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Congressionally Mandated Evaluation of the State Children's Health Insurance Program

Executive Summary

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EXECUTIVE SUMMARY

BACKGROUND

Congress mandated in the Balanced Budget Refinement Act of 1999 (BBRA) that the Secretary of the U.S. Department of Health and Human Services conduct an independent comprehensive study of the State Children's Health Insurance Program (SCHIP). The evaluation was funded through the $10 million appropriation in the BBRA. An interim report was sent to Congress in 2003 that summarized states' SCHIP designs and their early experiences with program implementation (Wooldridge et al. 2003). This final report presents findings from the congressionally mandated evaluation funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The study focused mainly on SCHIP programs in California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas. The evaluation drew on case studies and surveys of SCHIP enrollees and recent disenrollees in the 10 states. In addition, nationwide perspectives on SCHIP implementation and uninsured children's access to care were provided by two national surveys—a survey of state SCHIP administrators, conducted as part of the evaluation, and a survey of low-income, uninsured families, separately funded by ASPE in support of the evaluation.[1]

Program Design. SCHIP was created by the Balanced Budget Act (BBA) of 1997. To encourage states to implement a SCHIP program, the federal matching rate was enhanced relative to Medicaid. The BBA allowed states to cover children in families with incomes up to 200 percent of the federal poverty level and beyond. It also gave states considerable flexibility in designing their programs. States could introduce a separate program, expand Medicaid, or do both. Separate programs could deviate from Medicaid in several respects. They could have a different benefits package, though benefits package designs were restricted to several "benchmark" plan options. Separate programs could include cost sharing for families of enrollees, including up-front fees to enroll, monthly premiums and deductibles, and copayments for services. They could also impose a waiting period on families who dropped their children's private coverage to discourage families from substituting SCHIP for employer-based coverage. By law, Medicaid expansion programs under SCHIP were subject to all the requirements of Medicaid, except when using Section 1115 demonstration waiver authority. Thus, states that chose the Medicaid expansion model could not use a different benefits package for their SCHIP enrollees, employ cost sharing, or impose waiting periods. To improve continuity of care, all programs could offer continuous coverage up to 12 months.

Study Design. The BBRA specified the issues the evaluation was to investigate, as well as some of the methods to be used. Congress stipulated that the evaluation include 10 states with varied geographical and urban/rural representation, diverse approaches to program design, and a large proportion of the low-income, uninsured children in the United States. It also stipulated that the evaluation should survey SCHIP enrollees and disenrollees and children eligible for, but not enrolled in, SCHIP. The 10 states were drawn from the four census regions, adopted diverse program designs, and included 56 percent of uninsured children with families below 200 percent

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[1]Mathematica Policy Research, Inc. and its partners—The Urban Institute and the MayaTech Corporation—conducted the evaluation under contract to ASPE.

of the federal poverty level in 1997, when SCHIP began. (See Table 1.) These states included 62 percent of the children who were enrolled in SCHIP at any time during fiscal 2002.

Table 1. Characteristics of 10 SCHIP Programs Included in the Evaluation, 2002

State	Program Name	Program Type[a]	Ever Enrolled in Fiscal 2002	Maximum Income Eligibility (as % FPL)	Waiting Period Required	12-Month Continuous Eligibility	Any Service Copay Required (All, Some, No Enrollees)
California	*Healthy Families*	Separate[b]	856,994	250	Yes	Yes	All
Colorado	*Child Health Plan Plus*	Separate	51,826	185	Yes	Yes	Some
Florida	*KidCare*	Separate[b]	368,180	200	No	No	Some
Illinois	*KidCare*	Combination	68,032	185	Yes	Yes	Some
Louisiana	*LaCHIP*	Medicaid	87,675	200	No	Yes	None
Missouri	*MC+ for Kids*	Medicaid	112,004	300	Yes	No	Some
New Jersey	*FamilyCare*	Combination	117,053	350	Yes	No	Some
New York	*Child Health Plus*	Separate[b]	807,145	250	No	No	None
North Carolina	*Health Choice*	Separate	120,090	200	Prior to Feb. 2002	Yes	Some
Texas	*TexCare*	Separate	727,452	200	Yes	Yes	Some
Total			**3,316,451**				

SOURCES:

Enrollment Data 2002: Centers for Medicaid and Medicaid Services 2005. Accessed May 23, 2005 (http:www.cms.hhs.gov/schip/enrollment). Number of children ever enrolled in SCHIP during fiscal 2002.

