



WHO'S ENROLLED IN SCHIP?

Since 1997, States have used the State Children's Health Insurance Program (SCHIP) to provide health insurance coverage to uninsured low-income children who lack private health insurance but are ineligible for Medicaid due to family income. Demographic and health care information about children who enroll in SCHIP can help States understand enrollees' needs, assess the effects of program changes, and determine whether SCHIP improves low-income children's access to health care.

This Issue Brief summarizes findings from Child Health Insurance Research Initiative (CHIRI™) projects in five States with separate SCHIP programs that accounted for 30 percent of SCHIP enrollment in 2001. The families of new SCHIP enrollees were asked about their demographic characteristics and health care experiences before enrolling in SCHIP. These CHIRI™ findings reveal that new SCHIP enrollees resemble other low-income uninsured children in many respects, but they also depart from some expectations about who would enroll in SCHIP.

- Nearly two-thirds to three-quarters of new enrollees, depending on the State examined, lived in working families with incomes equal to or below 150 percent of the Federal Poverty Level.
- From one-quarter to nearly three-quarters of new enrollees were uninsured the entire year prior to SCHIP enrollment.
- A solid majority of new enrollees had received health care services prior to SCHIP enrollment, particularly preventive care, yet one-quarter to almost one-half of them had unmet health care needs.
- A significant proportion of new enrollees were black or Hispanic. Compared with white enrollees, minority enrollees had lower incomes, had poorer health status, and were more likely to have been uninsured the entire year prior to SCHIP enrollment.
- From 17 percent to 25 percent of new enrollees were children with special health care needs (CSHCN), which is higher than the prevalence in the general population.



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“Children were not entirely disconnected from the health care system prior to SCHIP enrollment. Nonetheless, they had wide-ranging unmet health care needs.”

WHAT WAS LEARNED

Researchers conducted surveys of new enrollees in separate SCHIP programs in five States—Alabama, Florida (adolescents only), Indiana (CSHCN only in both the separate and Medicaid expansion SCHIP programs), Kansas, and New York. This CHIRI™ Issue Brief describes enrollees’ demographic characteristics and health care experiences in the year prior to SCHIP enrollment.

Many SCHIP Enrollees Were From Low-Income Full-Time Working Families

The vast majority of children lived in households with a working adult (ranging from 80 percent to 87 percent in the study States) and most enrollees were from families with adults who worked full-time (63 percent to 74 percent). More than half of SCHIP enrollees lived in two-parent households, and in a substantial proportion of these families, both parents worked.

More SCHIP enrollees came from families with incomes at the bottom of the SCHIP eligibility range (100-150 percent of the Federal Poverty Level, or FPL) than from the top of the range (151-200 or 250 percent of FPL). From 65 percent to 79 percent of SCHIP enrollees lived in families with incomes equal to or below 150 percent of FPL (\$27,600 for a family of four in 2003).

A Significant Proportion of Children Were Uninsured Prior to SCHIP Enrollment

One-quarter to nearly three-quarters of SCHIP enrollees were uninsured the entire year before enrolling in SCHIP, depending on the State. Of enrollees with prior health care coverage, most had private health insurance (group or individual), but one-quarter to one-half of them had been enrolled in Medicaid. Families lost their prior insurance most often because of a change in employment, the high cost of insurance, or an income increase that resulted in the loss of Medicaid.

Despite Significant Connection to the Health Care System, Many Children Had Unmet Needs

The vast majority of children (75 percent to over 90 percent) had a regular source of health care before SCHIP enrollment—primarily private doctor’s offices,

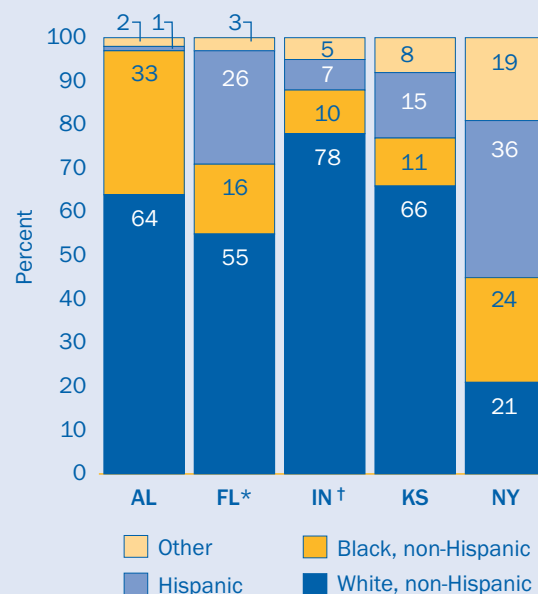
community health centers, and hospital clinics. From one-quarter to over one-third of children changed their regular source of care upon SCHIP enrollment. In addition, many children received health care services in the year before SCHIP, including a solid majority (67 percent to 73 percent) who received preventive care.

Even though most new SCHIP enrollees had some prior contact with the health care system, from one-quarter to almost one-half of them had unmet health care needs at the time of enrollment. Unmet needs were most frequently noted for mental health, specialty, dental, and vision care, and prescription medications. Families most often cited financial barriers as the cause of these unmet health care needs.

