

# Costs Of Enrolling Children In Medicaid And SCHIP

Enrollment costs could be reduced by almost 40 percent if the process were simplified, New York's experience shows.

**by Gerry Fairbrother, Melinda J. Dutton, Deborah Bachrach, Kerry-Ann Newell, Patricia Boozang, and Rachel Cooper**

**ABSTRACT:** As a way of saving Medicaid dollars, many states are reintroducing administrative hurdles into the enrollment process to deter people from enrolling. This study finds that administrative tasks associated with enrollment absorb sizable amounts of funds. We estimate that it costs approximately \$280 to enroll a child in Medicaid or the State Children's Health Insurance Program (SCHIP) in the New York City area. This amount could be reduced by approximately 40 percent if documentation requirements were simplified. In an era of scarce resources, the case for simplification is more compelling than ever.

FACED WITH RECORD BUDGET SHORTFALLS, many states are looking for ways to shrink their Medicaid budgets. Since the beginning of fiscal year 2003, forty-nine states have either cut or proposed cuts in their Medicaid spending, and thirty-two have planned a second reduction on top of that.<sup>1</sup> Many states are reintroducing administrative hurdles into the enrollment process in an effort to deter potential recipients from enrolling. For example, some states are increasing the frequency with which enrollees are required to prove their eligibility, making it more difficult to stay enrolled.<sup>2</sup> Although these increased barriers to enrollment will have the intended result of reducing the Medicaid rolls, they bring with them increased administrative costs. The burden of such costs to the health care system has been well documented (approximately 30 percent of all health care spending is administrative), but the administrative costs associated with enrollment in health insurance have not been assessed, partly because of the difficulty in calculating the cost, in time and dollars, of a complex enrollment process.<sup>3</sup> However, as states add administrative hurdles back into the enrollment process, it is important to understand the cost implications of these decisions.

■ **Out of tragedy....** Recent experiences in New York City shed light on some of

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these issues. Because the terrorist attacks of 11 September 2001 damaged Medicaid's central computer system, the typical enrollment procedures could not be followed. Instead, New York implemented a dramatically simplified process after September 11, which required people to complete a simple one-page application form and swear to the veracity of their reported income, residence, age, and other eligibility criteria.<sup>4</sup> Although this simplified process was radically different for New York, it is not unique. At least ten other states have similarly simplified their enrollment processes for children by eliminating documentation requirements and relying instead on a review of existing databases to check eligibility criteria.<sup>5</sup>

In this study we take advantage of the opportunity provided in New York to assess the administrative costs of enrolling children in Medicaid or the State Children's Health Insurance Program (SCHIP) in the New York City area and to compare those costs with those of a more streamlined process.<sup>6</sup>

■ **Unique features of the New York process.** The enrollment process in New York is similar to that in many states, but there are also important differences. Like many states, New York increased its outreach and recruitment in the late 1990s and has a joint application that covers both Medicaid and SCHIP. However, in New York, managed care organizations (MCOs) perform enrollment functions for both Medicaid and SCHIP, whereas state and local Medicaid offices perform these functions in most other states. New York MCOs engage in many of the same enrollment activities as state and local Medicaid offices, but because MCOs cannot make an official eligibility determination for Medicaid-eligible children, MCOs send the completed application to the local Medicaid agency for final determination. In this study we assess the MCOs' costs to enroll children. This study does not estimate the back-end processing costs of enrollment incurred by state and local Medicaid agencies but instead focuses on the front-end enrollment tasks that are most directly affected by policy changes in enrollment procedures.

## Study Methods

We first assessed the cost for the typical enrollment process in New York, then we determined cost savings realized during the dramatically streamlined process employed after September 11. To do this, we developed a detailed description of the typical enrollment process, assessed overall costs and time associated with each step in that process, and determined where reductions in time and cost were occurring in the post-September 11 process.

We performed these comparisons by using 2001 data from three of the sixteen MCOs enrolling both Medicaid and SCHIP children in the greater New York City area, representing a range of child membership sizes and serving a typically ethnically diverse clientele. To document the steps taken to enroll children, we conducted multiple interviews with directors of marketing and enrollment departments from the three MCOs. We then drafted a description of the enrollment process, which was reviewed and revised based on their comments.

