CHIRI
The Child Health Insurance Research Initiative

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DOES SCHIP BENEFIT *ALL* LOW-INCOME CHILDREN?

The State Children's Health Insurance Program (SCHIP), enacted in 1997, provides health insurance coverage to low-income children whose families earn too much to be eligible for Medicaid but lack private health insurance. Vulnerable children—minorities, children and adolescents with special health care needs, and the long-term uninsured—represent a large proportion of SCHIP enrollees. In addition to determining SCHIP's impact on enrollees in general, knowing whether particularly vulnerable children experience the same gains as other enrollees is critical to ensuring equitable and effective use of public resources.

This Issue Brief from the Child Health Insurance Research Initiative (CHIRI™) addresses two key questions: 1) What is the impact of SCHIP on new enrollees? and 2) How do the most vulnerable children fare under the program? Families of new SCHIP enrollees in three States with separate SCHIP programs were asked about their children's health care experiences before and after enrollment in SCHIP.

- After 1 year of SCHIP enrollment, more children had a regular place to get care and had received a preventive care visit, and fewer had unmet health care needs.
- Families of new SCHIP enrollees were more satisfied with the health care their children received after SCHIP enrollment than before SCHIP.
- Improvements in health care access and satisfaction were largely shared by vulnerable groups of enrollees.
- SCHIP significantly reduced unmet needs among new enrollees (a 12 percent to 43 percent reduction), yet some vulnerable children still had substantial unmet needs after SCHIP enrollment (almost one-third of children with special health care needs).
- In spite of significant gains from SCHIP, disparities in health care access and satisfaction remained for some vulnerable groups of enrollees.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

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"All boats rise with the SCHIP tide—vulnerable children enrolled in SCHIP experience improvements similar to those of other enrollees."

WHAT WAS LEARNED

This CHIRI™ Issue Brief describes the impact of SCHIP on health care access and satisfaction in the three diverse States with separate, freestanding SCHIP programs that included over 25 percent of all SCHIP enrollees in 2001. Researchers surveyed the parents of all SCHIP enrollees ages 1 to 18 in Kansas and New York and ages 12 to 18 in Florida shortly after enrollment and 1 year later.

SCHIP Improved Health Care Access and Satisfaction Among New Enrollees

While the impact of SCHIP enrollment varied by State and age group, 1 year after SCHIP enrollment:

- The vast majority of new SCHIP enrollees (88 percent to 98 percent) had a regular source of care, an increase from pre-SCHIP levels of 78 percent to 92 percent.
- Fewer enrollees experienced unmet health care needs (reductions of 12 percent to 43 percent).
- More enrollees (8 percent to 13 percent more) had preventive care visits.
- Families rated the health care their children received while covered by SCHIP more highly than the care received before enrollment.

