Contract No.: HHS-100-01-0002
MPR Reference No.: 8782-130

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

Final Report to Congress

October 26, 2005

Judith Wooldridge	*Mathematica Policy Research, Inc.*
Genevieve Kenney	*The Urban Institute*
Christopher Trenholm	*Mathematica Policy Research, Inc.*
with	
Lisa Dubay	*The Urban Institute*
Ian Hill	*The Urban Institute*
Myoung Kim	*Mathematica Policy Research, Inc.*
Lorenzo Moreno	*Mathematica Policy Research, Inc.*
Anna Sommers	*The Urban Institute*
Stephen Zuckerman	*The Urban Institute*

Submitted to:

U.S. Department of Health and Human Services
Office of the Secretary
Assistant Secretary for Planning and Evaluation
Room 442E, HHH Building
200 Independence Avenue, SW
Washington, DC 20201

Project Officer:
Rob Stewart

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
(609) 799-3535
and
The Urban Institute
2100 M Street, NW
Washington, DC 20037

Project Director:
Judith Wooldridge

ACKNOWLEDGMENTS

In preparing this report, we received support and assistance from many people. We would first like to thank the individuals who collected and processed the survey data on which much of this report is based: Welmoet van Kammen, who directed the survey, her assistant Barbara Schiff, and the many other staff who assisted in developing the survey instrument and interviewed the families; Brenda Cox, who developed the sampling design; Frank Potter, who led the sampling and weight development, and his assistant Mourad Touzani; Amy Zambrowski, who processed the administrative files from the states on which the sampling and elements of the analysis are based; and Tim Novak, who led the development of the initial survey data files. We also wish to thank the programmers and research assistants who assisted us with the analysis of the survey and administrative data files: Ece Kalay, Stephanie Chin, and Carol Razafindrakoto at Mathematica Policy Research and Matthew Fragale, John Graves, Justin Yee, and Alexandra Tebay at the Urban Institute. We also are grateful to Cathy Harper, who produced the report with William Garrett's help. Any errors or omissions in this report are the sole responsibility of its authors.

We also wish to thank the many individuals on whose work we drew in this report. We are grateful to Jamie Rubenstein, Frederic Blavin and Grace Ko of the Urban Institute, who made substantive contributions to the analyses based on the surveys of SCHIP and Medicaid enrollees. We thank Carol Irvin of Mathematica for her important contributions to the national survey of SCHIP administrators, as well as colleagues at the MayaTech Corporation, including Kristianna Pettibone, Joanna Shoffner, Jamie Chriqui, Raedell Wallace, Mathew Dunn, and Carissa Baker, for their work on this survey. In addition, Mary Harrington, Nancy Fasciano, Ruchika Bajaj, and William Black from Mathememática Policy Research, and Corinna Hawkes, Embry Howell, Heidi Kapusta, and Amy Lutzky from the Urban Institute, all participated in and contributed to the case studies. Jennifer Haley and Alexandra Tebay made important contributions to the analyses of low-income uninsured children based on data collected by the National Center for Health Statistics. Finally, we wish to acknowledge the work of Renee Schwalberg of Health Systems Research, Inc., and Hillary Bellamy, who conducted focus groups that informed our SCHIP research.

Many people provided critical review and comment on the report, for which we are also grateful. Margo Rosenbach provided an independent review of the full report and a number of valuable insights and comments that are reflected in this final version; and John Holahan and Embry Howell provided very helpful advice and guidance at many stages of the process.

Many current and former staff from the Office of the Assistant Secretary for Planning and Evaluation also provided critical comments on the report and other support to this evaluation, for which we are grateful. We especially wish to thank Rob Stewart, our project officer, Barbara Richards and Jennifer Babcock for extremely valuable reviews of earlier drafts. We also thank their colleagues, Stephen Finan, Tanya Alteras, Julia Paradise, Adelle Simmons, and Caroline Taplin for their support. In addition, we thank the members of the Technical Advisory Panel for their evaluation, which provided early input on the design of the survey and proposed analysis.

We gratefully acknowledge the assistance from state and contractor staff in acquiring and processing Medicaid and SCHIP enrollment data, which was crucial not only to this report, but to the evaluation as a whole. The names of these individuals are presented below:

California	Colorado	Florida	Illinois	Louisiana
Sandra Shewry	Barbara Ladon	Nancy Ross	Jane Longo	Ben Bearden
Gurmeet Hajrah	Jonathan Harner	Betsy Shenkman	Vicki Mote	Ruth Kennedy
Gene Hiehle	Al Hawker	Rose Naff	Kelly Carter	Joan Carmouche
Michael K. Fitzwater	Al Moore		Marsha Eiter	Robynn Schifano
	Nathan Nelson		Roderick R. Spurbeck	Rosie Shreve
	Ha Hoang			Regina Francise
Missouri	**North Carolina**	**New Jersey**	**New York**	**Texas**
Greg Vadner	June Milby	Heidi Smith	Judith Arnold	Jason Cooke
Pamela Victor	Patricia Slaughter	Nancy Scarlata	Ralph Bielefeldt	Gary Young
Richard Koon	Frances Ochart	Pat Stolpe	Susan Kahler	Randy Fritz
Melanie Berhost		Michael Chiofolo		
Shelley Farris		Michelle D. Walsky		
Julie Creach		Patrick J. Gallagher		
Jan Johnson				
William Gibson				

And finally, we would like to thank the many families who responded to the survey.

CONTENTS

TABLES

TABLES *(continued)*

FIGURES

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

[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

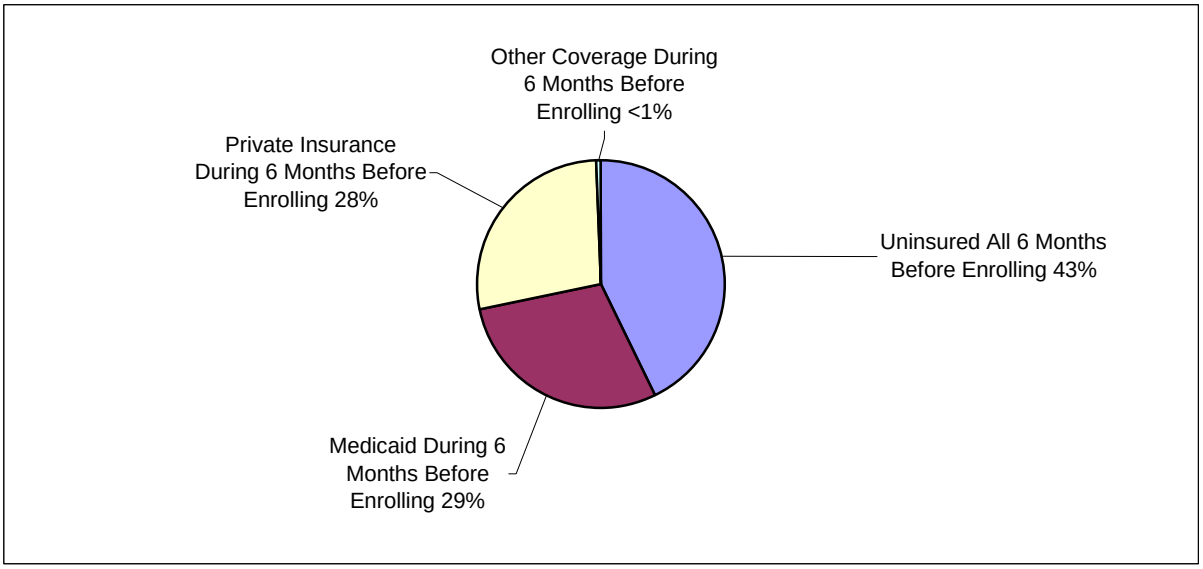
[a]Child is classified as having Elevated Health Care Needs if the child is in fair or poor health or if the child meets one or more of the following criteria; (1) had an impairment or health problem lasting at least 12 months that limits his/her ability to crawl, walk, run, or play; (2) a health care 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.

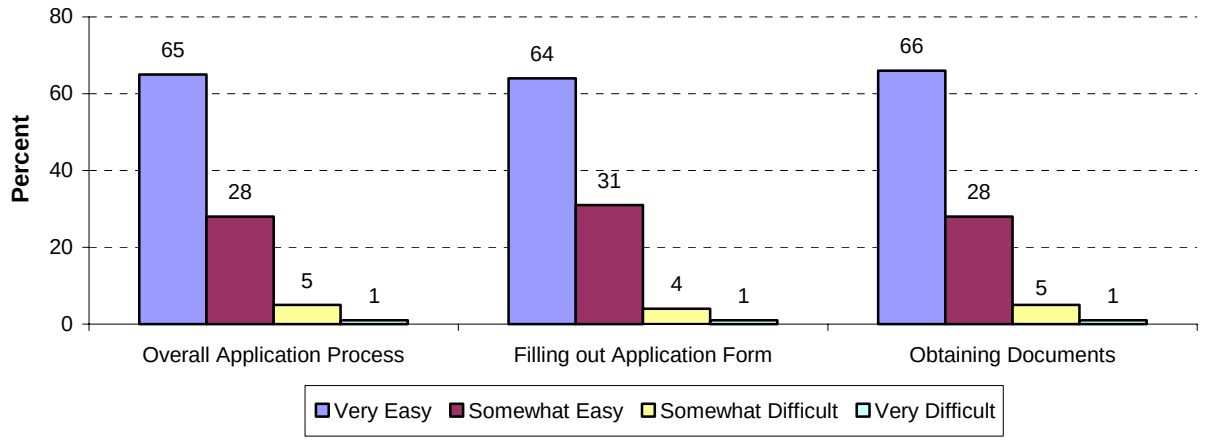
[b]This is an unduplicated estimate of any unmet need for one or more of the following services: physician, drug, specialist, hospital, or dental care. It applies to children age 3 and older.

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.

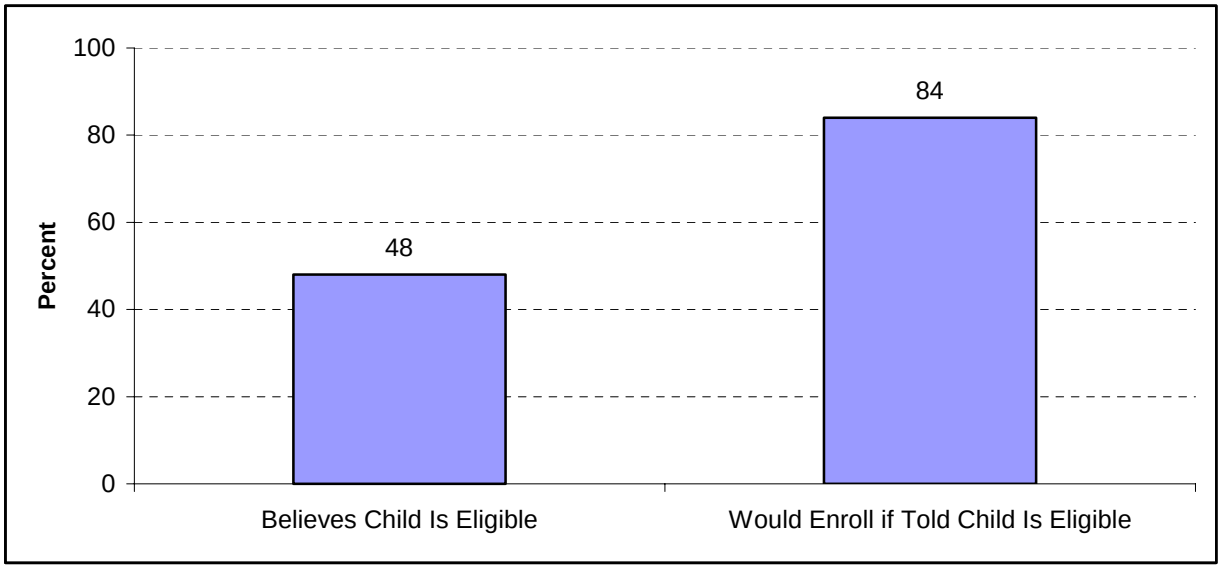
Six Months After Leaving SCHIP, One-Third of Children Are Uninsured But About Half of Them May No Longer Be SCHIP-Eligible

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.

