

ISSUE BRIEF

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TRENDS IN INSURANCE COVERAGE

Increasing Children's Coverage and Access: A Decade of SCHIP Lessons

by Margo Rosenbach

Expanding health coverage for children is at the center of health policy debates as reauthorization of the 10-year-old State Children's Health Insurance Program (SCHIP) continues. This brief is based on Mathematica's national evaluation of SCHIP conducted for the Centers for Medicare & Medicaid Services (CMS). The analysis highlights states' progress in conducting outreach, averting substitution, improving access, and reducing the number of uninsured low-income children.

Why SCHIP?

SCHIP was enacted at a time when the number and rate of uninsured children were growing rapidly, especially among those just above the poverty threshold—too poor to purchase private coverage but not poor enough to qualify for Medicaid. Recognition of the large number of uninsured children eligible for Medicaid but not enrolled was also mounting.

When Congress launched SCHIP as part of the Balanced Budget Act of 1997, it gave states considerable flexibility in designing programs to expand coverage for uninsured low-income children. They could expand coverage through Medicaid (M-SCHIP), create a separate child health program (S-SCHIP), or combine the two approaches. SCHIP represented the largest expansion of publicly sponsored health insurance coverage since Medicare and Medicaid were created in the mid-1960s.

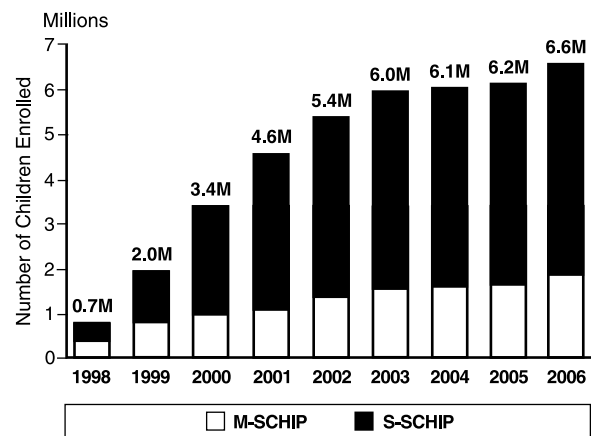
SCHIP HIGHLIGHTS

- SCHIP enrollment increased dramatically from its implementation in October 1997, with 6.6 million children ever enrolled in federal fiscal year 2006.
- SCHIP outreach and enrollment initiatives reversed declines in traditional Medicaid by reaching children who were eligible for Medicaid but uninsured.
- The number and rate of uninsured low-income children declined significantly, particularly during the early 2000s.
- Access to care improved significantly, although gaps remain for children with special health care needs and children of minority race/ethnicity.

Enrollment Grew Steadily

During the early years, considerable attention focused on states' progress in enrolling children in SCHIP. Although modest numbers enrolled during 1998, momentum picked up in 1999 and increased rapidly through 2001. Enrollment reached 6.6 million children in 2006 (Figure 1).

Figure 1: Trends in Enrollment, 1998 to 2006



As the program matured, the share enrolled in S-SCHIP increased, while the share in M-SCHIP declined. Three main factors accounted for this shift: (1) phasing in of coverage for adolescents under age 19 with family incomes below 100 percent of the federal poverty level under traditional Medicaid, (2) later implementation and “ramp-up” of S-SCHIP, and (3) broader expansion of S-SCHIP income eligibility thresholds. The number of states with SCHIP income thresholds at or above 200 percent of the federal poverty level rose from 25 in September 1999, to 36 two years later, and to 39 as of July 2005.

Outreach Strategies Evolved

States demonstrated creativity and adaptability in developing strategies to promote SCHIP. Outreach initially focused on the general population to create broad awareness of SCHIP, but it gradually shifted to those who were eligible but not enrolled (such as members of racial and ethnic minority groups, working families, and rural residents). States used feedback from many sources—including outreach workers, telephone help lines, and surveys—to identify vulnerable populations and underserved areas.