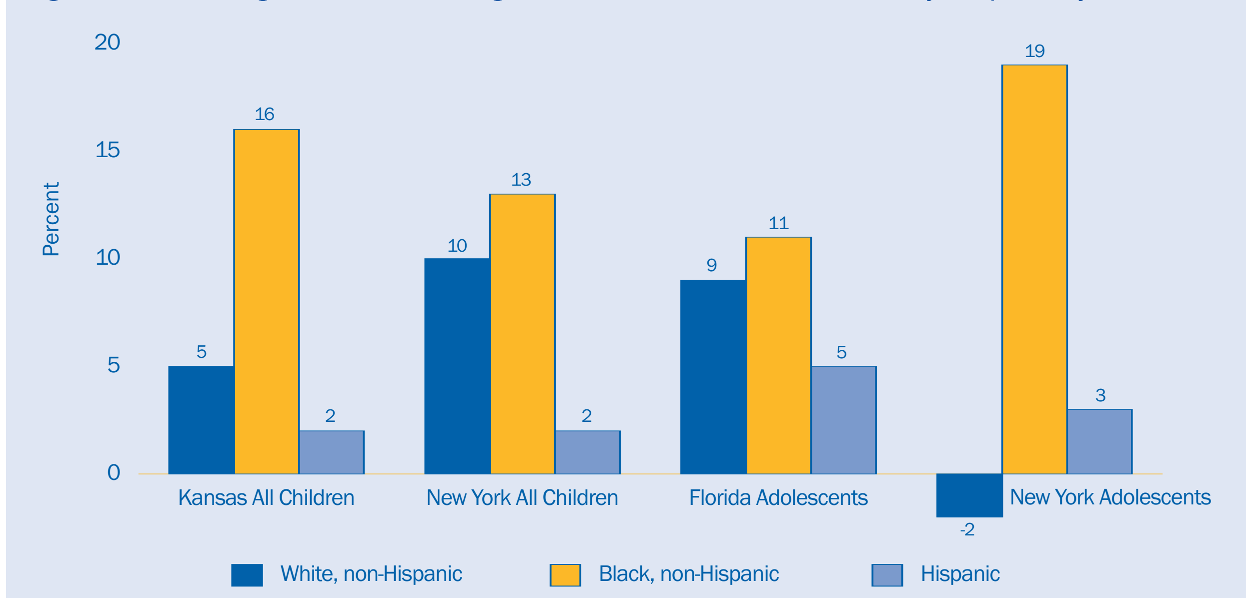
In spite of these improvements, 19 percent to 28 percent of children and adolescents did not receive a preventive care visit after 1 year of enrollment in SCHIP. Furthermore, 19 percent to 23 percent of children and adolescents still had unmet health care needs after SCHIP enrollment.

Vulnerable Children Experienced Gains Similar to Other SCHIP Enrollees

In order to determine the impact of SCHIP on vulnerable children, researchers examined whether being black or Hispanic, having a special health care need, or being uninsured for at least 12 months before enrollment made a difference in the gains experienced by SCHIP enrollees. For the most part, black and Hispanic children had improvements in health care access and satisfaction similar to those for white non-Hispanic children. Hispanic children, however, did not experience as large an increase in preventive care visits after SCHIP enrollment as did other enrollees (see Figure 1).

The impact of SCHIP on enrollees with special health care needs varied, depending on the State. In Kansas and New York, nearly all enrollees with special health care needs had a regular source of care after SCHIP. In all three States, families of these children and adolescents were considerably more satisfied with their

Figure 1. Percent Change in Enrollees Receiving Preventive Visits After SCHIP Enrollment by Race/Ethnicity



Definition

Children with special health care needs were defined in this study as children who had:

- a physical, developmental, behavioral, or emotional limitation;
- higher health care use; or
- a dependency on prescription medications for 12 months or longer.

child's health care after SCHIP enrollment than before enrollment.

Children and adolescents who were uninsured for long periods of time (i.e., at least the 12 months prior to enrollment) experienced substantial gains in health care access and satisfaction after SCHIP enrollment. In contrast, enrollees who had at least some health insurance during the year before SCHIP—most often Medicaid coverage—maintained their levels of access and satisfaction.

SCHIP Minimized Many Health Care Disparities, Yet Some Remained

Even though minority children and adolescents experienced many of the gains of other enrollees, some racial/ethnic disparities in access to health care were evident after SCHIP enrollment. These disparities frequently appeared only in one State, and for one group of minority enrollees (e.g., Hispanic but not black enrollees). The inability of SCHIP to fully eliminate these disparities was due to insufficient improvements for black and Hispanic children in areas where white children gained. In some cases, health care disparities remained because the disparities prior to SCHIP enrollment were so large.

There were few disparities between enrollees with special health care needs and other enrollees in health care access and family satisfaction after SCHIP enrollment. However, SCHIP did not reduce pre-enrollment disparities in unmet needs. This left a much higher proportion of enrollees with special health care needs with unmet needs after SCHIP compared with other enrollees. For example, about one-third of children with special health care needs had unmet needs after SCHIP enrollment, compared to one-sixth of children without special health care needs (see Figure 2).