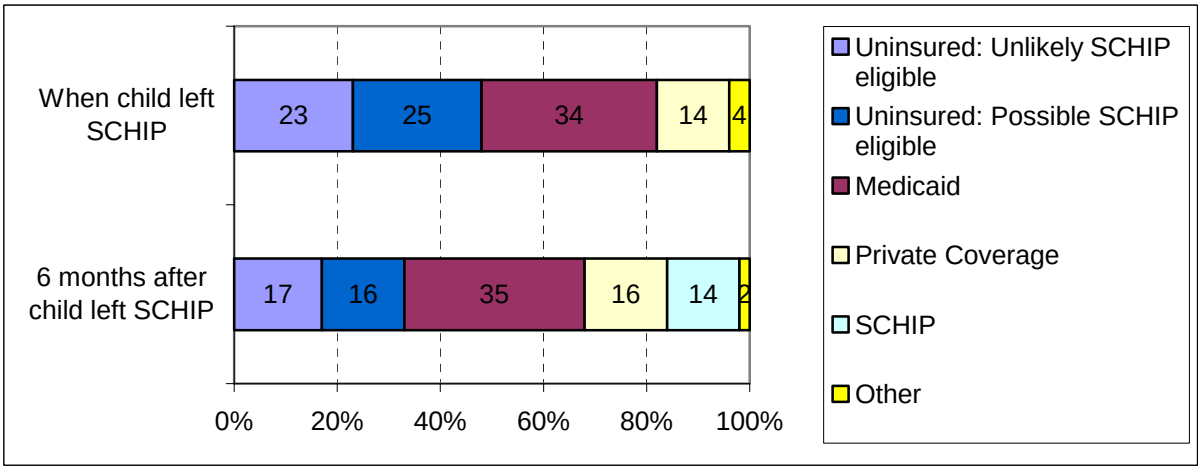
Figure 3. Perceptions of Medicaid/SCHIP Programs, Low-Income Uninsured Children, 2001



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.

PART 1: BACKGROUND

This report presents findings from the congressionally mandated Evaluation of the State Children's Health Insurance Program (SCHIP) funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (DHHS). The study focused mainly on SCHIP programs in California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas. These states were chosen to meet the congressionally mandated criteria of representing (1) different types of health insurance programs; (2) varied regions of the country; and (3) large numbers of low-income, uninsured children. 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.

Mathematica Policy Research, Inc. and its partners—The Urban Institute and the MayaTech Corporation—conducted the evaluation under contract to ASPE. This is the second evaluation report submitted to Congress. (An interim report covering implementation in 6 of the 10 states was submitted in February 2003.)

I. A BRIEF HISTORY OF SCHIP

The creation of SCHIP in 1997 as Title XXI of the Social Security Act was a landmark event in American health policy. The program substantially broadened the role of public health insurance for children from low-income families, reflecting popular support for ensuring children's coverage. SCHIP provided federal funding for the first insurance program for children since Medicaid was established as Title XIX of the Social Security Act in 1965. The numbers of uninsured low-income children had been rising, and there was bipartisan agreement about the need to provide coverage for these children. SCHIP was established to cover uninsured children from low-income working families who were not eligible for Medicaid.

SCHIP was created by the Balanced Budget Act (BBA) of 1997, which was signed into law in August 1997. Congress appropriated approximately $40 billion for the program's first 10 years (fiscal 1998 through fiscal 2007). The funds were allotted to the states based on a formula that considered both the number of low-income children and the number of low-income, uninsured children living in each state. The formula also included a factor for each state's relative health care costs. To encourage states to implement a SCHIP program, the federal matching rate was enhanced relative to Medicaid: on average, the states' share of SCHIP costs was 13 percentage points lower than the states' share of Medicaid costs. The BBA allowed states to cover children in families with incomes up to 200 percent of the federal poverty level and beyond.

The BBA also gave states considerable flexibility in designing their programs, including choice of program type, benefits covered, and extent of cost sharing required of participating families. States had three broad options for SCHIP program design. A state could introduce a private insurance coverage model as a separate program, use a Medicaid program model under which the Medicaid program was expanded to cover more children, or do both. The BBA allowed states that chose separate programs to have a benefits package distinct from Medicaid, though benefits package designs were restricted to several "benchmark" plan options. The BBA also allowed states that chose a separate state program to introduce cost sharing for families of enrollees, including up-front fees to enroll, monthly premiums, copayments for services, and deductibles. By law, Medicaid expansion programs under SCHIP were subject to all the requirements of Medicaid. Thus, states that chose the Medicaid expansion model could not use a different benefits package for their SCHIP enrollees, nor could they employ cost sharing (unless they introduced their SCHIP program through a Section 1115 demonstration under which this Medicaid program provision was waived).

Because policymakers were concerned that families with higher incomes, who were more likely to have employer-based coverage, might replace that coverage with SCHIP, states were required to discourage such substitution. To encourage families to keep private group health insurance for their children, states with separate programs were permitted to impose a waiting period on families who dropped their children's private coverage. Except when using Section 1115 waiver authority, states with Medicaid expansion programs were not permitted to impose waiting periods.

To improve continuity of care, some states offer 12-month continuous coverage, which does not require families to report any change in circumstances that might affect eligibility during the year, but does require them to renew eligibility after 12 months. However, other states do not

guarantee such 12-month coverage. Instead they require families to report all changes in family circumstances that might affect eligibility when they occur and if there are no such changes to renew eligibility at 12-month intervals. In practice however, this coverage functions as continuous coverage for many families whose circumstances do not change.

States rapidly implemented their SCHIP programs. In October 1997, some states began to enroll children. By December 1999, all state programs were approved for implementation, and by September 2000, all states (including the District of Columbia) had implemented their programs. Two states, Arkansas and Tennessee, dropped their SCHIP programs in fiscal 2002 (both states had pre-existing Section 1115 demonstrations that offered expanded Medicaid coverage; these demonstrations were revised in fiscal 2002).[3] 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 the District of Columbia, 18 had separate programs, 13 had Medicaid expansion programs, and 18 had both (combination programs).[4] In fiscal 2003, the program models among the 10 states selected for the evaluation (shown in Table 1) included three separate state programs (Colorado, North Carolina, and Texas), two Medicaid expansion programs (Louisiana and Missouri), and five combination programs (California, Florida, Illinois, New Jersey, and New York), slightly different from the national distribution. However, when California, Florida, and New York were selected for the evaluation, their Medicaid expansion components were expected to end during fiscal 2002, when the children covered by SCHIP Medicaid expansion components would become Medicaid eligible. For the purposes of the evaluation, these three states were treated as separate programs.[5]

As shown in Table 1, the 10 states varied with respect to income eligibility thresholds, use of waiting periods, continuous coverage, and cost sharing. The upper income thresholds varied from 185 percent of the federal poverty level in Colorado and Illinois to 350 percent in New Jersey. Three of the six states with separate programs and both states with combination programs included a waiting period before children could enroll in SCHIP after their parents dropped private coverage. (Another state, North Carolina, had a waiting period but dropped it.) Missouri, a Medicaid expansion state, also incorporated a waiting period under its Section 1115 demonstration. Six of the states adopted 12-month continuous coverage (California, Colorado, Illinois, Louisiana, North Carolina, and Texas), and one adopted 6-month continuous coverage (Florida). The three remaining states (Missouri, New Jersey, and New York) chose to redetermine eligibility every 12 months, which does not guarantee continuous coverage for 12 months. Seven of the eight states with separate program components included cost sharing for at least some of the enrollees, and one of the Medicaid expansion states, Missouri, included cost sharing for children in families over 250 percent of the poverty level.

[3]Arkansas and Tennessee had extended SCHIP coverage to 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").

[4]Appendix A, Table A.1 shows program type and enrollment for all programs operating at the end of fiscal 2003.

[5]In these three states, after their Waxman children became eligible for Medicaid, the Medicaid expansion SCHIP components continued. These remaining Medicaid expansion programs cover only a small number of children (from diverse groups) compared with the separate SCHIP program components.

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, that 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.

II. THE CONGRESSIONALLY MANDATED EVALUATION

A. CONGRESSIONAL MANDATES

Congress mandated in the Balanced Budget Refinement Act of 1999 that the Secretary of DHHS conduct an independent comprehensive study of the State Children's Health Insurance Program. The legislation specified the range of issues the evaluation was to investigate, as well as some of the methods to be used. A copy of the statutory language is included in Appendix B.

Congress stipulated the following study parameters:

- Include 10 states with varied geographical and urban/rural representation, diverse approaches to program design, and a large proportion of low-income, uninsured children in the United States
- Survey SCHIP enrollees and disenrollees and children eligible for, but not enrolled in, SCHIP

The evaluation incorporated these study parameters as follows. First, the states selected for the study met the stipulated geographic variability and contained a large share of low-income, uninsured children. The 10 states were drawn from the four census regions, and, at the time SCHIP began (1997), included 56 percent of uninsured children with families below 200 percent of the federal poverty level. These states included 62 percent of the children who were enrolled in SCHIP at any time during the last quarter of 2003. Moreover, as shown in Table 1, these states adopted varied program designs.

Second, the evaluation implemented surveys of SCHIP enrollees and disenrollees in the 10 study states in 2002, as mandated. (The evaluation also implemented a parallel survey of Medicaid enrollees and disenrollees in two of the states during 2002.) The evaluation did not collect information on children eligible for SCHIP who had not enrolled in the program. Instead, it drew 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. The sample included both children with and without special health care needs.

An interim report was sent to Congress in 2003 that summarized states' SCHIP designs and their early experiences with program implementation. The report was based on six case studies, a separately funded focus group study, and an analysis of preliminary data from the National Survey of Children with Special Health Care Needs, which provided quantitative findings on family perceptions of SCHIP and Medicaid, and the reasons families do not enroll their children in these programs (Wooldridge et al. 2003).

This final report to Congress presents findings from extensive analysis of the mandated surveys of SCHIP enrollees and disenrollees in 10 states, Medicaid enrollees and disenrollees in 2 states, and low-income, uninsured children nationwide from the National Survey of Children

with Special Health Care Needs. The report also draws on program information collected in case studies of all 10 states and on a national survey of SCHIP program administrators in 44 states.

B. EVALUATION QUESTIONS

The evaluation addressed a broad range of questions about SCHIP. These questions addressed (1) program design, implementation, and evolution, and the implications of different designs for 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 in the program, how long children stayed in the program and why they left, and what types of insurance coverage they had subsequently. (See Table 2.)

Table 2. Evaluation Research Questions

How did states design their programs, and how have they evolved?
Why did states choose their designs? How do designs vary across states? Were states concerned about "crowd out" and what policies did they follow to prevent it? How well did states coordinate their SCHIP and Medicaid programs? How and why have programs changed?
What are SCHIP enrollees' characteristics?
How old are SCHIP enrollees? What are their ethnic and racial backgrounds? What is their health status? What income, education, and recent working experience do their parents have? What is the main language spoken at home? Were SCHIP enrollees' parents born in the United States? How many parents live in the household?
Is SCHIP serving the target population of low-income uninsured children?
Is SCHIP covering children who were uninsured before enrolling? Is SCHIP substituting for employer coverage? Is SCHIP more likely than Medicaid to substitute for employer coverage?
Is SCHIP improving the access of children and the well-being of their families?
How well are SCHIP programs meeting children's primary health care needs? Are some children's primary health care needs better met than others? What are the effects of cost sharing on children's service use? Do SCHIP enrollees have better access to health care than they would have otherwise? How widespread are the improvements across different measures of access and use? Are the effects of SCHIP on access to care similar across states and subgroups?
Is Medicaid improving the access of children and the well-being of their families?
How well are Medicaid programs meeting children's primary health care needs? Do Medicaid enrollees have better access to health care than they would have otherwise? How widespread are the improvements across different measures of access and use? Are the effects of Medicaid on access to care similar across states and subgroups?