Most states started out by mounting mass media campaigns and partnering with statewide organizations. Over time, the focus shifted to building partnerships with community-based organizations that had access to hard-to-reach populations. In addition, media campaigns gave way to local, one-on-one outreach, including the use of mini-grants and application assistance fees to stimulate outreach and enrollment.

After many states reduced outreach because of budget constraints, they shifted their emphasis to “inreach”—providing education to current enrollees to improve retention. Inreach promoted the value of health coverage and educated families about the appropriate use of insurance to access care.

Traditional Medicaid Also Grew

SCHIP had a “spillover effect” on traditional Medicaid enrollment, although the magnitude is unclear. Activities such as using joint applications for SCHIP and traditional Medicaid, and creating brand identity (such as a new name and/or logo), enhanced awareness of both programs. In addition, SCHIP regulations required states to screen and enroll eligible children in traditional Medicaid.

States concur that traditional Medicaid enrollment increased as a result of SCHIP. Estimates suggest that the effect on traditional Medicaid enrollment may have substantially exceeded the effect on SCHIP enrollment in some states.

Retention Varied Across States

Early success led to a growing awareness that disenrollment from SCHIP was eroding enrollment gains. However, most studies are unable to distinguish whether children who left the program did so because they were ineligible (for example, because they moved, turned age 19, obtained other insurance coverage, or had a change in income), or whether they remained eligible and became uninsured. As a result, few studies measure SCHIP retention directly—defined as the proportion of children who stay enrolled, among those who remain eligible.

Mathematica’s evaluation estimated that retention in SCHIP 12 months after initial enrollment ranged between 31 and 98 percent, but exceeded 75 percent in most states. These percentages are similar to those in the individual insurance market and traditional Medicaid.

State policies may account for variations in retention. Factors that facilitated retention include 12-month continuous coverage, renewal simplifications, and passive renewal. Although evidence suggests that premiums and lockout provisions for nonpayment reduced retention of children subject to premiums, grace periods prolonged enrollment spans.

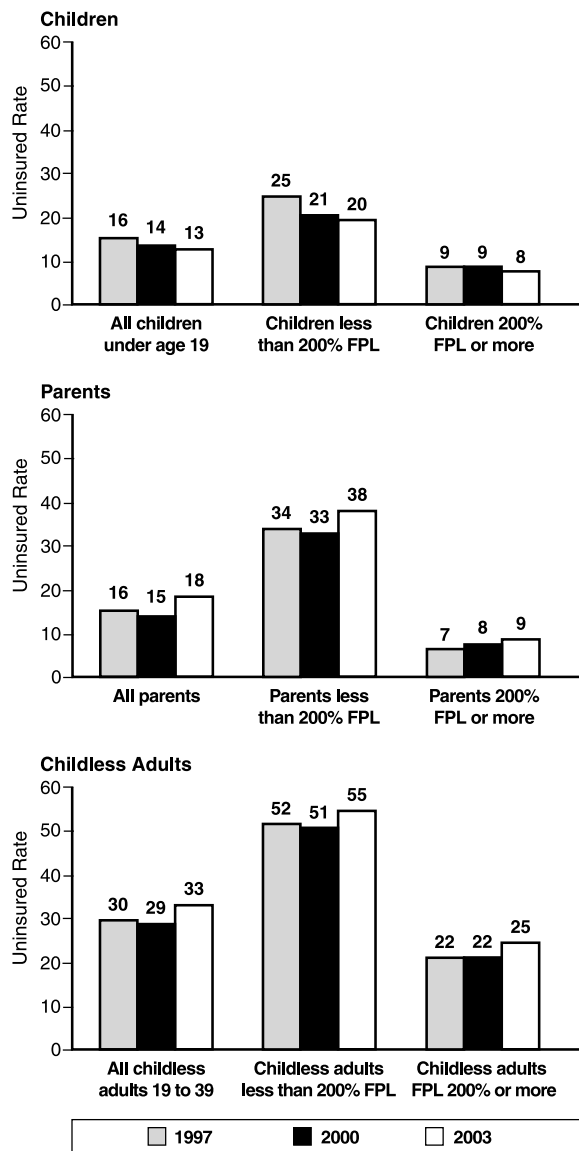
Fewer Uninsured Children

SCHIP improved health coverage among low-income children. Using data from the Current Population Survey, we found that, between 1997 and 2003, the proportion of children under age 19 who were uninsured decreased from 16 to 13 percent. The uninsured rate among low-income children declined by an even larger amount, from 25 to 20 percent. The number of uninsured, low-income children fell by nearly one-third, from 7.9 to 6.1 million.

