CHIRI The Child Health Insurance Research Initiative

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Do SCHIP Enrollees Stay Insured?

Since the State Children's Health Insurance Program (SCHIP) was implemented in 1997, the proportion of uninsured children has decreased from 16 percent to 11 percent, due in large part to the growth in public health insurance programs. SCHIP has helped by providing coverage to low-income children whose families earn too much to qualify for Medicaid but lack private coverage, and by increasing Medicaid enrollment through SCHIP outreach and enrollment efforts. Achievements in reducing uninsurance rates can only be sustained, however, if low-income children retain public insurance or transition to private insurance coverage.

This Issue Brief summarizes findings from a Child Health Insurance Research Initiative (CHIRI™) project that studied patterns of insurance coverage for low-income children enrolled in the Kansas and New York SCHIP programs. Researchers found:

- Over three-quarters of SCHIP enrollees were publicly insured (Medicaid or SCHIP) at least one year after enrollment.
- Some SCHIP enrollees (15 percent in Kansas and 4 percent in New York) obtained private insurance coverage after leaving SCHIP.
- Most children who left SCHIP within one year of enrollment reverted to their previous type of health insurance (Medicaid or private).
- SCHIP retention was increased by a simplified renewal policy that automatically reenrolled children in SCHIP unless their families submitted reenrollment forms indicating a change affecting their eligibility.
- Children who disenrolled from SCHIP when their eligibility was redetermined at one year were more likely to become uninsured than children who left during their first year of enrollment.

The David and Lucile Packard Foundation

CHIRI™ is funded by the Agency for Healthcare Research and Quality, The David and Lucile Packard Foundation, and the Health Resources and Services Administration.

In the short term, SCHIP did not serve as a pathway to private insurance coverage for most SCHIP enrollees.

WHAT WAS LEARNED

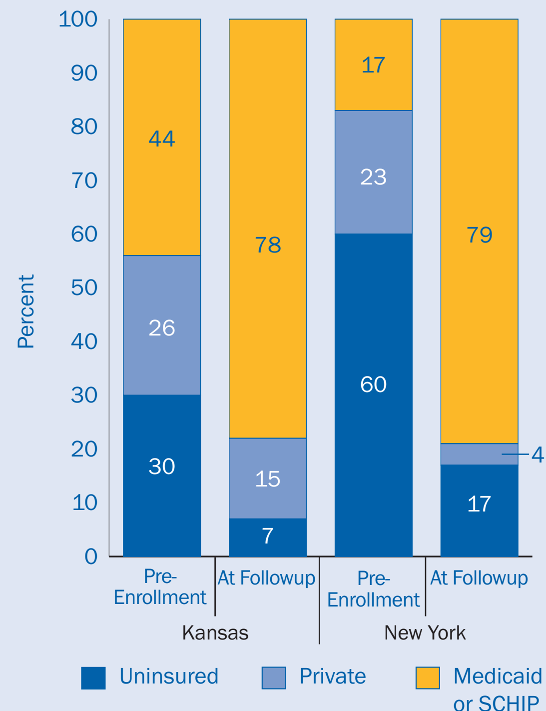
Researchers conducted surveys in 2000 and 2001 of families of children enrolled in SCHIP in Kansas and New York. The surveys were conducted shortly after enrollment and again at least one year later (followup) to examine the insurance experiences of SCHIP enrollees. Although Kansas and New York SCHIP differ in several key areas (see text box), researchers discovered consistent insurance coverage patterns in the two States.

Most Enrollees Were Publicly Insured at Least One Year After SCHIP Enrollment

Over three-quarters of SCHIP enrollees were publicly insured at followup, either through SCHIP or Medicaid (see Figure 1). Some enrollees became uninsured (7 percent in Kansas and 17 percent in New York).

Many SCHIP enrollees were uninsured the entire year prior to enrollment (30 percent in Kansas and 60 percent in New York). A substantial proportion of enrollees (44 percent in Kansas and 17 percent in New York) were previously insured by Medicaid and approximately one-quarter were covered by private insurance.