Are families aware of SCHIP, and what are their experiences enrolling in SCHIP?
Are low-income families aware of Medicaid or SCHIP?
Do they think their children are eligible for Medicaid or SCHIP?
Would they enroll their children in Medicaid or SCHIP if told they were eligible?
How easy is it to enroll in SCHIP and Medicaid?
Which families use application assistance?
What sources are important to families in deciding to enroll their children in SCHIP?
Are families familiar with the renewal requirements when they enroll?
How long do children stay in SCHIP, and what are their experiences after they leave?
How long are children enrolled?
How often do children gain coverage after leaving SCHIP?
Which children who leave SCHIP are most likely to become uninsured?
How important is private coverage to insuring children who leave SCHIP?
What factors affect whether children obtain coverage after leaving SCHIP?
How often do SCHIP disenrollees experience short gaps in coverage?

C. DATA AND METHODS

The evaluation drew on a variety of data sources and methods to address these questions. The data sources drawn on for this report include:

- Case studies of the 10 study states, conducted between May 2001 and January 2002[6]
- A national survey of state program administrators, conducted during 2002[7]
- Surveys of recent and established SCHIP enrollees and recent disenrollees in the 10 study states, collected during 2002, in which 16,700 interviews were completed—mostly with parents[8]
- Surveys of recent and established Medicaid enrollees and recent disenrollees in 2 of the 10 study states (California and North Carolina), collected during 2002, in which 2,600 interviews were completed. The Medicaid surveys mirrored the SCHIP surveys in structure and questions[9]
- SCHIP enrollment data for January 2002 through December 2002 in 10 states and Medicaid enrollment data for January 2002 through December 2002 in 7 states

[6]The first six case studies were documented in Hill, Harrington, and Hawkes 2002, from which the interim report to Congress drew. The full set of 10 case studies was documented in Hill, Hawkes, and Harrington 2003.

[7]The data collection methods and findings from the state program administrator survey were documented in Pettibone et al. 2005.

[8]The data collection methods, findings, and analytic methods for the surveys of SCHIP enrollees and disenrollees are documented in Kenney, Trenholm, et al. 2005.

[9]The data collection methods, findings, and analytic methods for the surveys of Medicaid enrollees and disenrollees are documented in Kenney, Trenholm, et al. 2005.

- The National Survey of Children with Special Health Care Needs, which is a module of the State and Local Area Integrated Telephone Survey (SLAITS) mechanism developed by the National Center for Health Statistics.[10] The module, funded by ASPE, was fielded from October 2000 through April 2002.

Since most of this report is dedicated to the findings from the analysis of the SCHIP enrollee and disenrollee surveys, a brief summary of these surveys is provided. In every state, 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
3. Recent disenrollees: children who had been disenrolled from the program in the most recent 2 months when sampled

To ensure accurate and comprehensive data collection over the entire cycle of SCHIP experience—before, during, and after SCHIP coverage—questions were tailored by sample. For example, questions about experiences before and while enrolling were addressed to the recent enrollee sample, questions about experiences during enrollment in SCHIP were addressed to the established enrollee sample, and questions about experiences just before and just after leaving SCHIP were addressed to the recent disenrollee sample. Access questions were tailored to three different periods: for recent enrollees, the 6-month period before they enrolled; for established enrollees, the most recent 6-month period; and, for recent disenrollees, the 6-month period before they left SCHIP (Table 3). Similarly, insurance coverage questions differed across samples: recent enrollee questions focused on the 6-month period before they enrolled in SCHIP,

Table 3. Survey Content, by Sampled Group

	Survey Content			
Sampled Group	Access to Care	Insurance Coverage	Enrollment	Disenrollment
Recent Enrollees	Access, use, and satisfaction before enrolling in SCHIP	Child's coverage before enrolling in SCHIP	Experience enrolling and reasons for enrolling	---
Established Enrollees	Access, use, and satisfaction while enrolled in SCHIP	Parent's coverage at the time of the interview	---	---
Recent Disenrollees	Access, use, and satisfaction before leaving SCHIP	Child's coverage after leaving SCHIP	---	Reasons child left SCHIP

--- = These questions were not germane to the sample.

[10]The analysis of this survey is documented in Kenney, Haley, and Tebay 2004. The survey is documented in Van Dyck et al. 2002 and Blumberg et al. 2003.

established enrollee questions focused on the parents' coverage at the time of the interview, and recent disenrollee questions focused on the child's coverage after leaving SCHIP. Questions about enrolling in the program were asked of recent enrollees and questions about reasons for leaving SCHIP were asked of recent disenrollees. A core set of demographic and health status questions was addressed in all three samples.

The survey was conducted by telephone with an in-person follow-up component. Each sample member was weighted to reflect the population represented and also to correct for nonresponse. All analyses used the appropriate sample weights.

Table 4 shows the data sources and samples used to analyze the evaluation questions. The table also indicates the section of the report where the questions are addressed. The analyses (primarily descriptive) combined bivariate and regression methods that took into account the demographic and socio-economic characteristics of sample members to address the questions shown in Table 4. The analysis of the impacts of SCHIP on access, service use, and whether the families were satisfied with the care their children received, employed a comparison group design. Details on methods are given in Kenney, Trenholm, et al. 2005.

Table 4. Evaluation Questions by Report Section, Source and Sample

Report Section	Question	Source and Sample
III page 15	**How did states design their programs and how have they evolved?**	1 National Survey of SCHIP Administrators 2 Case Studies of 10 States
IV page 23	**What are SCHIP enrollees' characteristics?**	Survey of Established SCHIP Enrollees in 10 States
V page 27	**Is SCHIP serving the target population of low-income uninsured children?**	
	Is SCHIP covering children who were uninsured before enrolling?	Survey of Recent SCHIP Enrollees in 10 States
	Is SCHIP substituting for employer coverage?	Survey of Established SCHIP Enrollees in 10 States
	Is SCHIP more likely than Medicaid to substitute for employer coverage?	Survey of Established Medicaid Enrollees in Two States
VI page 33	**Is SCHIP improving the access of children and the well-being of their families?**	
	Do SCHIP enrollees have better access to health care then they would otherwise?	Surveys of Recent and Established SCHIP Enrollees in 10 States
	How widespread are the improvements across different measures of access and use?	Survey of Established SCHIP Enrollees in 10 States
	Are the effects of SCHIP on access to care similar across states and subgroups?	
	How well are SCHIP programs meeting children's primary health care needs?	
	Are some children's primary health care needs better met than others?	
	What are the effects of cost sharing on children's service use?	
	Is Medicaid improving the access of children and the well-being of their families?	Survey of Recent and Established Medicaid Enrollees in Two States
VII page 45	**Are families aware of SCHIP?**	National Survey of Children with Special Health Care Needs
	What are families' experiences enrolling in SCHIP?	Survey of Recent SCHIP Enrollees in 10 States
VIII page 53	**How long do children stay in SCHIP and what are their experiences after they leave?**	
	How long are children enrolled?	1 Survey of Recent SCHIP Enrollees in 10 States. 2 SCHIP and Medicaid Enrollment Files
	What are their experiences after they leave?	Survey of Recent SCHIP Disenrollees in 10 States

PART 2: FINDINGS

Findings from the evaluation are presented in Part 2. Chapter III highlights findings from the implementation of SCHIP in the 10 case study states and nationwide. It describes the design choices states made, including type of program, coverage levels and outreach and enrollment approaches, benefits offered, cost-sharing approaches, and coordination between SCHIP and Medicaid. The subsequent chapters, IV through VIII, highlight the findings from the surveys of SCHIP and Medicaid enrollees and disenrollees and from the National Survey of Children with Special Health Care Needs. Chapter IV describes the characteristics of children who enrolled in SCHIP. Chapter V discusses the extent to which SCHIP enrollees substituted SCHIP for other health insurance coverage. Chapter VI describes access to services in SCHIP and how access in SCHIP compares to access available before enrolling in SCHIP. Chapter VII describes the awareness of low-income families of SCHIP and Medicaid and the experiences families have enrolling their children in SCHIP. Chapter VIII discusses how long children stay enrolled in SCHIP and the subsequent coverage of children who leave SCHIP.

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.

III. STATES DESIGNED GENEROUS PROGRAMS TAILORED TO STATE ENVIRONMENTS

Most states were quick to respond to the opportunity presented by SCHIP. Case study respondents reported that their swift response was driven by the availability of the enhanced federal matching rate, bipartisan support for children's health insurance coverage, and the healthy economies in their states at that time. In addition, 3 of the 10 states already had state-funded programs they were able to incorporate into SCHIP.[11]

States Chose Their Program Designs in Light of State Conditions

Political acceptance and ease of implementation were key factors in states' choice of program type; moreover, whether the Medicaid program was viewed positively or negatively also played a role in program choice.

Many state officials in the case study states with separate state programs viewed SCHIP as an opportunity to test (or continue) new models of health insurance patterned after private insurance, build new partnerships between government and the private sector, and design systems distinct from the Medicaid models of the past. Furthermore, case study respondents reported resistance to Medicaid—at the level of politicians, providers, and consumers—as a strong factor underlying choice of the separate program model. The state administrator survey reinforced these findings: 75 percent of the states with separate programs chose that model for political reasons, 38 percent chose it because of the ability to control program design, and 31 percent chose it because of the flexibility to try new ideas (Table 5). Furthermore, 50 percent of the 16 separate programs reported that Medicaid was not viewed positively in their states.

States chose Medicaid expansion programs for somewhat different reasons. Case study respondents reported that states chose Medicaid expansions because of the following factors: (1) comprehensive benefits and ease of implementation, (2) the Medicaid program was positively regarded, and (3) it was efficient to do so—they did not need to set up a new administrative structure to run their SCHIP program. The SCHIP administrator survey confirmed some of these findings: nationwide, 83 percent of Medicaid expansion program administrators said ease of implementation was a key reason for choosing that model. In addition, half of the states that chose a Medicaid expansion program implemented a plan to expand Medicaid coverage they had developed before SCHIP was implemented (see Table 5). The SCHIP administrator survey found that Medicaid was not positively viewed in only 2 of these 12 states (17 percent).

[11]This chapter draws on two reports prepared during the evaluation. Hill, Hawkes, and Harrington 2003 evaluated the design and implementation of SCHIP in the 10 study states based on 10 case studies. Pettibone et al. 2005 evaluated the responses of SCHIP administrators nationwide to a survey on program design, operations, and evolution.

Table 5. Five Principal Reasons States Chose Their Program Type

Reason	Total	Separate Programs	Medicaid Programs	Combination Programs
To Ensure Acceptance by Governor and State Legislature	50 %	75 %	17 %	50 %
Ease of Implementation	39	13	83	31
Ability to Control Program Design Issues, such as Cost and Enrollment	21	38	17	6
Used Previously Developed Plans to Expand Medicaid Coverage	23	6	50	19
Exercise Flexibility to Try New Ideas	18	31	0	19
Number of SCHIP Administrators Responding to the Question	**44**	**16**	**12**	**16**

SOURCE: SCHIP Administrator Survey, 2003.

NOTES: Additional reasons administrators gave for selecting program type were: expand a preexisting separate state health coverage program (seven states); less administrative burden (six states); simple for consumers to understand (four states); to take advantage of access to established networks of providers (four states); to create a program that was distinguishable from Medicaid (two states); and ability to include cost sharing (two states).

[a]One state indicated that this was originally a reason, even though the program had since been discontinued.

States Designed Generous Programs, Embraced Outreach, and Kept Applications Simple

Income eligibility levels for SCHIP were by design higher than Medicaid income eligibility levels, and SCHIP expanded coverage to families with incomes considerably higher than Medicaid levels in some states. States offered SCHIP coverage up to widely varying income eligibility levels, with the level among the study states ranging from 185 percent of the poverty level in Colorado and Illinois up to 350 percent in New Jersey. Nationwide, as a whole, the income eligibility range was broader than among the study states, varying from a low of 140 percent of the federal poverty level (in North Dakota) to a high of 350 percent of the federal poverty level (in New Jersey) (CMS 2004).