Remaining Data: Hill, Ian, et al., "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Cross-Cutting Report on Findings from 10 State Site Visits." Report submitted to the Department of Health and Human Services, Mathematica Policy Research Inc. and the Urban Institute, 2003.

NOTES:

FPL = Federal Poverty Level.

[a]Program type reflects states' options to either expand Medicaid (Medicaid), create or expand a separate state program (Separate), or combine the two approaches (Combination).

[b]These states actually had combination programs with small Medicaid components, which were expected to end by the time the surveys of SCHIP enrollees and disenrollees began. These children were expected to become Medicaid eligible at that time. Small Medicaid components continued, but the survey only sampled children enrolled in the separate program in these three states.

This report presents findings from an extensive analysis of the mandated surveys of SCHIP enrollees and disenrollees in 10 states, and the Medicaid enrollees and disenrollees in 2 States (conducted during 2002). Three groups of children were sampled: (1) Recent enrollees: children who had been enrolled in the program for 1 or 2 months when sampled; (2) Established enrollees: children who had been enrolled in the program for 5 or more months when sampled; and (3) Recent disenrollees: children who had been disenrolled from the program in the most recent 2 months when sampled.[2] To study children eligible for SCHIP and Medicaid who had not enrolled in the program, the report draws on data from a national sample of low-income, uninsured children collected in the National Survey of Children with Special Health Care Needs by the National Center for Health Statistics between 2000 and 2002. The report also draws on

[2]The survey instrument is included as an Appendix to the full report on the survey (Kenney et al. 2005).

case studies of all 10 states (conducted between May 2001 and January 2002) and a national survey of SCHIP administrators (conducted during 2003).

The evaluation addressed questions about: (1) SCHIP program design, implementation, and evolution, and SCHIP coordination with Medicaid; (2) who enrolled and whether families substituted SCHIP for private group coverage; (3) how the program affected access to care; and (4) family experiences enrolling their children, how long children stayed in the program, and what types of insurance coverage they had subsequently.

FINDINGS

This Congressionally mandated evaluation found the SCHIP program to be successful in nearly all of the areas examined. The findings reveal an effective program. For example, the findings demonstrate that states were prompt to develop generous programs and design effective outreach strategies to attract and enroll children, and that states adopted simplified application and enrollment processes to aid families and retain enrollees. SCHIP programs were found to provide health coverage to the population SCHIP was intended to serve, particularly to children who would otherwise have been uninsured. The programs availed enrollees of needed primary and other health care services, and were found to have a positive impact on enrollees' access to health care services, leaving enrollees with fewer unmet needs than they would have had in the absence of SCHIP. Families were satisfied with the ease of enrolling children, many of whom remained enrolled for 12 months, depending on the state.

States Implemented Diverse Program Designs Promptly

The evaluation found that states were quick to implement their SCHIP programs and take advantage of the enhanced federal funding for SCHIP. During fiscal 2004, 6.1 million children were enrolled at some point during the year (CMS 2005). In fiscal 2003, of the 48 states and Washington, DC, 18 had separate programs, 13 had Medicaid expansion programs, and 18 had both (combination programs). States selected program designs in response to local economic and policy environments. States choosing separate program components did so to take advantage of the flexibility separate programs offered—particularly the ability to include features of private insurance, such as premiums and cost sharing. But some states also made this choice because their Medicaid programs had a negative image. States choosing a Medicaid expansion did so because it offered a simple way of increasing coverage—without the need for a new administrative structure—and because the Medicaid programs in many of these states enjoyed a positive image. Some states adopted Medicaid expansions to cover children who were not currently eligible for Medicaid, but who would become Medicaid eligible when mandatory coverage for children under 100 percent of the poverty level up to age 19 was phased in during fiscal 2002 (colloquially known as "Waxman children"). Many states implemented generous benefits and simple application processes. They also modified numerous policies after start-up, for example, to increase eligibility thresholds and modify cost sharing. However, subsequent state budget shortfalls resulted in a number of states reducing or targeting outreach and limiting enrollment.