SCHIP also served as a safety net for low-income children during the 2000 recession and beyond, when many families lost employer-sponsored coverage. Although children and nonelderly adults experienced similar losses of private coverage between 2000 and 2003, earlier gains in children’s coverage were

sustained through continued growth in public coverage, largely attributable to SCHIP. In contrast, non-elderly adults, including parents and childless adults, lacked access to much of this public coverage, and their uninsured rates increased significantly (Figure 2).

Figure 2: Trends in Uninsured Rates, 1997 to 2003



If SCHIP did not exist, we estimate that the rate of uninsured children would have risen by 3.3 percentage points, instead of declining by 0.7 percentage points between 2000 and 2003. Furthermore, we estimate that the number of uninsured children would have grown by 2.7 million, rather than declining by 0.4 million. These measures illustrate how the

availability of public coverage protected many low-income children from becoming uninsured between 2000 and 2003.

Estimates of Substitution Vary Widely

Substitution of coverage—also known as crowdout—occurs when individuals drop or decline private coverage and enroll in public coverage. Existing data sources and methods yield wide-ranging estimates of substitution, with the magnitude varying depending on how substitution is defined and measured. The CMS national evaluation of SCHIP looked at evidence on substitution of coverage from three kinds of studies:

- Population-based studies estimate that substitution of SCHIP for private coverage ranges from 10 to 56 percent.** These studies define substitution as *any* decline in private coverage within the population of low-income children who were eligible for SCHIP (regardless of the reason for loss of coverage). These studies use multivariate methods to estimate substitution by simulating eligibility for SCHIP and comparing changes in private coverage among SCHIP-eligible children versus a comparison group. The methodology is designed to capture foregone opportunities for taking up private coverage after a child is enrolled in SCHIP. However, study limitations, as acknowledged by the authors, include the instability of estimates based on the choice of comparison group or multivariate methodology, error in self-reported insurance status, issues with imputing SCHIP eligibility, and limited ability to account for state-specific antisubstitution rules.
- Enrollee-based studies estimate that substitution is between 0.7 and 15 percent,** based on descriptive analysis of pre-SCHIP insurance status and access to employer coverage among children who recently enrolled in SCHIP. These studies take into account reasons for loss of coverage, and do not count involuntary loss of coverage as substitution (such as job loss, divorce, death of a parent). However, these studies may underestimate the extent of substitution because they generally do not account for the likelihood that families had access to private coverage before or after their children enrolled in SCHIP (also known as “foregone opportunities”).

- **Estimates from applicant-based studies are typically below 10 percent.** These studies estimate substitution among those who applied for SCHIP based on state administrative data and apply state-specific antisubstitution rules to their estimates of substitution (including waiting periods and reasons for dropping coverage). Like the enrollee-based studies, these studies focus on children’s availability of private insurance coverage at the time of SCHIP application or enrollment, and do not account for foregone opportunities for taking up private coverage after a child is enrolled in SCHIP.

Mathematica’s study suggests that some amount of substitution is unavoidable, regardless of how substitution is defined and measured. The salient policy questions include “how much” and “what kinds of” substitution are acceptable. On one hand, the population-based studies consider any reason for declines in private coverage as substitution, whereas the enrollee- and applicant-based studies take into account state-specific reasons for loss of private coverage (such as job loss, divorce, death of a parent, or in some cases, unaffordability of private coverage). Thus, conclusions about the extent of substitution in SCHIP will depend not only on how substitution is defined and measured, but also on perspectives on the circumstances under which substitution may be acceptable.