States embraced outreach as a key way to reach low-income families and enroll their children in SCHIP. The case studies found that states used mass-media approaches to raise general awareness of the programs and supported community-based approaches by trusted local organizations tailored to find and enroll "hard-to-reach" populations. Indeed, 6 of the 10 case study states reported that application assistance was made available in the community as part of outreach. Some study states with separate programs reported it was a challenge to market SCHIP jointly with Medicaid because of perceived public resistance to Medicaid. However, across the nation, most state program administrators reported that they coordinated some outreach with Medicaid (79 percent). Similar numbers of them reported that their most successful outreach approaches were paid media ads (17 percent), school-based outreach (12 percent), and face-to-face local outreach (34 percent) which is consistent with findings from the survey of enrollees. Successful outreach approaches reported by state program administrators are summarized in Appendix A, Table A.2. Although outreach was widely implemented, by the time of the state program administrator survey in 2003, 39 percent of

administrators reported that recent state budget constraints had led them to cut back their SCHIP outreach.

To encourage enrollment, states adopted a variety of policies aimed at having a simple SCHIP application process. These policies included using simplified joint applications for SCHIP and Medicaid, allowing families to mail in their children's applications, eliminating assets tests, and simplifying documentation requirements. Furthermore, some states adopted continuous 6- or 12-month eligibility for SCHIP, so that families only had to renew their eligibility once or twice a year. Sometimes, these policies spilled over to the Medicaid program. For example, most of the study states simplified Medicaid rules and procedures, but sometimes to a lesser extent than they simplified SCHIP. Although all 10 states permitted applications for SCHIP to be mailed in, two still required face-to-face interviews for SCHIP applicants referred to Medicaid. And, while only 2 of the 10 states had assets tests for SCHIP, 5 had assets tests for Medicaid (Hill et al. 2003). By 2003, 77 percent of the program administrators reported there was no difference between the SCHIP and Medicaid application processes.

Over time, as the numbers of children enrolled in SCHIP grew, states increasingly focused on streamlining the renewal process to increase the rate at which eligible children stayed in the program and on monitoring the reasons children left SCHIP. Among the study states, Florida had a simple passive renewal system: children in families who did not respond to the renewal notice by indicating a change in status were assumed still eligible.[12] In the remaining nine states, families could renew enrollment by mail, and in five of those states, computer systems preprinted the renewal form to make it easier for the families to review and submit. Eighty nine percent of program administrators nationwide reported they monitored the reasons children leave SCHIP.

States Had Similar Benefits and Delivery Systems in Their SCHIP and Medicaid Programs

The BBA gave states adopting separate programs flexibility in choosing their benefits packages—subject to certain benchmark plans. States adopting Medicaid expansion programs had to use the Medicaid benefits package unless their program was implemented under a Section 1115 demonstration with a benefits package waiver. Benchmark plans included the Blue Cross Blue Shield preferred provider option under the Federal Employee Benefits Program, the state employee health benefit plan, and the largest commercial non-Medicaid Health Maintenance Organization in the state (and separate programs could also choose the Medicaid benefit). Separate programs could also choose the actuarial equivalent of any of the benchmark plans.[13] In 2002, the eight case study states with a separate program component had comprehensive benefits with a few less services than Medicaid. Among case study respondents in the study states, SCHIP benefits were viewed widely as being adequate or very generous, regardless of the program model. The pattern of relatively small differences in program benefits between SCHIP

[12]As of October 2004, Florida has introduced active renewal and changed the renewal period from 6 months to 12 months.

[13]In addition, benefits could be "Secretary-approved." Secretary-approved coverage includes the Medicaid package, a pre-existing package (as in Florida), benefits more generous than the benchmark, or any other Secretary-approved coverage at the Secretary's discretion.

and Medicaid was also true nationwide. Almost two-thirds of the state program administrators from states with separate or combination programs reported no differences in the benefits covered between their SCHIP and Medicaid programs. Among those reporting differences in benefits between SCHIP and Medicaid programs, the most common differences were early and periodic screening, diagnosis, and treatment services (EPSDT), which are mandatory in Medicaid, but optional in separate programs. (Nationwide, six states with separate or combination programs reported that they excluded EPSDT from their programs.)

Health services delivery systems may differ between SCHIP and Medicaid, although using the same delivery system can make it easier for families to transfer from one program to the other. Among the eight case study states with a separate program component, most used the same or very similar delivery systems for SCHIP and Medicaid. (Medicaid expansion programs, by definition, use the same delivery system for both programs.) Case study respondents described aligning Medicaid and SCHIP service delivery systems as a desirable goal to ensure that children who transfer from one program to the other do not need to change physicians. This finding was also discovered nationwide. Two-thirds of program administrators with separate programs surveyed in 2003 reported there were no differences in delivery systems between their Medicaid and SCHIP programs. The remaining one-third of program administrators reported differences between delivery systems related to (1) using primary care case management in Medicaid but not SCHIP, (2) using different networks in the two programs, and (3) using fee-for-service in one program and capitated payment in the other. Differences in service delivery systems reported by program administrators are shown in Appendix A, Table A.3.

Most States Adopted Cost Sharing and Waiting Periods

Many states adopted cost sharing in SCHIP.[14] In most of the study states, case study respondents reported that cost sharing was viewed as a positive feature of SCHIP by many constituencies—including advocates for families. Consistently, case study respondents, who were interviewed between May 2001 and January 2002, described premium and copayment amounts as reasonable and affordable. However, cost sharing has been an area of program design that has been modified in a number of states as programs gained experience. (For example, Texas introduced, but subsequently dropped, deductibles, and Colorado introduced premiums, but subsequently replaced them with annual enrollment fees.) Cost-sharing policies in the 10 states are shown in Table 6. Compared with states nationwide, the 10 states were somewhat more likely to adopt premiums, copayments and annual enrollment fees.

Nationwide, cost sharing was widely adopted. By 2003, two-thirds of state program administrators with separate or combination state programs reported that their programs required premiums; one in six used annual fees; and one-half of the programs used copayments. Many states varied premium and copayment requirements by income level. In addition, some states

[14]Cost sharing is permitted up to a statutory limit of five percent of a family's annual income, and with the requirement that lower-income families may not have greater cost-sharing burdens than higher-income families. For children in families whose incomes are below 150 percent of the federal poverty level, even more rigorous protections exist. Cost sharing is not permitted for immunizations, well-baby and well-child care services, or preventive dental care.

adopted Medicaid expansions under Section 1115 demonstrations that permitted them to include cost sharing (such as Missouri, one of the 10 study states).

Table 6. Cost Sharing in the Study States, 2002

State	Annual Fees	Exceptions[b]	Premiums	Exceptions[b]	Co-payments	Exceptions[b,c]
California[a]	No	--	Yes	None	Yes	None
Colorado	Yes	Under 150% FPL	No	--	Yes	Under 100% FPL
Florida[a]	No	--	Yes	None	Yes	Medikids and CMS[d]
Illinois[a]	No	--	Yes	Under 150% FPL	Yes	Under 133% FPL
Louisiana[e]	No	--	No	--	No	--
Missouri	No	--	Yes	Under 225% FPL	Yes	Under 185% FPL
New Jersey[a]	No	--	Yes	Under 150% FPL	Yes	Under 150% FPL
New York[a]	No	--	Yes	Under 160% FPL	No	--
North Carolina	Yes	Under 150% FPL	No	--	Yes	Under 150% FPL
Texas	Yes	Under 150% FPL	Yes	Under 150% FPL	Yes	None
Number of States with Policy	**3**		**7**		**8**	

SOURCE: Case studies of 10 study states, 2001, documented in Hill et al. 2003.

NOTES: Among the 34 states (other than the 10 study states) whose administrators responded to the administrator survey, 3 used annual fees, 17 used premiums, and 16 used copayments.

Medicaid expansions may not include cost sharing unless the program is implemented under a Section 1115 demonstration that includes a waiver of cost-sharing prohibitions. In states with combination programs, the information in the table applies only to the separate state program.

[a]For these states, the information shown is for the separate program only.

[b]Exceptions to the policy apply to families meeting the criterion.

[c]Exceptions sometimes vary across services; when this is the case, the lowest limit is cited.

[d]Florida's SCHIP program (KidCare) includes three separate components (and a Medicaid expansion). Copayments are required in Healthy Kids but not in MediKids or Children's Medical Services.

[e]As a Medicaid expansion state without a Medicaid Section 1115 demonstration, Louisiana could not require cost sharing.

FPL = Federal Poverty Level.

CMS = Children's Medical Services Network.

When designing their SCHIP programs, many policymakers were concerned that government-sponsored health insurance would substitute for existing employer-based coverage—a phenomenon known as "crowd out." The statute required the states to ensure that the insurance provided under the state child health plan does not substitute for coverage under group health plans, and permitted, though did not require, waiting periods for children dropping employer coverage before they could enroll in SCHIP.[15] The final SCHIP regulations define procedures that states are required to implement to monitor and prevent substitution.[16] In the

[15]States are required to include "a description of procedures to be used to ensure….that the insurance provided under the State child health plan does not substitute for coverage under group health plans" [42 U.S.C. 1397bb § 2102 (b)(3)(C)].

[16]States that provide coverage to children in families with incomes at or below 200 percent of the FPL must have in place procedures to monitor the extent of substitution of SCHIP coverage for existing private coverage. States that cover children in families with incomes over 200 percent of the FPL must evaluate the incidence of substitution, and must identify in their state plans strategies to limit substitution that should be implemented should

study states, 6 of 10 introduced a waiting period as a "crowd-out" prevention strategy. This and other policies that had a bearing on "crowd out" are summarized in Table 7. Nationwide, nearly 40 percent of state program administrators reported in 2003 that "crowd-out" prevention was a concern when they designed their programs. Furthermore, 70 percent of state program administrators indicated that they used a waiting period as a strategy to limit "crowd out."

Table 7. State SCHIP Policies Affecting Substitution, 2002

State	Waiting Period (in Months)	Monitoring	Application Questions	Imposing Obligations on Employers and/or Insurers	Other
California	3	x	x	x	
Colorado	3	x	x		Limitation of benefits package
Florida	0	x	x		"Open enrollment" period
Illinois	3	x	x		Premium assistance program
Louisiana	[b]	x	x		
Missouri[a]	6	x	x		Verifying insurance status against a database of private coverage/price quotes
New Jersey	6[c]	x	x		Limitation of benefits package Premium assistance program
New York	0	x	x		
North Carolina	[d]	x	x		
Texas	3	x	x		
Number States with Policy	**6**	**3**	**10**	**1**	**6**

SOURCE: Case studies of 10 study states, 2001 documented in Hill et al. 2003.

NOTES:

[a]Missouri received a waiver to allow it to apply a waiting period.

[b]Louisiana had a 3-month waiting period until January 2001.

[c]New Jersey had a 12-month waiting period until January 1999.

[d]North Carolina had a 2-month waiting period until January 2002 (during the first 6 months of the program, the waiting period was 6 months).

States with Separate Programs Experienced Challenges Coordinating SCHIP and Medicaid

States with separate child health programs, either alone or in combination with a Medicaid expansion program, reported challenges in coordinating SCHIP with Medicaid, especially in enrollment and retention. These challenges occurred because of lack of alignment of eligibility

(continued)

substitution exceed a predetermined trigger point. States providing SCHIP coverage to children with family incomes exceeding 250 percent of the FPL must have substitution strategies in addition to monitoring in place. (Federal Register/Vol. 66, No. 8/ Thursday, January 11, 2001/ Rules and Regulations, Page 2603.)

policies and application forms, and use of different administrative data processing systems that could result in interruptions in children's coverage. More than one-quarter of SCHIP program administrators surveyed nationwide in 2003 reported that creating seamless coverage was a priority, and more than one-quarter of this group reported they were trying to reduce barriers to seamless transition.

Because Medicaid expansion SCHIP programs are extensions of state Medicaid programs, no coordination between Medicaid and SCHIP is necessary. Children who experience a change in income eligibility transfer "seamlessly" from Medicaid to SCHIP, often without knowing they have switched.