Diverse Children Enrolled in SCHIP

The evaluation found that children who enrolled in SCHIP in the 10 study states came from diverse racial and ethnic backgrounds, and had wide-ranging health needs and parental characteristics. (See Table 2.) Most SCHIP enrollees were of school age. Almost one-half of the enrollees were Hispanic, one-third were white, English-speaking, and 12 percent were black. One-third lived in households in which English is not the primary language. One-quarter had elevated health care needs. And almost all enrollees came from a family with at least one working parent, but over 90 percent of them lived in households with incomes under 200 percent of the federal poverty level.

Table 2. Characteristics of SCHIP Enrollees and Their Parents

Variable	Percent
Children's Characteristics	
Age (in years)	
0 to 5	19 %
6 to 12	48
13 and older	33
Race	
Hispanic/Latino	49
White	32
Black	12
Asian	6
All Other Races	2
Health	
Child's Overall Health is Good or Excellent	91
Child Has an Elevated Health Care Need[a]	24
Parent's Characteristics	
At Least One Parent Employed in Past Year	92
Household Characteristics	
Main Language (Other than English) Spoken in Household	
Spanish	28
Other	5
Household Income, by FPL Range[b]	
Less than 150% FPL	68
150 to 199% FPL	23
200% FPL or higher	9

SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

NOTES: FPL = Federal Poverty Level

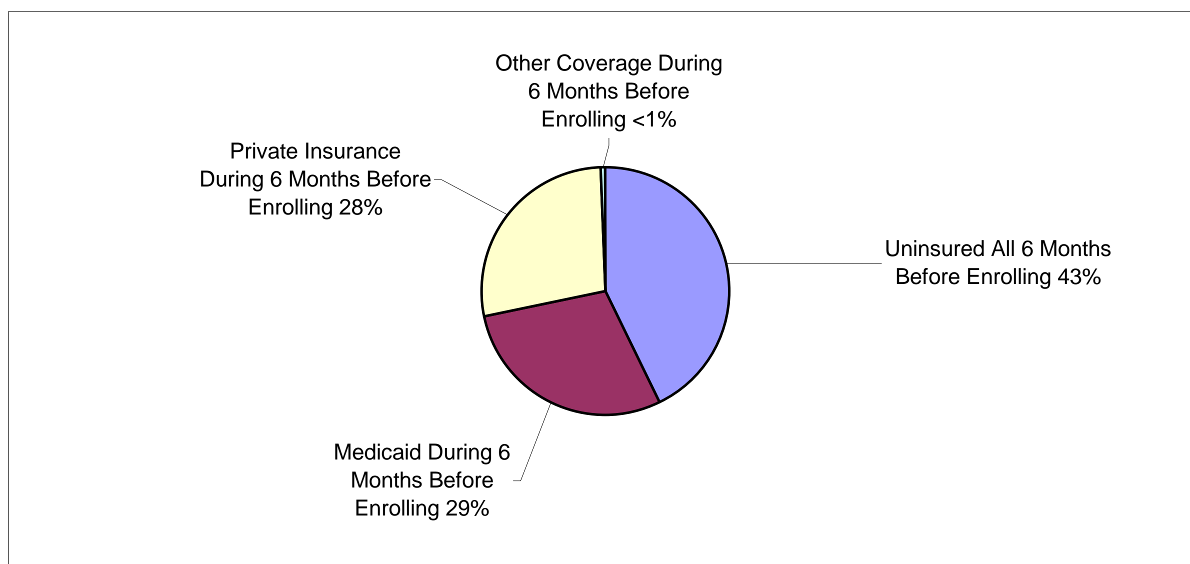
[a]Child is classified as having Elevated Health Care Needs if the child is in fair or poor health or if the child meets one or more of the following criteria; (1) had an impairment or health problem lasting at least 12 months that limits his/her ability to crawl, walk, run, or play; (2) a health care professional said that the child had asthma or has taken medication or required injections prescribed by a doctor for his/her asthma; (3) has taken medication or required injections for at least 3 months, excluding asthma; (4) a health professional said that the child had a mental health condition or behavioral problem or that the condition or behavioral problem limited his/her ability to do regular school work or to participate in the usual kind of activities done by most children his/her age.