Black and Hispanic Children Constituted a Significant Proportion of SCHIP Enrollees

In most States, a significant proportion of children who enrolled in SCHIP were black or Hispanic (see Figure 1). Black and Hispanic children were more likely than white children to live in single-parent or lower income families, to have lacked a regular source

Figure 1. Race and Ethnicity of New SCHIP Enrollees



*Adolescents only. †CSHCN only.



of health care, and to have poorer health status. Of children with prior health care coverage, minority children were more likely than white children to have had Medicaid coverage before SCHIP enrollment.

The Prevalence of CSHCN Was Higher Among New SCHIP Enrollees Than the General Population

From 17 percent to 25 percent of SCHIP enrollees in the study States had special health care needs. These were children who had physical, developmental, behavioral, or emotional limitations; higher health care use; or a dependency on prescription medications for 12 months or longer. The prevalence of CSHCN in the general population for the study States ranged from 12 percent to 15 percent, according to a study by the National Center for Health Statistics.

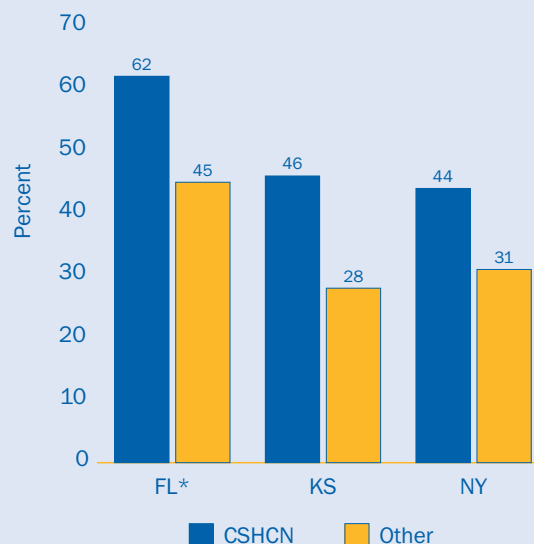
CSHCN were similar to other SCHIP enrollees in income, race/ethnicity, and prior health insurance status. They were more likely than other enrollees to have used health care services prior to enrollment, including the emergency department, mental health care, and specialty and acute care. Nevertheless, CSHCN were more likely to have unmet health needs upon enrollment (see Figure 2). Approximately one-third of CSHCN in each State changed their regular source of health care after enrolling in SCHIP.

CONCLUSION

When Congress enacted SCHIP in 1997, it sought to establish a health insurance program for children in low-income working families who lacked health insurance coverage. These CHIRI™ findings indicate that SCHIP is indeed insuring the population intended by Congress. It is important to note, however, that more children with special health care needs and children from lower income families enrolled in SCHIP than some policymakers might have predicted when SCHIP was enacted.

SCHIP appears to narrow the gap between private and public health insurance coverage for low-income children. In addition to providing coverage to children who were uninsured for a substantial period of time, SCHIP covered children whose families lost private insurance coverage, most often because of

Figure 2. Unmet Health Care Needs of CSHCN and Other SCHIP Enrollees Prior to Enrollment



*Adolescents only.

Note: The AL and IN CHIRI™ studies did not collect data on unmet health care needs.

high insurance costs or a job change. It also covered children who became ineligible for Medicaid, generally as a result of increases in family income or becoming too old for age-based eligibility categories.

SCHIP enrollees do not appear to differ dramatically from children enrolled in Medicaid. Many SCHIP enrollees, particularly CSHCN, had wide-ranging unmet health care needs. Black and Hispanic children, who constituted a significant proportion of SCHIP enrollees, suffered from worse health status than white children and were more likely to lack a regular source of care. SCHIP enrollees, however, were not disconnected from the health care system prior to enrollment. Most enrollees had received health care services in the prior year.

Ensuring that children maintain continuity of care with primary care providers is an important goal for public health insurance programs. Thus, it is noteworthy that many children changed their regular source of health care once they enrolled in SCHIP. The effect of these changes on children's access to and quality of health care is not clear. These findings underscore the importance of monitoring continuity of care during the transitions that low-income children make when their insurance coverage changes.

“SCHIP appears to narrow the gap between private and public child health insurance coverage.”



Monitoring the quality of health care and evaluating SCHIP's effectiveness in serving low-income children, particularly vulnerable populations, are also critical. Policymakers will likely want to ensure that SCHIP is meeting the needs of the many minority children and CSHCN who are enrolled in the program. Forthcoming CHIRI™ products will address the impact of SCHIP on access to and quality of health care for these groups.

CHIRI™ ARTICLES IN PEDIATRICS

Brach C, Lewit EM, VanLandeghem K, et al. Who's enrolled in SCHIP? Findings from the Child Health Insurance Research Initiative (CHIRI™). *Pediatrics*; 112(6):499-507; 2003.

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Szilagyi PG, Shenkman E, Brach C, et al. Children with special health care needs enrolled in SCHIP: patient characteristics and health care needs. *Pediatrics*; 112(6):508-20; 2003.