Program Policies Have Changed in Response to Experience and Budget Constraints

During the first 3 or 4 years after implementation, there were widespread, planned expansions in eligibility levels, modifications to cost sharing, and attempts to streamline application and renewal processes. During this period, service delivery systems and benefits changed much less. When state budget shortfalls grew after 2001, states increasingly introduced changes to limit their SCHIP program costs. At the time of the program administrator survey in 2003, 39 percent of state program administrators reported that, in response to budget reductions, they had cut back on outreach, and 16 percent reported they had introduced or planned to introduce enrollment caps or enrollment limits (for example, by eliminating presumptive eligibility or reintroducing income verification). Nevertheless, SCHIP remains a program with a great deal of support, and states have maintained their programs even while facing budget cuts.

IV. SCHIP SERVES A DIVERSE POPULATION OF LOW-INCOME CHILDREN

SCHIP enrollees were from diverse demographic and family backgrounds and had a variety of health and medical needs. The survey of SCHIP enrollees in the study states showed that SCHIP served children of all ages, although most of them were of school age—almost one-half were aged 6 to 12 and one-third were aged 13 to 18 (only 19 percent were 5 years old or younger) (see Table 8). Part of the reason SCHIP enrolled a higher proportion of school-aged children is that children aged 5 years or younger are eligible for Medicaid at a higher income level than are older children; hence, younger children are more likely to be enrolled in Medicaid.[17]

A large proportion (49 percent) of the SCHIP enrollees in these 10 states were Hispanic. White children were the next most populous group at 32 percent, followed by black children at 12 percent, and Asian children at 6 percent. The high proportion of Hispanic children at least partly reflects the inclusion in this sample of the six states with the largest Hispanic populations (California, Texas, New York, Florida, Illinois, and New Jersey [Guzman 2001]). Almost one-half of the SCHIP enrollees in these 10 states had at least one foreign-born parent and more than 25 percent lived in families in which Spanish was the main language spoken at home. Another 5 percent lived in families in which the main language spoken at home was other than English or Spanish.

Children enrolled in SCHIP appeared to be relatively healthy, although 24 percent had elevated health care needs and 9 percent were reported to be in fair or poor health status (on a 5-point scale that rated health from excellent to poor). Their parents reported that 16 percent of the children had asthma and 7 percent had mental or emotional problems. Compared to estimates from the Current Population Survey on low-income children, SCHIP enrollees in these 10 states were more likely to be reported by their parents to be in poor or fair health. This is consistent with research suggesting that children with greater health needs enroll in public health insurance at higher rates than healthier children (Dubay et al. 2002; and Davidoff et al. 2003).

Two other notable characteristics of SCHIP enrollees in these 10 states are: first, 40 percent of the children had parents who had attended college and three-quarters had parents with at least a high school diploma or its equivalent—the General Equivalency Degree (GED). Second, SCHIP enrollees came largely from low-income working families. Two-thirds of SCHIP enrollees had family incomes below 150 percent of the federal poverty level and 92 percent of them had one or more working parents.

[17]This chapter draws on data presented in the detailed report on the analysis of the congressionally mandated surveys of SCHIP enrollees and disenrollees (Kenney, Trenholm, et al. 2005; see Chapter I, Kenney et al.).

Table 8. Characteristics of SCHIP Enrollees and Their Parents

Variable	Percent
Children's Characteristics	
Age of Child (in years)	
0 to 5	19
6 to 12	48
13 and older	33
Child's Race	
Hispanic/Latino	49
White	32
Black	12
Asian	6
All Other Races	2
Child's Health	
Child's Overall Health is Good or Excellent	91
Child Has an Elevated Health Care Need[a]	24
Child Has Asthma	16
Child Has Mental Health Condition	7
Parent's Characteristics	
Highest Education Level of Parent(s)	
No GED or high school diploma	25
GED or high school diploma	35
Some college or college degree[b]	40
At Least One Parent Employed in Past Year	92
At Least One Parent Foreign Born	46
Household Characteristics	
Main Language (Other than English) Spoken in Household	
Spanish	28
Other	5
Household Structure	
Two parents	58
One parent	35
One parent and step/other guardian	6
Other	1
Household Income, by FPL Range[c]	
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; GED = General Equivalency Diploma.

[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]Includes 2-year associate degree and trade school.

[c]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 enrollee populations vary across the 10 study states—which is not surprising, given the variability in the programs and populations across these states. For example, the proportion of Hispanic children in the survey sample varies widely—from less than 10 percent in Louisiana, Missouri, and North Carolina to more than 69 percent in California and Texas. (In these states, there are wide differences in the percentages of the *total* population that is Hispanic [Guzman 2001].) Black children make up less than 5 percent of SCHIP enrollees in California and Colorado, but 32 percent in North Carolina, and 48 percent in Louisiana—again consistent with the total Black population in these states. Finally, the reported proportion of SCHIP enrollees with elevated health care needs varied substantially across states, with more than 30 percent of children enrolled in SCHIP in Illinois, Louisiana, Missouri, and North Carolina having such needs, compared with only 20 percent of SCHIP enrollees in California.

V. SCHIP SERVES THE TARGET POPULATION OF LOW-INCOME, UNINSURED CHILDREN

SCHIP was intended to enroll the uninsured children of low-income working families who are not eligible for Medicaid and the program has been successful in doing so. However, from the outset, policymakers had concerns that some parents would bypass their employer-sponsored health coverage plans to enroll their children in SCHIP, thereby substituting a publicly funded program for private group coverage. In fact, the BBA required states to implement strategies to monitor and prevent such substitution (as discussed in Chapter III). Among the strategies adopted by the 10 study states were: asking if children had employer coverage when they applied for SCHIP, adopting waiting periods for children with employer coverage, and imposing premiums so that SCHIP was not entirely free to families (Table 7).[18]

This chapter assesses the extent to which SCHIP was serving the target population of low-income, uninsured children in the 10 study states in 2002. First, the chapter describes the health insurance children had during the 6 months before they enrolled in SCHIP. The chapter then goes on to explain how the study examined two forms of substitution of SCHIP for private coverage. First, the study measured substitution at the time of enrollment by determining the proportion of recent enrollees who moved from group or private coverage to SCHIP, but had the option of retaining this coverage. Second, the study measured *potential substitution* among enrollees who had been covered by SCHIP for at least 5 months. To do this, the study assessed the share of established SCHIP enrollees whose parents had employer coverage at the time of the survey and might have had an option of enrolling their children in this coverage. Finally, the chapter contrasts substitution in SCHIP and substitution in Medicaid in 2 of the 10 states.

The study developed two substitution estimates, one at the point when children enroll in SCHIP and the second after the children have been enrolled in SCHIP for a period of time. It should be noted that although the second estimate of substitution is based on availability of dependent coverage when children have been enrolled for 5 months, it is not known when parents received the offers of dependent coverage, which might have occurred before application to SCHIP, or at some point during the enrollment period. Also, many states seek information on parental and dependent coverage during the application process, and HHS and some states have developed policies to leverage this private coverage for the benefit of SCHIP enrollees.

It is critical to note that these estimates cannot be added together to provide an estimate of the percent of enrollees who ever substituted SCHIP for private group coverage. (To do this would require a longitudinal survey.)[19] Adding the two cross-sectional estimates would overstate substitution because there is overlap between the two. That is, some portion of the recent enrollees who voluntarily left private coverage retained or gained access to a parent's employer coverage after enrollment, but it is not known how large this overlap is. Due to this

[18]This chapter draws on data presented in the detailed report on the analysis of the congressionally mandated survey of SCHIP enrollees and disenrollees (Kenney, Trenholm et al. 2005; see Chapter VI, Sommers A., S. Zuckerman, and L. Dubay).

[19]A longitudinal survey would be required to create an estimate of substitution across the whole period of enrollment. Such a survey could track information on the child's coverage prior to enrollment, and parental coverage from the time a child enrolls until the child leaves SCHIP. With this approach, one could estimate the number of months each sampled enrollee substituted coverage relative to the total number of months each child was enrolled.

limitation, the estimates must be viewed simply as two cross-sectional perspectives of substitution, that should not be combined.

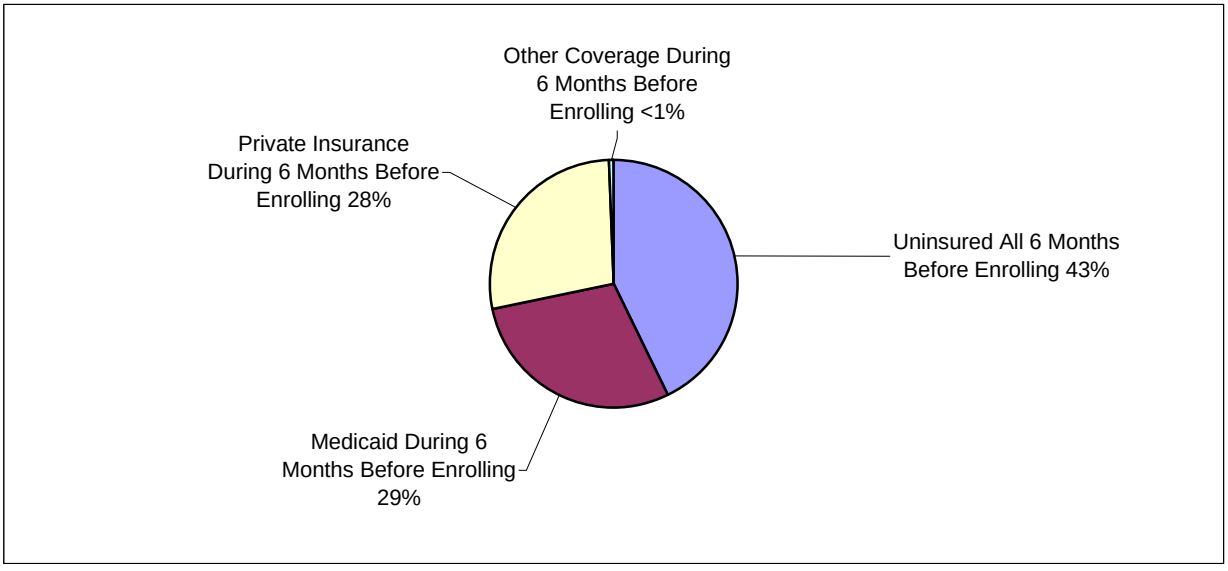
Most Children Enrolling in SCHIP Would Have Been Uninsured in the Absence of SCHIP

In the 10 study states, SCHIP is reaching many children who otherwise would have been uninsured. More than 40 percent of the children enrolling in SCHIP in 2002 had been uninsured for 6 months before they enrolled and another 29 percent had been enrolled in Medicaid for at least some of that 6-month period (Figure 1). If SCHIP had not been available, many of the children with Medicaid coverage would have been uninsured when that coverage ended. Twenty-eight percent of the children had private coverage (mostly through employers) at some point in the 6 months before they enrolled in SCHIP.

Table 9 shows that one-half of the 28 percent of children with private coverage (14 percent of all recent enrollees) lost their coverage involuntarily either because (1) their parent lost or changed jobs or their parent's employer dropped coverage, or (2) a change in family structure occurred (such as a death or a divorce). Therefore, this 14 percent of enrollees cannot be considered to have substituted SCHIP coverage for private coverage. In addition, one-quarter of all recent enrollees (8 percent of the total) cited lack of affordability as the reason for ending the child's private coverage. Some states (for example, Colorado and Texas), allow enrollment in SCHIP for income-eligible children in families with high-cost employer coverage. As shown in Table 9, substitution estimates range from 7 to 15 percent, depending on whether affordability is treated as a voluntary reason for dropping private coverage.

Some states exempt children from the waiting period requirements under certain conditions. Among our 6 study states with waiting periods, some, for example, Colorado and Texas, exempt children from the waiting period if they drop a high-cost employer plan, while others (for example, California and New Jersey, exempt children from the waiting period if they drop high-cost individual coverage).

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.

Table 9. Reasons Private Coverage Ended Among Recent Enrollees

Reason Coverage Ended	Loss of Coverage Was Voluntary or Involuntary	Percent of All Recent Enrollees	Total
Employment Change or Benefit Loss at Same Job	Involuntary	13%	14%
Loss of Parent or Family Structure Change	Involuntary	1	
Affordability	Could be considered voluntary, but depends on state policy	8	8
Prefers SCHIP or Dislikes Other Insurance	Voluntary	2	7
Miscellaneous	Voluntary	5	
Total		28	

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

NOTE: Miscellaneous category includes moved/relocated, wanted child to be insured, enrolled based on provider/agency recommendation, and other reasons with insufficient information to determine whether substitution played a role.