[b]Household income (total income from all sources during the past 12 months) has a missing rate of 11 percent, which is considerably higher than the other variables.

SCHIP Serves Low-Income Children Who Would Otherwise Have Been Uninsured

SCHIP is predominantly serving the target population of low-income children who otherwise would have been uninsured. Many recent enrollees in the 10 study states (43 percent) had been uninsured for 6 months before they enrolled, and another 29 percent moved to SCHIP from Medicaid. (See Figure 1.) Roughly 28 percent of recent enrollees had private coverage (mostly employer) during the 6 month period before enrollment. However, one-half of these (14 percent of the total) lost coverage involuntarily during that period, and therefore did not substitute public coverage for private insurance. In addition, one-quarter of recent enrollees who were previously enrolled in private coverage (7 percent of the total) were enrolled in coverage their families found unaffordable. State-to-state variation among the 10 study states was fairly small, and in no state was the share of recent enrollees who could have had employer coverage at the time they enrolled above 20 percent.

Figure 1. Coverage of Recent Enrollees During the 6 Months Before They Enrolled



SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states and State Enrollment Data Files.

The evaluation also found that parents of some SCHIP enrollees may be able to purchase dependent coverage during their child's SCHIP enrollment period. Between 28 and 36 percent of established enrollees (children enrolled for 5 or more months) have insured parents whose employers pay for at least a part of the cost of dependent coverage. However, it is not known what proportion of the premium the employers paid, and parents whose employers made small contributions may still have been unable to afford the coverage available.

Substitution estimates of 7 to 14 percent for recent enrollees and 28 to 36 percent for established enrollees cannot be added together to provide an estimate of the percent of enrollees who ever substituted SCHIP for private group coverage because there is overlap between the two groups of enrollees. Some families with the option to take up dependent coverage after 5 months of SCHIP enrollment may have had that option prior to the child's SCHIP enrollment, and therefore already be counted in the recent enrollee estimate. Summing the two estimates would overestimate the incidence of substitution.

SCHIP Meets the Primary Health Care Needs of Most Children Who Enroll

SCHIP programs are meeting the primary health care needs of most children who enroll. SCHIP enrollees experienced high levels of access to care, as measured by their receipt of preventive care, the presence of a usual source of care for medical and dental care, and parents' perceptions about their children's health care coverage. (See Table 3.) For example, 91 percent of SCHIP enrollees had a usual source of medical care, and the parents of 81 percent of enrollees were very confident that they could meet their children's health care needs. There was little cross-state variation in the access and service-use measures considered in this study, but families in states with Medicaid expansions or combination programs were more likely than families in states with separate programs to believe that providers "looked down on" SCHIP enrollees.

While overall, SCHIP programs provide high levels of access to care, some groups of enrollees had better access than others. SCHIP enrollees whose parents had more education tended to receive more care, their parents had fewer concerns about meeting their child's health needs, and reported better accessibility to and communication with providers than did enrollees whose parents had not completed high school. As might be expected, SCHIP enrollees who did not have elevated health needs had fewer reported unmet needs than did enrollees with elevated health needs, and their parents reported lower levels of worry and financial difficulty associated with meeting their child's health needs. Enrollees in households where the primary language was English also appeared to have better access to care than did enrollees in households where the primary language was not English. Many of the access differentials identified for SCHIP enrollees have been found in other studies and are not unique to SCHIP. However, addressing these differentials would allow more SCHIP enrollees to take full advantage of the health care offered through SCHIP.