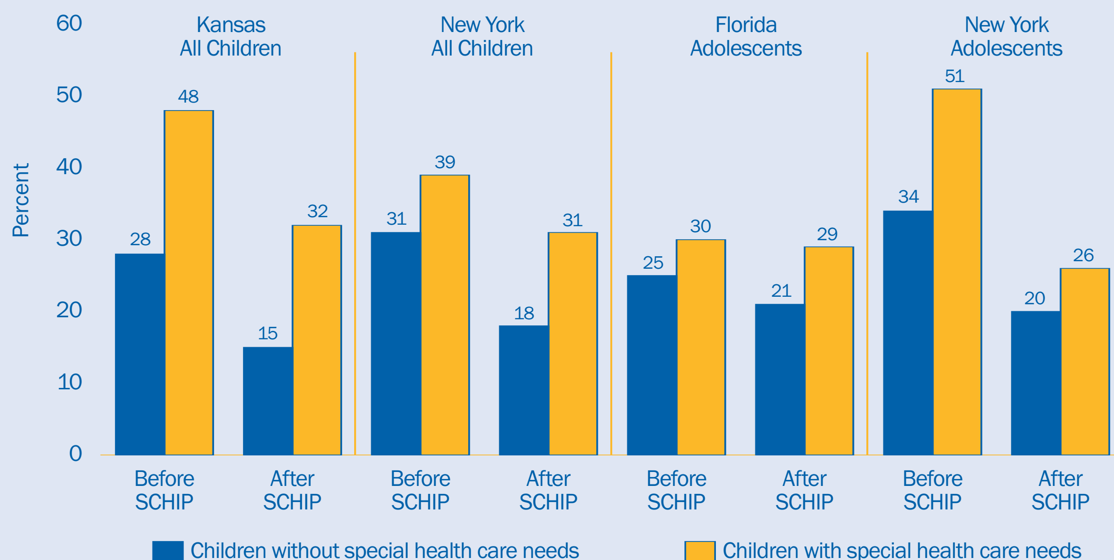
Disparities in health care access and satisfaction between previously insured and long-term uninsured children were fairly common prior to SCHIP. Twelve months after enrolling in SCHIP, however, these disparities between the two groups had been eliminated.

CONCLUSION

These CHIRI™ findings provide consistent evidence from three diverse States that SCHIP improves health care access and satisfaction for low-income children and adolescents, including more vulnerable enrollees. Within 1 year of enrollment in SCHIP, access to a regular source of care was increased to very high levels, the proportion of children and adolescents with unmet needs dropped, and gains were made in preventive care and satisfaction with care.

On the other hand, children who were insured prior to SCHIP maintained access to health care but did

Figure 2. Unmet Needs by Special Health Care Needs Status, Before and After SCHIP Enrollment



“SCHIP eliminated disparities in access to health care and satisfaction with care between the long-term uninsured and other enrollees.”

not experience gains as large as their long-term uninsured counterparts. For these children—many of whom had Medicaid prior to SCHIP enrollment and might have become uninsured in the absence of SCHIP—the program appears to have preserved a level of access to health care that otherwise might have decreased.

In spite of the many benefits from SCHIP enrollment, there are several opportunities for further improvement. Preventive visits showed only small gains among most enrollees, especially for Hispanic children and adolescents. A substantial proportion of enrollees, particularly those with special health care needs, still had unmet needs after SCHIP enrollment. Unmet health care needs among enrollees with special health care needs after SCHIP enrollment may reflect their poorer health status and greater health care needs and/or SCHIP benefit packages that were not specifically designed to meet special health care needs.

This CHIRI™ study used standard research methods that adjust for differences in demographic characteristics across vulnerable groups of enrollees. Vulnerable SCHIP enrollees, however, have different characteristics from other low-income children that place them at higher risk for poor health care access. For example, minority enrollees were more likely to come from single-parent families who had lower educational achievement and lower incomes and who were more likely to have been uninsured for a long period of time. These CHIRI™ findings show that being from one of these vulnerable groups does not prevent children and adolescents from enjoying SCHIP benefits similar to those of other enrollees. Vulnerable children and adolescents, however, may not have the same access to health care as other enrollees due to the characteristics that were controlled for in this study.