Across the 10 states, the extent to which recent SCHIP enrollees appeared to substitute SCHIP for private coverage varied. This variation can be attributed to two factors: differences in rates of private coverage in the 6 months before enrolling, and the reasons private coverage ended. The share of SCHIP enrollees who voluntarily dropped their private coverage (including those reporting that private coverage was not affordable) ranged from 7 percent in Illinois and Missouri to 19 percent in California. However, when affordability is not categorized as substitution, the share of SCHIP enrollees who dropped private coverage is 10 percent or less in all 10 states.

Some Children Stayed Enrolled in SCHIP While Potentially Eligible for Employer Coverage

This section assesses the extent of potential substitution (when children become eligible for employer coverage after they have enrolled in SCHIP and their parents forgo that coverage) by examining the share of established enrollees whose parents had employer coverage. The analysis assumes that if parents declined employer coverage (for any number of reasons), then such coverage would not be an option for their children in the absence of SCHIP.

Among children who had been enrolled in SCHIP for at least 5 months (established enrollees), 39 percent had parents covered by an employer plan (Table 10, row A.) Some of these employers made no contribution toward the parents' premiums. Because low-income families who have to pay the full premium are unlikely to be able to afford to cover their children as well, children from these families arguably should not be included in the estimate of families who would substitute SCHIP for employer coverage. After dropping this group (3 percent of SCHIP enrollees), the upper-bound estimate of potential substitution is 36 percent (Table 10, row C).

Table 10. Potential Substitution Estimates for SCHIP Enrollees in 10 States

	Aspects of Parent's Employer Coverage and Children's Needs	Percent with Characteristic	Substitution Estimate (percent)
A	Any Parent Has Employer Coverage	39.0%	
B	Employer Pays None of the Premium	3.3	
C	Substitution Estimate 1 (A-B) ***Employer Pays Some or All of the Premium***		35.7%
D	Employer Pays Some or All of the Premium and Child Has Elevated Health Care Needs	7.7	
E	Substitution Estimate 2 (C-D) ***Employer Pays Some or All of the Premium and the Child Does Not Have Elevated Health Care Needs***		28.0

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

This upper-bound estimate implicitly assumes that all parents whose employers paid some or all of their premiums would enroll their child in their employer plan if SCHIP did not exist, but there is no way of knowing the precise share who would enroll. However, concerns about potential substitution are not likely to be uniform within this group. For example, employers paying "some" of the premium may pay a large or small share of the total. Families with employers who pay a small proportion of the total premium also may not be able to afford to cover their children in the private plan.

Also, policymakers in some states (for example, North Carolina) make exceptions for children with significant health care needs. An alternative estimate of substitution could exclude such children. Table 10, row D shows that 7.7 percent of SCHIP enrollees have elevated health care needs and a parent with an employer who pays some or all of their premiums. Row E shows the lower-bound estimate of substitution of 28 percent, when these children are excluded.

Potential substitution of SCHIP for employer coverage after enrollment among established enrollees varies across the 10 study states. The range around the higher estimate of potential substitution (36 percent) shown in Table 10 is 18 percent (in New Jersey) to 47 percent (in North Carolina). The range around the lower estimate of potential substitution (28 percent) shown in Table 10 is 12 percent (in New Jersey) to 34 percent (in California). One reason New Jersey is consistently at the low end of the range of potential substitution is that more parents in New Jersey are covered by SCHIP (under a waiver program) and fewer have employer coverage.

Medicaid Enrollees Are Even Less Likely to Forgo Employer Group Coverage

Substitution of Medicaid for employer coverage is likely to be much lower than substitution of SCHIP for employer coverage because Medicaid uses lower income thresholds than SCHIP does. And, in the two study states where this outcome was examined, California and North Carolina, potential substitution was much lower among parents of Medicaid enrollees than among parents of SCHIP enrollees. Table 11 shows estimates of potential substitution among

Medicaid and SCHIP enrollees in California and North Carolina using the same approach described for SCHIP. As expected, the rates of employer coverage among parents of Medicaid enrollees were much lower than among parents of SCHIP enrollees. In California, the percentage of Medicaid parents with employer coverage was 10 percent compared to 43 percent for parents of SCHIP enrollees. In North Carolina, the percentage of Medicaid parents with employer coverage was 18 percent, compared to 51 percent of parents of SCHIP enrollees. Potential substitution among Medicaid enrollees was only 8 to 10 percent in California and 11 to 15 percent in North Carolina, compared with ranges for current SCHIP enrollees of 34 to 40 percent in California and 35 to 46 percent in North Carolina.

Table 11. Potential Substitution Among Medicaid and SCHIP Enrollees in Two States

		California		North Carolina	
	Aspects of Parent's Employer Coverage and Children's Needs	Medicaid	SCHIP	Medicaid	SCHIP
A	Any Parent Has Employer Coverage	10.4%	42.5%	17.8%	51.1%
B	Employer Pays None of the Premium	0.0	2.9	2.8	5.3
C	Substitution Estimate 1 (A-B) ***Employer Pays Some or All of the Premium***	10.4	39.6	15.0	45.8
D	Employer Pays Some or All of the Premium and Child Has Elevated Health Care Needs	2.5	5.7	4.2	11.3
E	Substitution Estimate 2 (C-D) ***Employer Pays Some or All of the Premium and the Child Does Not Have Elevated Health Care Needs***	7.9	33.9	10.8	34.5

SOURCES: 2002 congressionally mandated survey of SCHIP enrollees in 10 states and Medicaid enrollees in 2 states.

VI. SCHIP AND MEDICAID ENROLLMENT BENEFIT CHILDREN AND THEIR FAMILIES

It is important to assess the extent to which SCHIP programs are providing access to the primary health care services that children need. To meet the health care needs of children, SCHIP programs chose fairly comprehensive benefit packages, imposed modest copayments for services, and established broad service delivery networks. In this section, the report examines the measures of access to care that include: receipt of preventive care, mental health care and other services; parental perceptions about their ability to meet their child's health care needs; the presence and type of usual source of care; and unmet needs. Also described are access differences across subpopulations, such as ethnic minorities and children with elevated health care needs, and an assessment of how cost sharing may affect service use. Subsequent sections examine the impacts of SCHIP on access to care for the children who enroll and present access estimates for two Medicaid programs.[20]

Most Children on SCHIP Have Regular Access to Health Care, Although a Few Areas Could Be Improved

By and large, it appears that SCHIP programs are successfully meeting the primary health care needs of most of the children who enroll. SCHIP enrollees enjoy high levels of access across a wide range of different measures, but there are areas within the program that could be improved (Table 12).

Service Use. Two-thirds of SCHIP enrollees had seen a doctor or other health professional in the past 6 months, and nearly one-half had received a well-child visit. Additionally, more than one-half had had a dental checkup or cleaning.

Unmet Needs. Fewer than 20 percent of SCHIP enrollees had an unmet need for any type of care and 3 percent had more than one unmet need. The principal factor driving this rate was that 12 percent reported unmet need for dental care.[21] About one in ten SCHIP enrollees had at least one reported unmet need for prescription drugs, specialty care, physician services, or hospital care.

Parental Perceptions. More than three-quarters of SCHIP enrollees' parents were confident they could meet their child's healthcare needs, were never or not often stressed about meeting their needs, and never, or rarely, had financial difficulties meeting their children's needs. Additionally, the parents of more than 80 percent of enrollees believe that children with SCHIP coverage get better care than children who are uninsured, and fewer than 20 percent believe that providers "look down on" SCHIP enrollees.

[20]This chapter draws on data presented in the detailed report on the analysis of the congressionally mandated survey of SCHIP enrollees and disenrollees (Kenney, Trenholm et al. 2005; see Chapters III [G. Kenney, J. Rubenstein, A. Sommers, and G. Ko], VII [G. Kenney], and VIII [G. Kenney, J. Rubenstein, A. Sommers, S. Zuckerman, M. Kim, and F. Blavin]).

[21]Dental benefits are optional in SCHIP.

Table 12. Parents' 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 estmimate 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.

Usual Source of Care. More than 90 percent of SCHIP enrollees had a usual source of care, and of these, almost two-thirds went to a private doctor's office or group practice, and 72 percent usually saw the same provider at their usual source of care. Over three-quarters had a usual source of dental care.

Provider Communications and Accessibility. Communication with physicians was very good—almost 90 percent said they could understand the explanations providers gave, and three-quarters could reach their doctor after hours. Moreover, 84 percent reported that travel time to the provider was less than 30 minutes.

Access to Care Under SCHIP is Better for Some Enrollees than for Others

It appears that overall SCHIP is providing high levels of access to care, but that some groups of children have better access than others. For example, access and use varied with respect to the child's race/ethnicity and primary language, age, health needs, and the parent's educational attainment. Table 13 shows differences in selected access measures across subgroups controlling for selected individual and family characteristics. These outcomes were selected from the over 30 possible outcomes either because they are important markers for primary health care (for example, whether the child had received a preventive visit, whether the child had a usual source for health care, whether the parent feels confident that their child can get needed health care, and whether the child had any unmet need for health or dental care) or because they reflect different provider characteristics (for example, whether the child's usual source of care is a private doctor's office and whether the provider explained things in understandable ways). (For the full results on all outcomes, see Chapter III of Kenney, Trenholm et al. 2005.) Many of the access differentials identified below have been found in other studies and are not unique to SCHIP. However, addressing these differentials may allow more enrollees to take full advantage of the health care offered through SCHIP.

Race/Ethnicity and Language. Relative to white enrollees, Hispanic enrollees whose primary language is Spanish were less likely to have a private doctor's office for their usual source of care, and their parents were more likely to be concerned about their ability to meet their children's health care needs and to report more communication and accessibility problems with providers. When there were differences between Hispanic and white children, the differences tended to be smaller for Hispanic children whose primary household language was English than for those whose primary household language was Spanish. For example, other things being equal, relative to white children, Hispanic children with English as their primary language were 9 percentage points less likely to have parents who felt confident that they could meet their child's health care needs, while those with Spanish as their primary language were 14 percentage points less likely to have parents who felt confident about their ability to meet their child's needs.

Age. Service use patterns varied with the age of the child in ways that reflect the changing types of care children need as they grow and develop. The recommended rate at which children should receive well-child check-ups varies by age, with more frequent visits recommended for younger children than for adolescents. Thus, lower rates of preventive visits among older children should not necessarily be interpreted as problematic. However, it appears that

Table 13. Variation in Selected Access Measures Under SCHIP, by Child and Parent Characteristics

Characteristic	Percent of Parent's Reporting for the Past 6 Months: Child Had a Preventive Visit	Parent Confident Child Could Get Needed Health Care	Child Had a Usual Source of Care	USC Type: Private Doctor's Office	Providers Explain in Understandable Ways	Child Had an Unmet Need for Care
All SCHIP Enrollees	45%	81%	91%	64%	89%	18%
Race/Ethnicity and Language						
Hispanic						
English Language	46	80**	92	66**	90	17
Spanish Language	46	75**	92	49**	82**	23*
Non-Hispanic						
English-Speaking						
White	*44*	*89*	*94*	*76*	*94*	*18*
Black	52**	85	90*	64**	94	15
Non-English-Speaking	41	62**	75**	69	77*	13
Age of Child						
0 to 5 years	57**	82	94	66	89	17
6 to 12 Years	*43*	*81*	*91*	*64*	*89*	*17*
13 to 18 Years	42	81	91	64	90	22**
Highest Education of Parents						
Less than High School	*37*	*77*	*90*	*57*	*85*	*20*
High School	47**	83*	91	67**	89	16
More than High School	49**	83*	94	67**	91*	20
Health Status of Child						
Without Elevated Health Care Needs	*44*	*82*	*91*	*65*	*90*	*16*
With Elevated Health Care Needs	51**	78*	94**	63	87	26**

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

NOTES: Tests of significance compare children with this characteristic to the reference category (in italics). Based on multivariate analyses controlling for observed characteristics of enrollees and their families.