Figure 1. Insurance Status of SCHIP Enrollees at Pre-Enrollment and Followup



Selected SCHIP Characteristics in Kansas and New York, 2000-2001

Characteristic	Kansas	New York
Year of SCHIP Implementation	1999	1991+
Eligibility	≤ 200% Federal poverty level	≤ 250% Federal poverty level
Redetermination Process	Active	Active (New York State) Simplified (New York City)*
Frequency of Redetermination	Every 12 months	Every 12 months
Disenrollment Sanctions for Nonpayment of Premiums	At redetermination	After 60 days
Waiting Period**	6 months	None

+ New York operated a State-funded children's health insurance program prior to SCHIP's passage.

* From September 2001 to late 2002, due to the loss of system capacity after the 9/11 terrorist attacks.

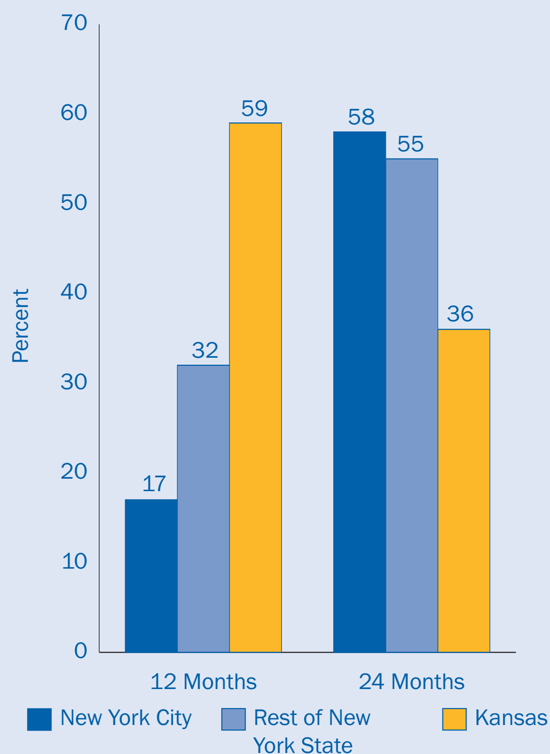
**Required period of uninsurance prior to SCHIP enrollment.

State SCHIP renewal policies substantially affected continuity of coverage.

Most Enrollees Did Not Obtain Private Insurance Coverage After SCHIP Enrollment

Some SCHIP enrollees (15 percent in Kansas and 4 percent in New York) had private insurance at followup. Followup insurance status was related to prior insurance status for those enrollees who left SCHIP within one year in both study States. In this case, SCHIP enrollees previously covered by private insurance were the most likely to have private insurance after SCHIP. SCHIP enrollees who were uninsured or had Medicaid prior to enrollment were highly unlikely to obtain private insurance after leaving SCHIP. Most of these enrollees had public insurance coverage at followup.

Figure 2: Percentage of Children Disenrolled at Redetermination (Kansas and New York)



Temporary Simplified Renewal in New York City

Immediately after the terrorist attacks of September 11, 2001, New York City temporarily suspended its active renewal policy due to a loss of system capacity. New York City SCHIP enrollees were automatically reenrolled in SCHIP at their 12-month eligibility redetermination unless their family submitted reenrollment forms indicating a change (e.g., income, family status) that affected their eligibility.

Simplified Renewal Policies Promoted SCHIP Retention and Continuity of Coverage

Active renewal policies that require families to submit documentation to verify their continued eligibility appeared to contribute to substantial drops in SCHIP enrollment (see Figure 2). New York City was much less likely to disenroll children from SCHIP when using a simplified renewal process (see text box) at a child's 12-month eligibility redetermination than either the rest of New York State or Kansas, both of which used an active renewal process. When the active renewal policy was reinstated in New York City in late 2002, SCHIP enrollees were more than three times more likely to disenroll from SCHIP than they were under the simplified renewal process (58 percent versus 17 percent).

Children who disenrolled from SCHIP at renewal were more likely to be uninsured at followup than children who left during the first year of enrollment. Indeed, more than half of children who disenrolled during renewal became uninsured versus one-third of children who disenrolled earlier from SCHIP. A substantial proportion of children who disenrolled at renewal returned to SCHIP within 3 months (18 percent in Kansas and 27 percent in New York). Researchers analyzed other factors typically associated with insurance status (e.g., family characteristics, prior insurance status, health care experiences) of SCHIP enrollees to try to predict which children would be most likely to disenroll, but found that these factors did not affect disenrollment.