SCHIP and Medicaid Coverage Improve Access to Care

SCHIP had positive effects on access to care among the children who enrolled compared with children's experience before enrolling. SCHIP enrollees received more preventive care, had fewer unmet needs, and had better access to and communication with providers than recent enrollees in the 6 months before they enrolled. SCHIP enrollees' parents also had greater peace of mind about their ability to meet their child's health care needs. These positive impacts were found in every one of the 10 study states. Likewise, SCHIP had positive impacts on all subgroups examined, including those defined by age, race, ethnicity, health status, and socioeconomic status. The largest positive impacts were found for children with elevated health needs, for adolescents, and for those whose parents had some college education. Thus, benefits of SCHIP enrollment are not limited to one type of program, or state, or to particular subgroups of children. Instead, it appears that enrollment in SCHIP leads to access improvements across the board.

Table 3. Parent's Reports of Access, Use, and Perceptions Under SCHIP Among Established Enrollees

Reports for the Past 6 Months	Percent
Service Use Based on Parent's Report	
Any Doctor/Other Health Professional Visit	67%
Any Preventive Care or Check-Up Visit	45
Any Dental Visit for Checkup/Cleaning[a]	57
Any Specialist Visit	17
Any Mental Health Visit	5
Any Specialist or Mental Health Visit	20
Any Emergency Room Visit	18
Any Hospital Stay	4
Unmet Needs Based on Parent's Assessment	
Doctor/Health Professional Care	2
Prescription Drugs	4
Specialist	3
Hospital Care	1
Any Unmet Need (Excluding Dental Care)	9
Dental Care[a]	12
Any Unmet Need (Including Dental Care)[b]	18
More than One Unmet Need	3
Parental Perceptions about Meeting Child's HealthCare Needs	
Very Confident Could Get Needed Health Care for Child	81
Never or Not Very Often Stressed about Meeting Child's Health Care Needs	78
Never or Rarely Worried about Meeting Child's Health Care Needs	55
Meeting Child's Health Care Needs Never or Rarely Causes Financial Difficulties	83
Usual Source of Care (USC) Based on Parent's Report	
Had USC in Past 6 Months	91
USC Type: Private Doctor's Office/Group Practice	64
Usually Saw Same Provider at USC	72
Had USC for Dental Care in Past 6 Months[a]	81
Provider Communication and Accessibility Based on Parent's Report	
Would Recommend USC	92
Could Reach Doctor After Hours	76
Providers Explain in Understandable Ways	89
Provider Treats with Courtesy/Respect	94
Provider Talks About How Child Feeling	86
Rated Ease of Getting Care Excellent or Very Good	71
Wait Time for Care Less than 30 Minutes	52
Travel Time to USC Less than 30 Minutes	84
Number	5,394

SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

[a]Applies to children age 3 and older.