**p-value (of difference) < .01 level; *p-value (of difference) < .05 level.

adolescents had more unmet needs than younger children. The share with unmet needs was about 5 percentage points higher among children aged 13 to 18 years compared to younger children.

Parent's Education. SCHIP enrollees whose parents had more education fare better in SCHIP. They were more likely to receive preventive and other types of health care, their parents had fewer concerns about meeting their child's health care needs, and they appear to have providers that are more accessible. For example, enrollees whose parents had not completed high school were 12 percentage points less likely to have had a preventive health visit in the past 6 months and 6 percentage points less likely to have providers who explain things in understandable ways relative to enrollees whose parents had some college education.

Health Status. SCHIP enrollees with elevated health needs were, not surprisingly, more likely to receive preventive visits, specialty care, and other types of health care. However, they experienced more unmet needs than other enrollees. Also, their parents reported greater levels of worry and financial difficulty associated with meeting their child's needs. For example, they were 10 percentage points more likely to have an unmet health need and their parents were four percentage points less likely to be confident that they could meet their child's health care needs.

SCHIP Access Measures Vary Little Across States

Variation in access and use among SCHIP enrollees across states was limited to a handful of measures. The predominant pattern was similarity across states, not differences. For most measures, three or fewer states differed from the other states, but there were a few areas for which six or more states differed from the other states.[22] These areas were: type of usual source of care, travel times to the usual source of care, dental care, and parents' perceptions of SCHIP programs. Cross-state variation in a selection of these measures is illustrated in Table 14.

There is considerable variability across states in the type of provider on which enrollees rely for their usual source of care, other things equal. For example, SCHIP enrollees in Florida and New Jersey are about 34 percentage points more likely than enrollees in Colorado to rely on a private doctor's office or group practice as their usual source of care. For the preventive measure of having a dental checkup in the past 6 months, there was less variability across states (the difference between the state with enrollees who used preventive dental care the most compared with the state with enrollees who used preventive dental care the least was 17 percentage points) even though dental care is an optional benefit in SCHIP. While in all states fewer than one-third of parents believed providers "look down on" SCHIP enrollees, families in the four states with a Medicaid expansion or a combination program were more likely than families in states that relied on a separate SCHIP program to believe that providers "look down on" them.

[22]For each measure, we tested whether a given state had an outcome that was different from the nine other states at the .01 and .05 levels of significance, controlling for characteristics of the enrollee populations in each state.

Table 14. Variation in Selected Measures of Access and Use Under SCHIP, by State

State	Percent of Parents Reporting for the Past 6 Months: Usual Source of Care Is a Private Doctor's Office	Preventive Dental Visits	Parents Report Providers Look Down on SCHIP Enrollees
Separate Programs	%	%	%
California	55 **	65 **	18
Colorado	43 **	51 *	15 *
Florida	77 **	52 *	16
New York	67	60	12 **
North Carolina	65	65 **	17
Texas	67	55	18
Combination Programs			
Illinois	55 **	56	26 **
New Jersey	77 **	54	32 **
Medicaid Programs			
Louisiana	72	50 *	24 *
Missouri	66	48 **	27 **
All SCHIP Enrollees	**65**	**58**	**18**

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

NOTES: Tests of significance compare each state to the mean of all other states. Based on multivariate analyses controlling for characteristics of enrollees and their families.

** p-value (of difference) < .01 level;* p-value (of difference) < .05 level.

SCHIP Improves Access to Health Care Services for Children Who Enroll

A yardstick by which SCHIP may be measured is how much it improves children's access to and receipt of care. SCHIP is expected to lower the costs and other barriers associated with obtaining care for children, particularly relative to being uninsured. Thus, SCHIP is expected to increase enrollees' access to health care. This section presents an assessment of SCHIP impacts in the 10 study states by contrasting the experiences of established enrollees who had been in the program for at least five months, to the pre-SCHIP experiences of a separate sample of recent enrollees, controlling for a number of possibly confounding factors, as illustrated in the matrix that follows.[23,24]

[23]This approach is a variant on one used by Lave et al. 1998, Szilagyi et al. 2000, Damiano et al. 2003, and Dick et al. 2004.

[24]The estimates were subjected to many sensitivity tests because of concerns about the validity of the impact estimates. In particular, there is a concern that the experiences children have just prior to enrolling are atypical, and that the recent and established enrollee samples are not comparable. We found that the results were extremely robust to all the alternative models that were estimated.

How Impacts of SCHIP on Access of Enrollees Were Estimated:	
Survey Samples Compared:	**Access Periods Compared:**
Established enrollees (children enrolled in SCHIP for 5 months or more at the time they were sampled)	Access during the 6 months before the interview (during which they were enrolled in SCHIP)
↓	↓
Compared to	**Compared to**
↓	↓
Recent enrollees (children who were enrolled in SCHIP for only 1 or 2 months at the time they were sampled)	Access during the 6 month period before they enrolled in SCHIP

The comparison group of recent enrollees was further classified into two groups: those who were uninsured for the entire 6 months before they enrolled, and those who had insurance at some point during the 6 months, and estimates were computed for each group. A selection of these estimates of SCHIP impact on access, service use, unmet needs and parental attitudes is presented in Table 15. Estimates for established enrollees are shown relative to both recent enrollee groups.

Findings from the impact analysis suggest that SCHIP programs are having positive impacts on the lives of the children who enroll and on their families. SCHIP appears to improve health care access along a large number of dimensions, particularly relative to being uninsured.

Beneficial impacts were found with respect to many measures of service use, unmet needs, stress and financial burden, and provider accessibility and communication.[25] Other things equal, relative to the experiences children had prior to enrolling in SCHIP, established SCHIP enrollees are

- More likely to receive preventive dental care and to have parents who have confidence in their ability to meet their child's health care needs, more likely to have a usual source for medical care, to see the same provider when they go for care, and to have a usual source for dental care;
- More likely to rely on a private physician or group practice than a clinic or health center, to rate the care they receive as excellent or very good, to have providers they can reach after hours, to have short waits (of 30 minutes or less) when they go for appointments and short travel times (of 30 minutes or less); and
- Less likely to have unmet needs for physician services, prescription drugs, dental care, specialty care and less likely to have parents who say that meeting their child's needs causes stress, financial burden, or worry.

[25]Additional estimates (not shown) of children with private insurance coverage in the 6 months before they enrolled in SCHIP found that SCHIP enrollees had better experiences for a few measures than children with private coverage for all 6 months before enrolling (though the sizes of the impacts were smaller than for uninsured children).

Table 15. Impact of SCHIP on Measures of Access, Use, and Parental Perceptions

Reports for the Past 6 Months	Percentage Difference Between Established SCHIP Enrollees Compared to: Uninsured Children Who Subsequently Enroll[a]	Insured Children Who Subsequently Enroll[b]
Service Use Based on Parent's Report		
Any Doctor/Other Health Professional Visit	7 **	-8 **
Any Preventive Care or Check-Up Visit	11 **	-10 **
Any Dental Visit for Checkup/Cleaning[c]	25 **	-2
Any Specialist Visit	4 *	-1
Any Mental Health Visit	1	0
Any Specialist or Mental Health Visit	4 *	-1
Any Emergency Room Visit	-7 **	-12 **
Any Hospital Stay	1	-1
Unmet Needs Based on Parent's Assessment		
Doctor/Health Professional Care	-6 **	-1
Prescription Drugs	-6 **	-1
Specialist	-6 **	-1
Hospital Care	-6 **	-2 *
Any Unmet Need (Excluding Dental Care)	-12 **	-4 *
Dental Care[c]	-11 **	-4 *
Any Unmet Need (Including Dental Care)[d]	-13 **	-4 *
More than One Unmet Need	-10 **	-2 *
Parental Perceptions About Meeting Child's Healthcare Needs		
Very Confident Could Get Needed Health Care for Child	43 **	24 **
Never or Not Very Often Stressed about Meeting Child's Health Care Needs	40 **	16 **
Never or Rarely Worried about Meeting Child's Health Care Needs	33 **	16 **
Meeting Child's Health Care Needs Never or Rarely Causes Financial Difficulties	39 **	23 **
Usual Source of Care (USC) Based on Parent's Report		
Had USC in Past 6 Months	21 **	1
USC Type: Private Doctor's Office/Group Practice	12 **	0
Usually Saw Same Provider at USC	23 **	-2
Had USC for Dental Care in Past 6 Months[c]	31 **	8 **
Provider Communication and Accessibility Based on Parent's Report		
Would Recommend USC	3	-1
Could Reach Doctor After Hours	16 **	0
Providers Explain in Understandable Ways	6 *	-1
Provider Treats with Courtesy/Respect	2	-1
Provider Talks About How Child Feeling	3	-1
Rated Ease of Getting Care Excellent or Very Good	17 **	1
Wait Time for Care Less than 30 Minutes	9 **	0
Travel Time to USC Less than 30 Minutes	7 **	2

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

NOTES: Impacts reflect the difference in percentage points between established enrollees and recent enrollees. For example, established SCHIP enrollees are 7 percentage points more likely than uninsured children and 6 percentage points less likely than insured children who subsequently enrolled to have a doctor/other health professional visit. Tests of significance compare established enrollee sample with each of the two recent enrollee samples, based on multivariate analyses controlling for observed characteristics of enrollees and their families.

[a]Includes those uninsured all 6 months before enrolling.

[b]Includes those insured some or all of the 6 months before enrolling.

[c]Applies to children age 3 and older.

[d]This is any 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.

** p-value (of difference) < .01 level; * p-value (of difference) < .05 level.

Not surprisingly, greater improvements under SCHIP were found relative to children who had been uninsured for the full six months prior to enrolling in SCHIP. The findings reported are from models that combined all 10 states, but separate models estimated for each state produced very similar patterns, as did separate models for different subgroups of enrollees. Thus, it appears that SCHIP benefits children and families with different backgrounds and health care needs in diverse SCHIP programs that serve different types of enrollees in different health care environments.

Service Use. SCHIP enrollees were more likely to receive doctor visits, preventive medical and dental checkups, and specialist or mental health services than children who had no insurance in the 6 months before they enrolled (Table 15). However, compared to children with some insurance before they enrolled (one-half had Medicaid, and one-half had private coverage), SCHIP enrollees were less likely to have had a doctor visit or a preventive medical check up.

Unmet Needs. SCHIP enrollees had fewer unmet needs than both recent enrollees who had been uninsured and those who had had coverage before enrolling. For example, SCHIP enrollees were 13 percentage points less likely than the uninsured recent enrollees to have unmet needs for one or more of the following services: hospital, specialist, doctor, prescription drugs, or dental care. Moreover, there were significant differences between SCHIP enrollees and the two comparison groups for most of the components of unmet needs.

Parental Perceptions. The parents of SCHIP enrollees felt substantially more confident and less worried about being able to meet their child's health care needs compared to the pre-SCHIP experiences of recent enrollees. There were large and significant differences in parental confidence that they could meet their child's health needs, in the rate of being worried and stressed about meeting their child's health care needs, and in the frequency of having financial difficulties meeting their child's health care needs. For example, the parents of established enrollees were 43 percentage points more likely to feel confident about their ability to meet their child's health care needs relative to the parents of the uninsured recent SCHIP enrollees. Parents of SCHIP enrollees also had more positive perceptions about their ability to meet their child's health care needs compared to the parents of recent enrollees who had insurance for some or all of the 6 months before enrolling in SCHIP. In particular, parents of SCHIP enrollees were 20 percentage points more likely to feel confident about being able to meet their child's health care needs and 26 percentage points more likely to say that meeting their child's health care needs never or rarely caused financial difficulties relative to the parents of recent enrollees who had private coverage for the 6 months before enrolling in SCHIP (see Kenney Trenholm et al. 2005) see Chapter VII, Kenney G.[26]

Usual Source of Care. SCHIP enrollees were more likely than recent enrollees who had been uninsured to have usual sources for both medical and dental care. For example, established SCHIP enrollees were 21 percentage points more likely to have a usual source for medical care and 31 percentage points more likely to have a usual source for dental care compared to the

[26]Differences in parental perceptions between established SCHIP enrollees and recent enrollees with any coverage during the six months before enrolling in SCHIP were greatest among recent enrollees who were uninsured for some of the six months before enrolling and smallest among recent enrollees who were covered by Medicaid for the six months before enrolling in SCHIP (data not shown.)

recent enrollees who were uninsured for the 6-month period before they enrolled. While there was no difference between established SCHIP enrollees and recently insured enrollees, in terms of the presence of a usual source for health care, established SCHIP enrollees were 8 percentage points more likely to have had a usual source for dental care.