CONCLUSION

As this CHIRI™ study illustrates, SCHIP is an essential component of the public insurance coverage landscape for low-income children. Although SCHIP does not appear to be a direct pathway to private insurance, SCHIP may affect the long-term trajectory of health insurance for children who initially enroll. Most children who leave SCHIP generally do not become uninsured. Indeed, nearly 80 percent of SCHIP enrollees successfully enrolled in Medicaid or reenrolled in SCHIP.

It is unclear from this study whether children who became uninsured after leaving SCHIP were still eligible for public insurance coverage (SCHIP or Medicaid). However, other CHIRI™ research found that many families who left SCHIP mistakenly thought they were ineligible for the program when in fact they were still eligible. A recent study found that 62 percent of all uninsured children were eligible for Medicaid or SCHIP. Of these children, 34 percent previously had public insurance coverage that they had lost. Poor retention remains a key issue for public insurance programs.

States' SCHIP renewal policies are critical to ensuring continuous insurance coverage for enrollees, because many low-income children become uninsured during the renewal process and many return to SCHIP shortly after disenrollment. It is not clear from this study whether some of the children who left SCHIP during renewal actually were no longer eligible for the program. Nonetheless, administrative errors, misinformation about program eligibility requirements, and difficulties understanding or complying with renewal processes are factors known to contribute to renewal-related disenrollment.

By taking advantage of a natural experiment of one State's changes to its renewal process, this study confirms previous CHIRI™ research regarding the success of simplified reenrollment in promoting SCHIP retention. Taken together, these CHIRI™ results illustrate the important impact of renewal—a process that appears to weed out many children with an ongoing insurance need. Furthermore, it has been shown that cost savings from enrollment reductions are largely offset by the administrative costs associated with active renewal policies and reenrollment of children who return to the program after a brief period of disenrollment.

POLICY IMPLICATIONS

This CHIRI™ study underscores the importance of ensuring continuous insurance coverage for SCHIP enrollees. States have used numerous strategies to address retention in SCHIP, many of which were not directly examined by this study but nonetheless are important considerations for States. These strategies include the following:

- Simplify and facilitate reenrollment processes to retain eligible SCHIP enrollees in public insurance programs, such as:
  - Using public databases to verify eligibility
  - Only requiring updates to previously supplied information
  - Describing the reenrollment process in ways that are clear and understandable to families (e.g., plain language, foreign languages)
  - Providing families with multiple notices (written and phone) and reenrollment forms well before their coverage lapses
  - Enlisting community-based groups or enrollment brokers to help families complete the reenrollment forms
- Educate families about the importance of maintaining coverage for their families.
- Develop mechanisms that facilitate or encourage transitions to private insurance coverage. (See CHIRI™ Issue Brief No. 6 on premium subsidies.)
- Strengthen administrative processes to encourage seamless transitions among public insurance programs, such as:
  - Using a common reenrollment form for Medicaid and SCHIP
  - Ensuring that Medicaid and SCHIP databases can share information easily
  - Screening and enrolling children in other public insurance programs at reenrollment
  - Providing continuous coverage for 12 months to reduce the frequency of transitions
- Monitor the effectiveness of State enrollment, retention, and reenrollment policies (e.g., conduct surveys to determine reasons for disenrollment).

STUDY METHODOLOGY

This CHIRI™ Issue Brief is based on a longitudinal study of new SCHIP enrollees (ages birth to 18 years) in two States with separate, freestanding SCHIP programs—Kansas and New York. Telephone interviews were conducted shortly after enrollment (baseline) and again 13 to 15 months after enrollment (followup). Researchers interviewed the adult in the household most knowledgeable about the child's health insurance and medical care (one child per family) between 2000 and 2002. The Kansas data consisted of 751 enrollees at baseline and 434 enrollees at followup. The New York data consisted of 2,644 enrollees at baseline and 2,310 enrollees at followup. The data were weighted to account for nonresponse bias. The estimates of SCHIP enrollees publicly insured at followup could be overstated, because children lost to followup may be more likely to have been uninsured or to have private coverage than those who were found at followup.