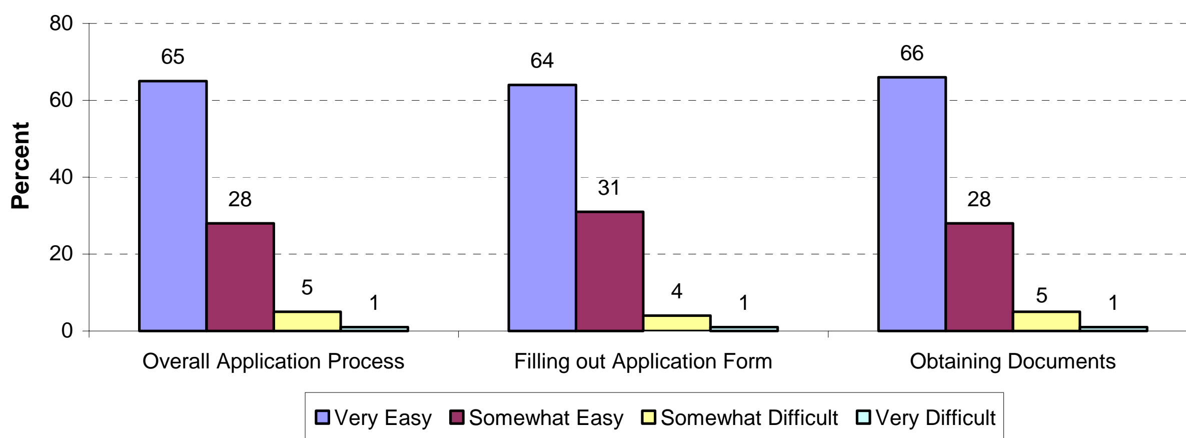
[b]This is an unduplicated estimate of any unmet need for one or more of the following services: physician, drug, specialist, hospital, or dental care. It applies to children age 3 and older.

Medicaid programs also have positive impacts on children who enroll. A study of Medicaid impacts in California and North Carolina found results for the Medicaid programs similar to those for the SCHIP programs in the two states. In addition, SCHIP and Medicaid programs in California and North Carolina provided fairly comparable levels of access to care, although Medicaid enrollees appeared to have worse access to dental care than SCHIP enrollees, and their parents had less positive views about their health insurance program.

Most Families Found Enrolling Their Children in SCHIP Was Easy

States focused on developing simple application processes for SCHIP. Across the 10 study states, almost all low-income parents who enrolled their children in SCHIP found the application process easy (over 90 percent said it was very or somewhat easy). (See Figure 2.) States put a lot of resources into outreach and application assistance in the early SCHIP implementation years, and one-third of low-income families got help enrolling their children—especially Spanish-speaking families and those with the least education. The percentage reporting that they received help varied widely across states (from a high of 63 percent in California to a low of 11 percent in Louisiana). Families' decisions to enroll their children were influenced most by health care providers, public agencies, and families and friends. Although many saw TV ads or heard radio announcements about SCHIP, these were rarely the factors that most influenced parents' decisions to enroll their children.

Figure 2. Ease of Application Among Recent Enrollees in 2002



SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

At the same time that states developed simple approaches to SCHIP application and enrollment, they also simplified Medicaid processes, though to a lesser extent than SCHIP. In California and North Carolina, the two study states where Medicaid surveys were conducted, Medicaid enrollees found application easy, but less so than SCHIP enrollees.

Therefore, findings show that state efforts to ease the application process were largely successful. Still, taken alone, these findings may overlook potential barriers to SCHIP enrollment because these findings do not include eligible children who did not enroll. Some of

these barriers can include a lack of awareness of the program among some potentially eligible families and perceptions among eligible families about whether SCHIP is targeted at working families like their own. In 2001, just over one-half (57 percent) of parents with low-income, uninsured children were aware of SCHIP nationwide. (Awareness of the program has likely improved since the National Survey of Children with Special Health Care Needs—the source of these data—was conducted between 2000 and 2002.) Most parents of uninsured, low-income children reported they would enroll their child if they were told that their child was eligible (84 percent), but less than one-half (48 percent) thought their child may be eligible (actual eligibility is not known until after the application and eligibility determination processes are complete). (See Figure 3.) Also, among low-income families with uninsured children who were aware of SCHIP, just over one-half (54 percent) perceived the application process to be somewhat or very easy. Among families who had ever applied and enrolled in SCHIP, three-quarters thought it was easy or somewhat easy. Approximately 68 percent of families who had applied but not enrolled thought the application was very or somewhat easy.