■ **Cost assessments.** Costs were assessed for major components of the enrollment process through examinations of the 2001 expenditure reports, using widely accepted cost-accounting procedures.<sup>7</sup> We included expenses from marketing and enrollment departments and an estimate of the portion of the expenses in management information systems (MIS), human resources, mailroom facilities, and other than personnel services (OTPS) allocated to enrollment. Cost per enrolled child was determined by dividing total cost by the number of completed child enrollments in Medicaid and SCHIP for each MCO and taking the average of the three.<sup>8</sup>

■ **Time assessments.** We assessed time spent on tasks for the typical and simplified enrollment processes using structured questionnaires. Enrollers' activities included filling out the application; explaining and assembling documentation to prove eligibility; troubleshooting problems; following up with the family regarding missing information; processing the application; following up with specific agencies after submitting an application; and training staff about regulatory changes or clarifications with respect to eligibility screening. Twenty-seven enrollers (nine from each MCO) were asked to estimate the time spent on these activities in an average week before September 11 and then the time saved on these activities in the simplified enrollment process. MCO supervisors' activities included health education and outreach; eligibility-related activities; checking the applications for completeness and accuracy; data entry; training enrollers; and general administration and supervision. They also estimated time spent in an average week pre-September 11 and then time saved post-September 11.

■ **Cost assessments by functional category.** Staff estimates of time spent in activities in the two enrollment processes were used to calculate costs associated with these activities, using average salary and benefits associated with the staff member performing the activities. Activities were then sorted into four functional categories: (1) outreach and health insurance education (first interaction between applicant and enroller, informing applicant about health care options, and helping family initiate an application); (2) application completion/documentation (determining which program the child is qualified for, helping the family complete the application form and gather required documents to prove eligibility, and copying and processing the application); (3) quality assurance (checking application for completeness and confirming that calculations for eligibility based on income were performed correctly); and (4) application submission/troubleshooting (entering application information into electronic databases and transmitting Medicaid applications manually to the Department of Social Services and SCHIP applications to the MCOs).

■ **Simplified procedure.** The simplified enrollment process differs from the typical process in the following ways. First, the application itself is shorter (only one page long) and easier to complete than the regular joint application for children (four pages long). Second, the only supporting documentation required is proof of identity from the applying family member.

## Study Findings

■ **Costs of typical enrollment.** The average administrative cost to enroll a child in health insurance for the three MCOs was \$282 (Exhibit 1).<sup>9</sup> Overall costs are shown for marketing and enrollment departments, along with the portion of other departments or functions that support marketing and enrollment.

■ **Time spent in typical enrollment process.** We categorized the time that enrollment workers reported spending on tasks into five major functional areas: eligibility screening, gathering documents, application processing, outreach and health insurance education, and other enrollment activities. Enrollers typically spend approximately 16 percent of their time in the initial eligibility screening interview with the family and approximately 20 percent of their time securing documents for families. The latter includes explaining what documents are needed and helping to secure documents. Approximately 27 percent of enrollers' time is spent in application processing, which includes copying the documents, completing internal paperwork to accompany the application, submitting the application, and following up if problems arise. Approximately 18 percent of their time is spent in outreach (6 percent)

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### EXHIBIT 1 Average Cost To Enroll For Three Managed Care Organizations, 2002

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Cost component	Dollar amount
Marketing and enrollment	5,759,131
Marketing	4,655,959
Salaries	2,726,775
Fringe benefits	548,824
OTPS	1,380,360
Enrollment	1,103,172
Salaries	739,210
Fringe benefits	141,660
OTPS	222,302
Support for marketing and enrollment	1,283,388
Human resources (recruitment)/training	
Salaries	103,339
Fringe benefits	20,321
MIS	
Salaries	319,204
Fringe benefits	63,543
Mailroom facilities	
Salaries	63,258
Fringe benefits	13,866
OTPS	699,856
Total cost	7,042,519
Cost per child (average for three MCOs)	282