Survey data were matched with SCHIP administrative data to confirm enrollment for 2 years after SCHIP enrollment. Data from the surveys involved demographics (e.g., child's age, gender, race/ethnicity), prior health insurance status, health care access, utilization, and quality of care before and during SCHIP, and post-SCHIP insurance status for those who disenrolled.

Bivariate and multivariate analyses were conducted to assess children's health and medical experience before, during, and after SCHIP and to relate these experiences to retention in SCHIP, disenrollment, and post-SCHIP insured status.

The percentage of enrollees who disenrolled during the eligibility redetermination process was calculated by comparing the number of children enrolled in SCHIP before redetermination with the number of children enrolled in SCHIP after redetermination. Children were considered disenrolled at redetermination if they disenrolled within a month of their redetermination date.

SOURCES AND RELATED STUDIES OF INTEREST

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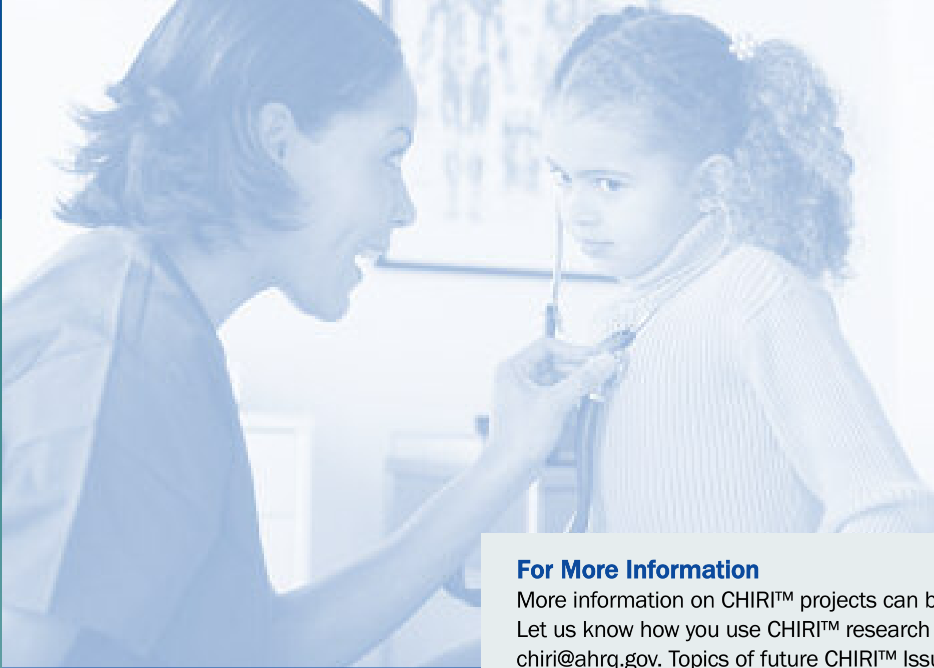

For More Information

More information on CHIRI™ projects can be found at www.ahrq.gov/chiri/. Let us know how you use CHIRI™ research findings by contacting chiri@ahrq.gov. Topics of future CHIRI™ Issue Briefs include:

- The impact of public insurance delivery systems on children's use of care.
- What are the mental health needs of low-income children with special health care needs?
- What has been learned from CHIRI™?

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. Two CHIRI™ projects contributed to this Issue Brief: "Evaluation of Kansas HealthWave" (Principal Investigator: Rober St. Peter, Kansas Health Institute) and "New York's SCHIP: What Works for Vulnerable Children" (Principal Investigator: Peter Szilagyi, University of Rochester).

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.

Credits: This CHIRI™ Issue Brief was written by Karen VanLandeghem and Cindy Brach based on a research study, "SCHIP enrollment, retention, and disenrollment: the dynamics of health insurance for low-income children," conducted by Peter G. Szyilagyi, Andrew W. Dick, Andrew Allison, Jonathon D. Klein, Laura P. Shone, Robert St. Peter, and Betsy Shenkman.

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