Access to Health Care Improved

Access to care has improved for children enrolled in SCHIP, although gaps remain. Evidence from the literature and state monitoring efforts suggests that SCHIP increased the likelihood of having a usual source of care, reduced the level of unmet need, and improved access to dental care. Two subgroups—the long-term uninsured (those without coverage for more than six months before SCHIP) and adolescents—saw the greatest gains under SCHIP. Two other subgroups—those with special health care needs and members of minority racial or ethnic groups—were less likely to post consistent gains. Although disparities have lessened, substantial gaps remain.

Access to care varied among states. For example, states differed in their progress toward meeting national Healthy People 2010 goals on such indicators as unmet need, usual source of care, and dental care.

Similarly, performance on the following four core performance measures varied, both across states and, in some cases, compared to commercial and Medicaid benchmarks: (1) well-child visits in the first 15 months of life, (2) well-child visits in the third through sixth years of life, (3) use of appropriate medications for asthma, and (4) visits to primary care providers. However, lack of consistent methods for measuring performance across states may account for some variation, but the magnitude and direction are unknown.

Need for Ongoing Monitoring

As SCHIP reauthorization approaches, this study suggests further opportunities for improving program performance, monitoring progress, and conducting future research. The SCHIP program has made great strides in implementing a performance measurement system to track access to and quality of care. Data completeness and quality have improved dramatically during the past three years to help CMS formulate strategies for program improvement. However, it may be necessary to pay more attention to the consistency of data across states. Over the longer term, CMS—in consultation and collaboration with states—may want to incorporate measures that reflect additional populations or services, such as adolescent well-child visits or annual dental visits. Finally, the experience with performance measurement in SCHIP may serve as a model for the Medicaid program, which covers the vast majority of low-income children.

Considerations for Reauthorization

The reauthorization debate highlights the delicate balance that must be struck in designing SCHIP as a national program by standardizing certain components, while at the same time preserving flexibility for states to make program choices consistent with their political, economic, and social environment. Considerations for the reauthorization of SCHIP that emerged from this evaluation include the following:

- Maintain the option of M-SCHIP and S-SCHIP program models.
- Continue the nonentitlement option of S-SCHIP plans, which allows states to cap enrollment during budget shortfalls.
- Maintain the flexibility of S-SCHIP benefit packages.
- Provide more flexibility to states in developing premium assistance components.

- Enhance coordination with traditional Medicaid, especially at renewal. A process parallel to “screen and enroll,” during the renewal process, would facilitate transfers between SCHIP and Medicaid.
- Strengthen performance-monitoring capabilities through submission of detailed enrollment and utilization data.

Reauthorization of SCHIP offers many opportunities to cover even more low-income children who would otherwise be uninsured and to enhance their access to health care through the SCHIP program. The lessons of the past decade can inform the SCHIP reauthorization process to strengthen the program even further.

This evaluation was funded by the Centers for Medicare & Medicaid Services. For more information, contact Margo Rosenbach at (617) 301-8967 or mrosenbach@mathematica-mpr.com.

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ABOUT THE EVALUATION

Mathematica’s SCHIP evaluation included the following components:

- Synthesizing results of state SCHIP evaluations for a CMS report to Congress
- Analyzing enrollment, disenrollment, and re-enrollment patterns based on the SCHIP Enrollment Data System and the Medicaid Statistical Information System
- Assessing trends in the number and rate of uninsured children from 1997 through 2003 using the Current Population Survey
- Synthesizing the literature on retention, substitution (“crowdout”), and access to care
- Conducting studies on outreach and access to care based on state SCHIP annual reports
- Using quantitative and qualitative methods to analyze outreach and enrollment effectiveness
- Producing a case study of implementation in eight states based on site visits and focus groups with parents
- Analyzing performance measures reported by states in their annual SCHIP reports for federal fiscal years 2003 through 2005

To view reports from the evaluation, go to www.mathematica-mpr.com/health/schippubs.asp.

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