Many Children Are Enrolled in SCHIP for 12 Months, but States Varied

As the SCHIP programs matured, program administrators started to pay more attention to retaining eligible children in the program. Among recent SCHIP enrollees in the 10 study states, 60 percent stayed enrolled for 12 months. While longer stays were found in states that offered 12 months of continuous eligibility, we are not sure it was this policy that caused the longer stays since several state policies might affect length of stay.

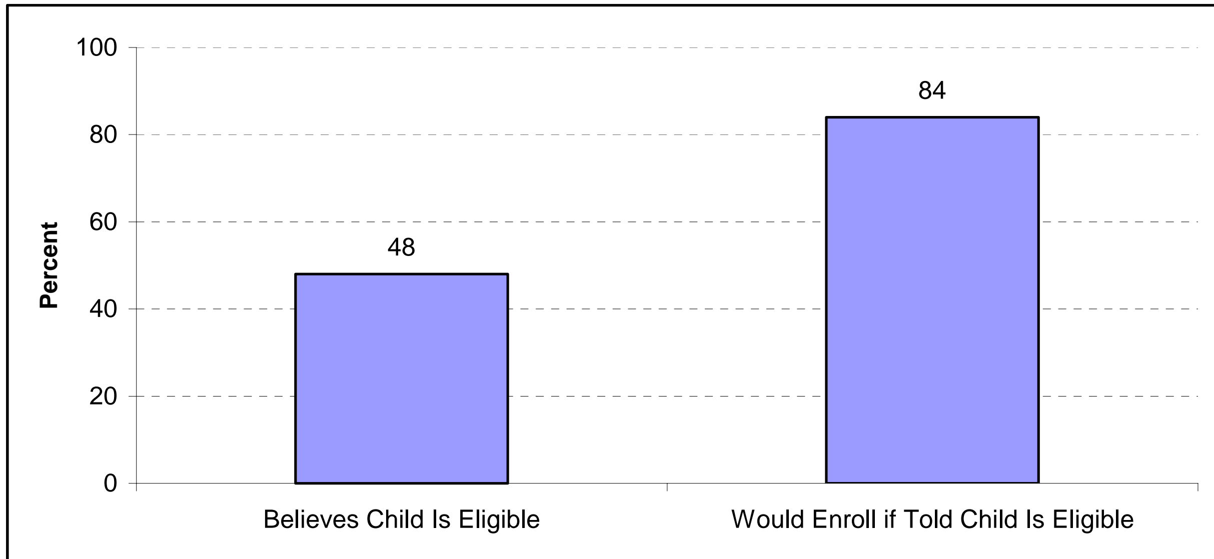
Six Months After Leaving SCHIP, One-Third of Children Are Uninsured But About Half of Them May No Longer Be SCHIP-Eligible

When they left SCHIP, 48 percent of children were uninsured, 34 percent transferred to Medicaid, and 14 percent obtained private insurance coverage (Figure 4). Of the children who were uninsured, nearly half (23 percent of all disenrolled children) appear to no longer be eligible for SCHIP primarily due to changes in household income or the child turning age 19. This leaves 25 percent of disenrolled children who were uninsured and might still have been eligible for SCHIP. Six months later, the percentage of children uninsured fell to one-third, of whom about half (16 percent of all disenrolled children) might still have been eligible for SCHIP. Most of the decline resulted from reenrollment in SCHIP, which accounted for 14 percent of all disenrolled children after 6 months. At least some of these children presumably could have been retained in SCHIP without a gap in coverage. In fact, 75 percent of the parents of children who left SCHIP and then returned within 6 months did not realize their child had been disenrolled.

Children Who Lost SCHIP Coverage in Medicaid Expansion Programs are Likely to Obtain Medicaid or Other Coverage

There is significant state-to-state variation in the coverage of children after they leave SCHIP, and type of program appears to play a key role in this variation. The six states in our study with separate programs demonstrated lower rates of children enrolling in Medicaid when losing SCHIP coverage than Medicaid expansion states. Children served in separate programs were also more likely to be uninsured after losing SCHIP eligibility.