Policy Implications

Even though SCHIP enrollees are a diverse group and State SCHIP programs vary, these CHIRI™ findings point to strategies that States can use to improve children's access to care and better inform SCHIP design, monitoring, and evaluation.

- *SCHIP program design, including benefit design, should consider that many new SCHIP enrollees, particularly CSHCN, have a wide range of unmet health care needs.*
 - ✓ Most State SCHIP benefit packages currently cover the most frequently unmet needs (i.e., vision, dental, and mental health care, and prescription medications).
 - ✓ Additional strategies to address unmet needs include educating enrollees about accessing benefits and ensuring that a sufficient number of providers are available.
- *Steps can be taken to promote continuity of health care for the many children who change their regular source of care upon SCHIP enrollment.*
 - ✓ Procedures can be implemented that facilitate smooth transitions between health insurance programs, monitor the reasons for changing providers, and minimize unnecessary transitions.
- *Comprehensive baseline data can help States accurately assess SCHIP's effectiveness in providing quality health care to diverse populations.*
 - ✓ Analysis of race/ethnicity and CSHCN data and use of the findings for program improvement can help ensure equity in access to health care.
 - ✓ Information on the prevalence and prior health care experiences of CSHCN can help States tailor programs to meet the needs of this population.
 - ✓ Program evaluation that compares baseline to post-enrollment data can be accomplished through a variety of strategies, including partnerships between State SCHIP programs and research organizations.

STUDY METHODOLOGY

The findings highlighted in this CHIRI™ Issue Brief are drawn from a group of articles published in a supplement to the American Academy of Pediatrics' journal *Pediatrics*, where individual study methodologies are described in greater detail. CHIRI™ projects in five States (Alabama, Florida, Indiana, Kansas, and New York) participated in the articles. This CHIRI™ Issue Brief mainly highlights findings from two of the articles, one on the race/ethnicity of new SCHIP enrollees and one on CSHCN enrolled in SCHIP. Four of the five States participated in each article. Findings were produced for each State and then compared across States. All projects studied children aged 0-18 years who were enrolled in separate SCHIP programs, with two exceptions. The Florida project included only children aged 11.5-18 years, and the Indiana project included only CSHCN enrolled in either the separate or Medicaid expansion SCHIP program.

In order to maximize the comparability of findings across the study States, several CHIRI™ researchers developed a set of survey questions, known as the CHIRI™ Common Core, that were used by all projects. These questions were mainly drawn from validated survey instruments and assess children's health care experiences prior to enrollment. They include the Child and Adolescent Health Measurement Initiative CSHCN screener—a five-question screener used in national studies to identify CSHCN.

In Florida, Indiana, Kansas, and New York, telephone interviews were performed 2 to 7 months following enrollment in SCHIP in 2001. Interviewers spoke with the adult in the household (a parent in 95 percent of cases) who was the most knowledgeable about the child's health insurance and medical care (one child per family). In Alabama, surveys were mailed 9 to 11 months after enrollment. The number of new enrollees who were surveyed in the study States ranged from 767 in Kansas to 3,740 in Alabama.

Bivariate and multivariate analyses were conducted to determine whether there were differences among children in different racial/ethnic groups and among children with different health care needs.

SOURCES AND RELATED STUDIES OF INTEREST

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For More Information

More information on CHIRI™ projects can be found at www.ahrq.gov/chiri/. Topics of future CHIRI™ Issue Briefs include:

- Adolescents' quality of care.
- SCHIP's impact on access to care for vulnerable populations.
- Disenrollment and retention in public insurance programs.

ABOUT CHIRI™

The Child Health Insurance Research Initiative (CHIRI™) is an effort to supply policymakers with information to help them improve access to, and the quality of, health care for low-income children. Nine studies of public child health insurance programs and health care delivery systems were funded in the fall of 1999 by the Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA). These studies seek to uncover which health insurance and delivery features work best for low-income children, particularly minority children and those with special health care needs.

Five CHIRI™ projects contributed to this Issue Brief: "Access and Quality of Care for Low-Income Adolescents" (Principal Investigator: Elizabeth Shenkman, University of Florida); "Evaluation of Kansas HealthWave" (Principal Investigator: Robert St. Peter, Kansas Health Institute); "Health Care Access, Quality and Insurance for Children with Special Health Care Needs" (Principal Investigator: Nancy Swigonski, Indiana University School of Medicine); "New York's SCHIP: What Works for Vulnerable Children" (Principal Investigator: Peter Szilagyi, University of Rochester); and "Provider Participation and Access to Care in Alabama and Georgia" (Principal Investigator: Janet Bronstein, University of Alabama).

CHIRI™ FUNDERS

The Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use and access.

The David and Lucile Packard Foundation is a private family foundation that provides grants in a number of program areas, including children, families and communities, population, and conservation and science.

The Health Resources and Services Administration, also part of the U.S. Department of Health and Human Services, directs national health programs that provide access to quality health care to underserved and vulnerable populations. HRSA also promotes appropriate health professions workforce supply, training and education.

OTHER FUNDERS

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