**SOURCE:** Authors' analysis.

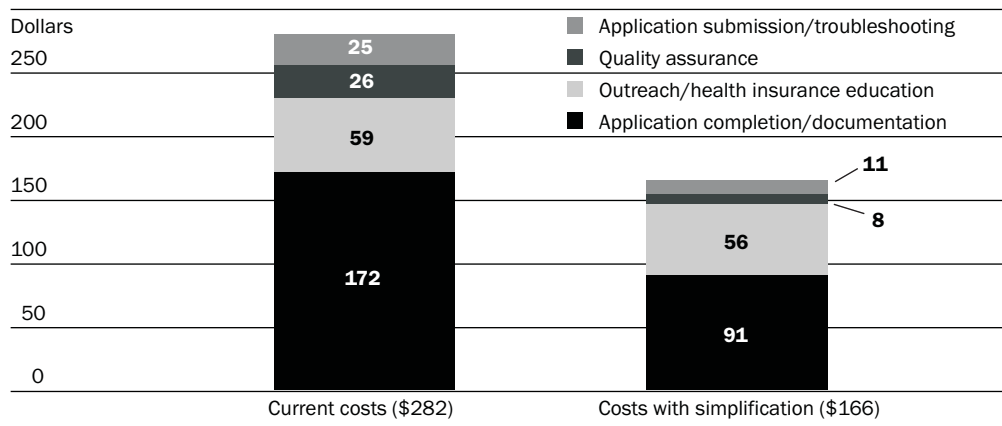
**NOTES:** All costs are average of three managed care organization (MCOs). Other than personnel services (OTPS) includes promotional items (marketing), supplies, telephone, printing/postage, and miscellaneous items; it does not include dues, interest, insurance, advertising, or rent. MIS is management information systems.

and health insurance education (12 percent); 19 percent is spent on other activities, including training.

■ **Comparison of costs under typical and simplified systems.** Not surprisingly, 61 percent of the total cost of enrollment is devoted to application completion and gathering documents (Exhibit 2). An additional 9 percent is spent on quality assurance. This means that 70 percent of time is spent in administering the complex rules of the process. A further 9 percent is spent on application submission, troubleshooting, and follow-up, much of which relates to answering questions about eligibility proof and calculations. Thus, arguably, up to 80 percent of the enrollment cost is associated with the complex rules, proofs, and calculations surrounding eligibility. Outreach and health insurance education, activities that help the family, together account for only 21 percent of the enrollment cost.

Under a simplified enrollment process, most of the time and money would be saved in the front-end work of eligibility screening, application completion, and document assembling. Based on the estimates of time saved, we determined that almost half of the current costs for these tasks could be saved if the rules were simplified (Exhibit 2). These changes would bring with them reduced time and cost in quality assurance, since the simplified system would be less conducive to errors. We estimate that current costs for quality assurance could be reduced by approximately 70 percent in a simplified system. Likewise, the time spent in monitoring the approval process at Medicaid, answering questions about the application, and other general troubleshooting activities would be reduced if the proof of eligibility were more straightforward. Education about the importance of health insurance and how to access care would remain essentially the same, as would the level of outreach needed to reach potential enrollees. However, less time would be required to explain the rules. Overall, enrollment costs would be re-

**EXHIBIT 2**  
**Costs Of Functional Enrollment Categories For Enrolling People In Medicaid And The State Children’s Health Insurance Program, With And Without Simplification, 2002**



SOURCE: Authors’ analysis.

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duced by approximately 40 percent in a simplified system.

It would still be necessary to verify eligibility under the simplified system. This could be done through cross-checking existing databases, such as the databases for income tax; wage reporting; or Temporary Assistance for Needy Families (TANF), food assistance, or other means-tested social programs. Some cross-checking is now done, but more might be needed. We did not add in costs for additional cross-checking with existing databases because these costs would vary depending on the extent of the cross-checking, the sophistication of the data systems, and whether verification was done for a sample or the whole population.

## Discussion

States contemplating adding more frequent enrollment checkpoints or adding other complexities to the enrollment process should consider the substantial administrative costs involved. Our estimate of cost to enroll is equivalent to more than two months' health care premiums paid to the MCOs in New York. Thus, administrative costs for enrollment absorb sizable amounts of funds that could be either realized as cost savings or deployed elsewhere.

