTAL
Low Scenario (Base minus 10pp)	1,495	1,755	**3,250**	1,973	2,317	**4,290**
Base Scenario (Oregon model)	2,093	2,457	**4,550**	2,571	3,019	**5,590**
High Scenario (Base plus 15pp)	2,990	3,510	**6,500**	3,468	4,072	**7,540**

Note: Base scenario assumes 35% enrollment in year one and 43% enrollment in year two. Low scenario assumes 25% enrollment in year one and 33% enrollment in year two. High scenario assumes 50% enrollment in year one and 58% enrollment in year two. All figures are based on estimates of 13,000 undocumented children, of whom approximately 46% would qualify for HUSKY A and 54% would qualify for HUSKY B

3 Cost per Child

The Connecticut Office of Fiscal Analysis estimates that HUSKY A costs $315 per member per month, and HUSKY B costs $183 per member per month.[25] Research shows that immigrants have 14 to 20 percent lower health care utilization, even after adjusting for health status, race/ethnicity, gender, health insurance coverage, and other factors.[26] Providing health coverage to currently uninsured children would likely increase their use of health care services but utilization will likely remain lower than that of citizens.[27] This research was borne out in Oregon's expansion

of coverage to cover undocumented children; the newly covered immigrants had lower emergency department utilization rates and only 60 percent of the overall ambulatory care utilization rate compared to their citizen peers, even in the first year when policymakers may have anticipated higher utilization based on pent up demand.[28] Therefore, it is reasonable to assume that the per-child costs will be lower for the newly covered immigrant group. Assuming a 15 percent lower cost would result in monthly costs of $268 per child in HUSKY A and $156 per child in HUSKY B.

> Policymakers in Connecticut should work to identify the potential cost savings associated with structuring the HUSKY A coverage expansion as a wrap-around benefit.

Federal Financial Participation for Emergency Medicaid Services

Costs associated with expanding HUSKY B to undocumented children would be covered entirely by the state. However, some costs associated with HUSKY A coverage would continue to be eligible for federal matching funds. As noted, federal financial participation is limited to emergency Medicaid services for noncitizens who meet all of the Medicaid eligibility rules except for immigration status. Federal matching funds are available for emergency Medicaid costs, even if the state provides comprehensive coverage using state-only funds. Emergency Medicaid covers medical conditions that manifest with sudden onset of acute symptoms that, if left untreated, could result in placing a person's health in serious jeopardy, severe impairment of bodily functions, or serious dysfunction of any organ.[29] Federal matching funds for emergency Medicaid services are available regardless of the care setting (care does not have to be delivered in an emergency room or inpatient hospital setting to qualify).[30] States that cover undocumented children today continue to draw down federal matching funds for the portion of the costs within the scope of emergency Medicaid.

Connecticut could follow California's model and set up the expanded HUSKY A coverage as a wrap-around benefit to

existing emergency Medicaid coverage in order to continue to draw down federal matching funds for services related to treatment of an emergency medical condition. With a wrap-around benefit design, enrollees would have two benefit packages. One would be limited to emergency Medicaid services and eligible for federal matching funds. The second benefit package would be paid for with state-only funds and include more comprehensive, preventive benefits that "wrap-around" the emergency-only services.[31] These offsetting savings are not included in this memo because emergency Medicaid spending data are not available. However, in California, providing comprehensive coverage to children was estimated to be less expensive than providing restricted-scope, emergency-only services on a per child, per month basis.[32] Providing coverage that included preventive and routine health services was estimated to cost about $60 less per child annually than providing emergency-only services, even before adjusting for the lower health care utilization of the undocumented population.[33] Policymakers in Connecticut should work to identify the potential cost savings associated with structuring the HUSKY A coverage expansion as a wrap-around benefit.

Based on the analysis, expanding HUSKY A and HUSKY B to undocumented children in Connecticut is estimated to cost $11.3 million for year one and $13.9 million for year two, for a total of approximately $25.3 million over the biennium. These estimates are based on a total population of undocumented children in Connecticut of approximately 13,000, 46 percent of whom would qualify for HUSKY A and 54 percent of whom would qualify for HUSKY B. Enrollment is expected to increase over time, starting with about 4,550 children in year one and reaching about 5,590 children in year two. Total estimated costs based on lower and higher enrollment are shown in Table 3. Per-child costs are based on current per-child costs for HUSKY A and HUSKY B, minus 15 percent based on lower health care services utilization among immigrant children. The costs for emergency medical services for children in HUSKY A would continue to qualify for federal matching funds, which would lower the total amount of state general revenue needed to pay for the expanded coverage, below the levels estimated here.

Table 3: Estimated Enrollment and Costs in Expanded HUSKY A and B

SCENARIO	YEAR 1					
	HUSKY A Enrollment	HUSKY A Costs	HUSKY B Enrollment	HUSKY B Costs	Total Enrollment	Total Costs
Low Scenario (Base minus 10pp)	1,495	$4,807,920	1,755	$3,285,360	**3,250**	**$8,093,280**
Base Scenario (Oregon model)	2,093	$6,731,088	2,457	$4,599,504	**4,550**	**$11,330,592**
High Scenario (Base plus 15pp)	2,990	$9,615,840	3,510	$6,570,720	**6,500**	**$16,186,560**

SCENARIO	YEAR 2					
	HUSKY A Enrollment	HUSKY A Costs	HUSKY B Enrollment	HUSKY B Costs	Total Enrollment	Total Costs
Low Scenario (Base minus 10pp)	1,973	$6,346,454	2,317	$4,336,675	**4,290**	**$10,683,130**
Base Scenario (Oregon model)	2,571	$8,269,622	3,019	$5,650,819	**5,590**	**$13,920,442**
High Scenario (Base plus 15pp)	3,468	$11,154,374	4,072	$7,622,035	**7,540**	**$18,776,410**

Note: Base scenario assumes 35% enrollment in year one and 43% enrollment in year two. Low scenario assumes 25% enrollment in year one and 33% enrollment in year two. High scenario assumes 50% enrollment in year one and 58% enrollment in year two. All figures are based on estimates of 13,000 undocumented children, of whom approximately 46% would qualify for HUSKY A and 54% would qualify for HUSKY B. Estimated costs are based on annualized per child per month costs of HUSKY A and HUSKY B provided by the Office of Fiscal Analysis minus 15 percent, or $268 per child per month or $3,216 per child per year for HUSKY A and $156 per child per month or $1,872 per child per year for HUSKY B.

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22 In 2017, the child participation rate in Medicaid/CHIP in Connecticut was 95.7% compared to 94.5% in Oregon and 93.1% nationwide. See Haley JM et al., Table A2. May 2019.

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