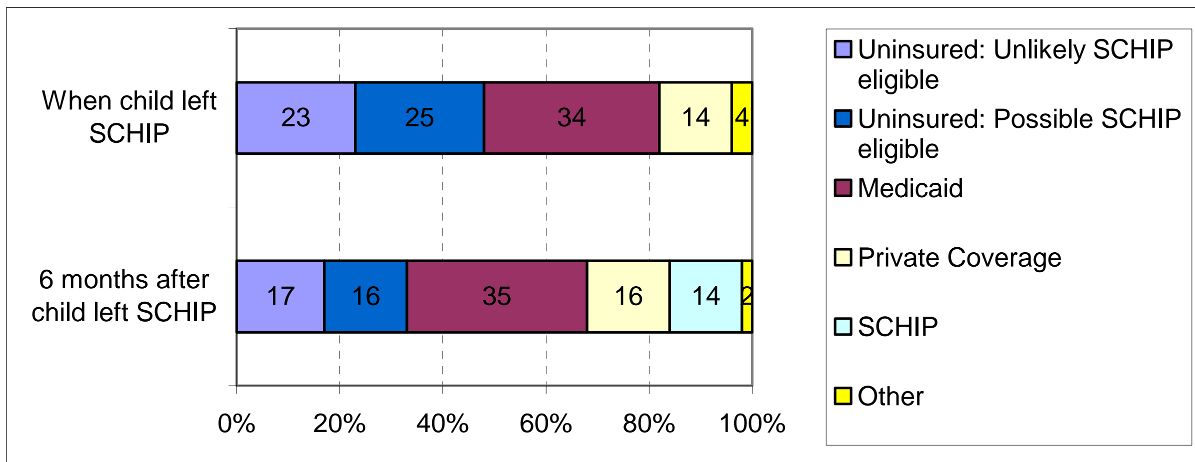
Figure 3. Perceptions of Medicaid/SCHIP Programs, Low-Income Uninsured Children, 2001



SOURCE: National Survey of Children with Special Health Care Needs, State and Local Area Integrated Telephone Survey, National Center for Health Statistics, 2001.

NOTE: These questions were asked only of respondents who had indicated that they had heard of Medicaid and/or the separate SCHIP program in their state.

Figure 4. Insurance Coverage of SCHIP Disenrollees, by Time Since Leaving SCHIP



SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

The two study states with Medicaid expansion programs demonstrated high rates of children being covered by Medicaid when they lost SCHIP coverage. Similarly, in the two study states with combination programs, children who were enrolled in the Medicaid expansion component were also more likely to be covered subsequently by Medicaid. Children served in Medicaid expansion programs also demonstrated low rates of uninsurance following loss of SCHIP coverage. However, these results are to be expected given the natural coordination between SCHIP and Medicaid afforded by the Medicaid expansion model. A Medicaid expansion SCHIP program is an extension of a state's Medicaid program to children at a higher income eligibility level, so Medicaid-eligible and SCHIP children in states with Medicaid expansions are served by one seamless program.

Conclusion

This evaluation found that SCHIP is predominantly serving its target population of low-income, uninsured children who otherwise would have been uninsured. The program did not lead to widespread substitution of SCHIP for employer coverage, even though almost all families enrolling their child had at least one working parent. Families reported that it was fairly easy to enroll their child in SCHIP (though barriers to SCHIP enrollment still exist for some families who lack awareness of the program or its eligibility criteria or who perceive that the enrollment process is difficult). Sixty percent of children have SCHIP coverage for at least 12 months, though this varies across states. During their coverage by SCHIP, children's access to primary health care is good—and this is true across states and across children with different characteristics. SCHIP also improves access relative to the coverage children had in the period before they enrolled in SCHIP. After leaving SCHIP, a substantial minority of children become and remain uninsured, and state-to-state variation suggests that effective coordination between SCHIP and Medicaid may help to increase coverage among these children. In short, SCHIP plays an important role in insuring low-income children and improving their access to health care.