Furthermore, SCHIP enrollees in this study who had been uninsured for at least 12 months before enrollment had better connections to the health care system before they enrolled than is characteristic of the uninsured. This finding indicates that their families may be more skillful at accessing health care than is typical for this group. Their gains under SCHIP may, therefore, not be indicative of what other long-term uninsured children and adolescents might experience if enrolled.

Policy Implications

At a time when States are implementing cost-saving measures and making the most of program resources, policymakers will want to consider how SCHIP benefits low-income and more vulnerable children and possible strategies for program improvements.

- Investments in public health insurance for low-income children produce measurable improvements in access to and satisfaction with health care.
- States that have achieved high levels of access to a regular source of care for SCHIP enrollees may want to turn their attention to the quality of care provided to enrollees at their regular source of care.
- There is considerable opportunity to improve preventive care use for SCHIP enrollees.
    - ✓ States use a range of approaches to strengthen preventive care use, including conducting outreach to key target groups; educating parents about the importance of preventive care; providing health plans and providers with incentives for meeting preventive care guidelines; and ensuring that adequate numbers of providers are available at convenient locations and times.
- SCHIP coverage provides an important opportunity to address unmet health care needs of all enrollees, particularly those with special health care needs.
    - ✓ Strategies to reduce unmet health care needs include conducting needs assessments and screening for special health care needs, changing reimbursement policies to reflect greater needs of some enrollees, expanding benefit packages, and coordinating SCHIP benefits with wraparound services (e.g., case management) provided by other programs and agencies.
- States can use data to identify vulnerable children and adolescents who are lagging behind other children.

STUDY METHODOLOGY

This CHIRI™ Issue Brief is based on a longitudinal study of new SCHIP enrollees in three States with separate, freestanding SCHIP programs—Florida, Kansas, and New York. The Kansas and New York CHIRI™ projects included newly enrolled SCHIP children ages 1-18 years; the Florida CHIRI™ project included newly enrolled SCHIP adolescents ages 12-18 years.

In all study States, two telephone interviews were conducted in 2001 with the adult in the household most knowledgeable about the child's health insurance and medical care (one child per family). Shortly after enrollment, respondents were asked about the child's health care experiences for the 12 months prior to enrollment. A year later, they were asked about the 12 months following enrollment. Only children whose families completed both interviews (434 in Kansas, 944 in Florida, and 2,290 in New York) were included in the analyses. Florida and New York analyses were restricted to those children and adolescents who remained enrolled for at least 12 months. The same restriction was not made for the Kansas analyses because of its small sample size; approximately 20 percent of Kansas enrollees were not enrolled in SCHIP for the full 12 months.

Identical measures were used by all three States, with the exception of the measure of unmet health care needs. The presence of special health care needs was determined by the Children with Special Health Care Needs screener. Children and adolescents were defined as being long-term uninsured if they were uninsured the entire 12 months prior to enrollment. Satisfaction with health care received from all health care sources was rated on a scale of 0 to 10.

Multivariate analyses to assess SCHIP's impact on each of the three sub-groups of vulnerable children and adolescents (minority children, those with special health care needs, and long-term uninsured) controlled for demographic and socioeconomic measures (i.e., child's age, gender, race/ethnicity, single-parent household, household size, family income, maximum parent education, parental employment status, and urbanicity). These analyses also assessed differences between vulnerable children and other enrollees, both before and after SCHIP enrollment. Separate analyses were performed for each of the three study States; data were not pooled.

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:

- Care of children with special health care needs under SCHIP.
- Disenrollment and retention in public insurance programs.
- The impact of SCHIP enrollment on provider participation in Medicaid.
- The role SCHIP plays in the patchwork insurance system for children.

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). Additional support for the Kansas project was provided by the Kansas Health Foundation, the United Methodist Health Ministry Fund, and the Prime Health Foundation. 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.

Three 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); and "New York's SCHIP: What Works for Vulnerable Children" (Principal Investigator: Peter Szilagyi, University of Rochester).

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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.

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