The full administrative cost to enroll could be even higher, in that our estimates do not include the substantial costs to local and state governments to process Medicaid and SCHIP applications or MCOs' administrative overhead. Instead, we included only the costs that are most closely associated with determining eligibility and applying the regulations of the enrollment process.<sup>10</sup> Further, our estimates are for costs to enroll children; enrolling adults is even more complex.

■ **Disenrollment effects.** Higher administrative costs are not the only adverse consequence of enrollment complexity. Studies repeatedly show that approximately 50–60 percent of children fail to recertify at each redetermination point.<sup>11</sup> Many of these children remain eligible; in New York 66 percent of the remaining group came back on the rolls within the next twelve months. Only a small share of enrollees—less than 10 percent—became ineligible because of changes in income or family composition.<sup>12</sup> Hence, the combined effect of shortening the enrollment process is to disenroll eligible children as well as to add to the cost of administrative processing. Because some children never reenroll, and some delay the process, the tactic of shortening the enrollment period will, in all likelihood, save funds in the short term.<sup>13</sup> However, it will do so by failing to serve eligible children.

■ **Implications for other states.** Our findings have implications beyond New York. Despite the fact that MCOs carry out enrollment in New York, whereas state or local Medicaid offices perform these functions in most states, the functions that are subject to simplification—the complex rules, proofs, and calculations around el-

igibility—are comparable for MCOs and states. The lesson here is that enrollment complexity results in higher administrative costs for whatever entity is carrying it out, and conversely, simplifying these processes can save money. In this era of scarce resources, the case for simplification is more compelling than ever.

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**NOTES**

1. V. Smith et al., *Medicaid Spending Growth: A Fifty-State Update for Fiscal Year 2003* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2003).
2. D. Cohen Ross and L. Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission, July 2003).
3. S. Woolhandler, T. Campbell, and D.U. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine* 349, no. 8 (2003): 768–775.
4. Typical enrollment process is described in G. Fairbrother et al., “An Examination of Enrollment of Children in Public Health Insurance in New York City through Facilitated Enrollment,” *Journal of Urban Health* (Submitted). Simplified enrollment process is described in K. Haslanger, “Radical Simplification: Disaster Relief Medicaid in New York City,” *Health Affairs* (Jan/Feb 2003): 252–258.
5. D. Bachrach, R. Belfort, and K. Lipson, *Closing Coverage Gaps: Improving Retention Rates in New York’s Medicaid and Child Health Plus Programs*, Report of the New York State Coalition of PHSPs (New York: Kalkines, Arky, Zall, and Bernstein, December 2000).
6. New York has separate Medicaid and SCHIP programs, Child Health Plus A and Child Health Plus B, respectively. To reduce confusion, we refer to the programs by their federal names, Medicaid and SCHIP.
7. S.A. Finkler and D.M. Ward, *Cost Accounting for Health Care Organizations: Concepts and Applications* (Gaithersburg, Md.: Aspen Publishers, 1999).
8. We used budgets from calendar year 2001. However, because the enrollment process was disrupted in New York after 11 September 2001, we used enrollments in the twelve-month period September 2000–August 2001 to calculate cost per child.
9. We also assessed cost for enrolling in three selected community-based organizations, funded by New York State to enroll children in high-need areas. Generally, these organizations enroll at their offices, targeting families already using those services and others who come in through word of mouth seeking health insurance. Costs are considerably lower for this type of enrollment (approximately \$119 per enrolled child).
10. MCOs have a vested interest in enrolling members and might invest additional resources in enrollment activities, which could partially offset the costs that we did not include.
11. A. Dick et al., “Consequences of States’ Policies for SCHIP Disenrollment,” *Health Care Financing Review* (Spring 2002): 65–88; and T. Riley et al., *Why Eligible Children Lose or Leave SCHIP: Findings from a Comprehensive Study of Retention and Disenrollment* (Portland, Maine: National Academy for State Health Policy, February 2002).
12. M. Birnbaum and D. Holahan, *Renewing Coverage in New York’s Child Health Plus B Program: Retention Rates and Enrollee Experiences* (New York: United Hospital Fund, 2003); and K. Lipson et al., *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York’s Public Health Insurance Programs*, Pub. no. 656 (New York: Commonwealth Fund, August 2003).
13. In the long term, some of these savings will be offset by increased need when the children do reenroll or will be shifted to the safety net.