Provider Communication and Accessibility. SCHIP enrollees appear to have fewer accessibility and communication problems with providers than the recent enrollees who were uninsured. For example, established enrollees were 16 percentage points more likely to have providers who could be reached after hours. Also, they were 9 percentage points more likely to have travel times to their usual source of care that were under 30 minutes, compared to children who were uninsured for all 6 months before enrolling in SCHIP. There were no significant differences in terms of provider communication and accessibility between the established SCHIP enrollees and the recent enrollees who had been insured prior to enrolling.

SCHIP Impacts for Enrollee Subgroups. Positive impacts were found for each different subgroup that was examined. Separate models were estimated for subgroups defined by the child's race/ethnicity/language grouping, age, health care needs, and the parents' educational attainment (data not shown). However, larger impacts were found among children with elevated health care needs and for adolescents, while smaller improvements were found for children whose parents had not completed high school (data not shown). Larger, positive impacts of SCHIP enrollment were found for adolescents than for younger children in terms of parental perceptions about their ability to meet their child's needs and the presence of a usual source of care and usual provider. In addition, while SCHIP enrollees whose parents had not completed high school benefited from their SCHIP enrollment, the gains were smaller than for children whose parents had more education. SCHIP improved access to care across a number of measures for all racial and ethnic groups. For example, the evaluation found that established SCHIP enrollees in each of four subgroups that were studied—white, black, English-speaking Hispanic, and Spanish-speaking Hispanic were less likely to have unmet needs compared to the experiences their uninsured counterparts had before enrolling in SCHIP. However, similar to the findings from the Children's Health Insurance Research Initiative (Dick et al. 2004), the evaluation did not find that racial disparities in access were eliminated. Finally, while enrollees with elevated health care needs were more likely than other children to have unmet health needs, they experienced larger reductions in unmet needs after enrolling in SCHIP, compared to children in better health.

Medicaid Also Improves Access to Care for Children Who Enroll

A parallel study of Medicaid impacts on access to care in two states (California and North Carolina) found similar results to those found for SCHIP. The results indicate that established Medicaid enrollees are better off compared to the experiences that recent Medicaid enrollees had before enrolling (Table 16). However, the impacts of Medicaid were, as with SCHIP impacts, more pronounced relative to children who had been uninsured for the entire 6-month period before they enrolled in Medicaid than for children who had been insured for some or all of the 6 months prior to enrolling. For example, established Medicaid enrollees were 12 percentage points less likely than uninsured recent enrollees to have had an unmet dental need, and over 28 percentage points more likely to have had a usual source for both medical and dental care.

Access Levels in Medicaid Are Comparable to SCHIP for Most Measures

Other things being equal, SCHIP and Medicaid provided comparable levels of access to care in California and North Carolina for most access measures, although Medicaid enrollees had a lower level of access to dental care than did SCHIP enrollees, and their parents had less positive views about their health insurance program than did the parents of SCHIP enrollees (data not shown). For example, in California, Medicaid enrollees were 8 percentage points less likely to have had a preventive dental visit than SCHIP enrollees, and in North Carolina the difference was 14 percentage points. Parents of children enrolled in Medicaid were more likely than those whose children were enrolled in the separate SCHIP program to believe that providers "look down on" people in their program (a difference of 13 and 15 percentage points in North Carolina and California, respectively). In California, Medicaid enrollees were more reliant on emergency room care than were SCHIP enrollees, but no similar pattern was found in North Carolina.

Table 16. Impact of Medicaid on Measures of Access, Use, and Parental Perceptions in California and North Carolina

Reports for the Past 6 Months	Percentage Difference Between Established Medicaid Enrollees Compared to: Uninsured Children Who Subsequently Enroll[a]		Insured Children Who Subsequently Enroll[b]	
Service Use Based on Parent's Report				
Any Doctor/Other Health Professional Visit	8		-10	*
Any Preventive Care or Check-Up Visit	7		-12	*
Any Dental Visit for Checkup/Cleaning[c]	17	**	6	
Any Specialist Visit	3		0	
Any Mental Health Visit	2		1	
Any Specialist or Mental Health Visit	4		1	
Any Emergency Room Visit	5		8	
Any Hospital Stay	-2		-2	
Unmet Needs Based on Parent's Report				
Doctor/Health Professional Care	-6	**	1	
Prescription Drugs	-2		3	
Specialist	2		-2	
Hospital Care	-3		-1	
Any Unmet Need (Excluding Dental)	-6		3	
Dental Care[c]	-12	**	-7	
Any Unmet Need (Including Dental)[d]	-13	**	1	
More than One Unmet Need	-6	*	-2	
Parental Perceptions About Meeting Child's Healthcare Needs				
Very Confident Could Get Needed Health Care for Child	32	***	9	
Never or Not Very Often Stressed about Meeting Child's Health Care Needs	27	***	9	
Never or Rarely Worried about Meeting Child's Health Care Needs	23	***	7	
Meeting Child's Health Care Needs Never or Rarely Causes Financial Difficulties	26	***	23	***
Usual Source of Care (USC) Based on Parent's Report				
Had USC in Past 6 Months	28	***	4	
USC Type: Private Doctor's Office/Group Practice	19	***	2	
Had USC for Dental Care in Past 6 Months[c]	30	***	2	
Usually Saw Same Provider at USC	24	***	8	
Provider Communication and Accessibility Based on Parent's Report				
Would Recommend USC	7		2	
Could Reach Doctor After Hours	8		-6	
Providers Explain in Understandable Ways	4		-1	
Provider Treats with Courtesy/Respect	-7		-2	
Provider Talks About How Child Feeling	9		5	
Rated Ease of Getting Care Excellent or Very Good	11	*	5	
Wait Time for Care Less than 30 Minutes	9		-3	
Travel Time to USC Less than 30 Minutes	9		2	

SOURCE: 2002 congressionally mandated survey of SCHIP enrollees in 10 states and Medicaid enrollees in 2 states.

NOTES: Impacts shown reflect the difference in percentage points between established enrollees and recent enrollees. Tests of significance compare established enrollee sample with each of the two recent enrollee samples, based on on multivariate analyses controlling for observed characteristics of enrollees and their families.

[a]Includes those uninsured all 6 months before enrolling.

[b]Includes those insured some or all of the 6 months before enrolling.

[c]Applies to children age 3 and older.

[d]Includes any unmet need for physician, drug, specialist, hospital, or dental care. It applies to children age 3 and older.

***p-value (of difference) < .01 level; **p-value (of difference) <.05 level; *p-value (of difference) <.10 level.

VII. MOST FAMILIES FOUND IT EASY TO APPLY FOR SCHIP THOUGH MANY LOW-INCOME FAMILIES FACED ENROLLMENT BARRIERS

To enjoy the benefits of SCHIP, families need to enroll their children and keep them in the program a reasonable length of time. Using data from a 2001 nationwide survey, this chapter reviews low-income, uninsured families' awareness and perceptions of the SCHIP and Medicaid programs. The chapter goes on to discuss the experiences families had enrolling their children in SCHIP (and Medicaid), drawing on the information from surveys of recent SCHIP and Medicaid enrollees.[27]

Many Low-Income Families Face Barriers to Enrolling Their Children in SCHIP and Medicaid

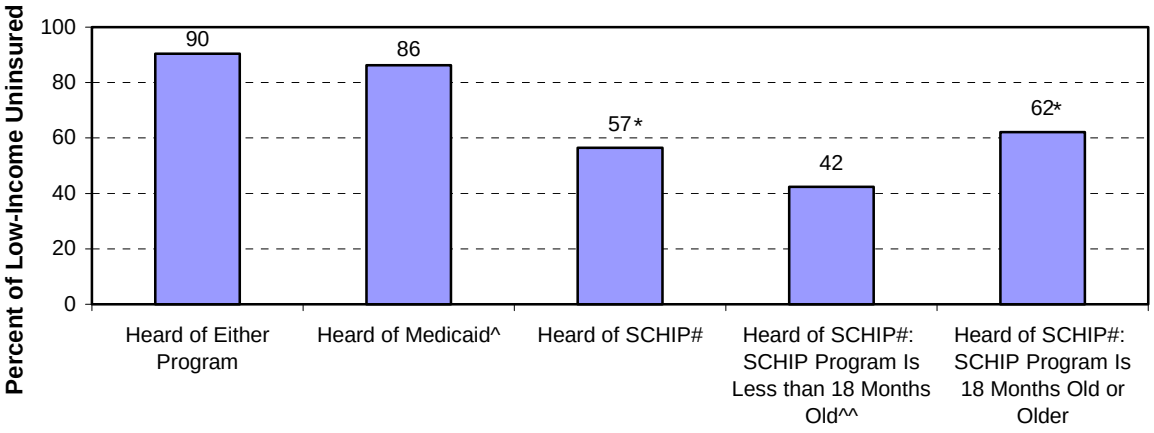
The first barrier parents faced in enrolling their children in SCHIP or Medicaid was not knowing about the program. Just over one-half (57 percent) of the parents of low-income, uninsured children included in the 2001 survey were aware of the separate SCHIP program in their state, leaving nearly one-half unaware of the program (Figure 2). Far more parents (86 percent) were aware of the Medicaid program, which has been in existence considerably longer than SCHIP. In addition, awareness of the SCHIP programs that had been operating for 18 months or more was greater than the awareness of those operating for less than 18 months (62 percent compared to 42 percent). Given that few years have passed since these data were collected, it is possible that awareness of SCHIP programs has increased beyond the levels reported here.

A second potential barrier to families enrolling a child in SCHIP (or Medicaid) was not knowing who is eligible for the program. Many parents with low-income, uninsured children surveyed in 2001 did not think their child was eligible for coverage through Medicaid or SCHIP. As shown in Figure 3, fewer than one-half of the parents of low-income, uninsured children (children in families with incomes below 200 percent of the federal poverty level) believed their child was eligible for SCHIP. Even fewer parents of white children, adolescents, children from families with incomes close to 200 percent of the federal poverty level, as well as parents of Hispanic children who were interviewed in Spanish, believed their child was eligible for SCHIP (data not shown).

Interest in enrolling children in Medicaid and SCHIP was high among the parents of low-income, uninsured children. Many of these parents (84 percent) would enroll their child if told the child was eligible. Moreover, interest in enrolling their child was high across different population subgroups (above 75 percent for each group examined), and interest was even higher among the poorest families, in families with black and Hispanic children, and for children with special health care needs.

[27]This chapter draws on data from two reports. The data on low-income, uninsured children is drawn from a detailed report on the National Survey of Children with Special Health Care Needs (Kenney, Haley, and Tebay 2004). The data on recent SCHIP enrollees is drawn from the detailed report on the analysis of the congressionally mandated survey of SCHIP enrollees and disenrollees (Kenney, Trenholm et al. 2005; see Chapter II, Kim, M.).

Figure 2. Awareness of Medicaid and Separate 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.

^Group serves as reference group for significance tests against "Heard of SCHIP" and "Heard of Either Program."

^^Group serves as reference group for significance test against "Program Is 18 Months Old or Older."

*Indicates estimate is significantly different from estimate for reference group at the 0.05 level.

#"Heard of SCHIP" is defined for the 29 states that had a separate SCHIP program with a different name from the Medicaid programs. These 29 states are Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Iowa, Illinois, Kansas, Kentucky, Maine, Michigan, Mississippi, Montana, North Carolina, North Dakota, New Hampshire, New Jersey, Nevada, New York, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming. As a result, the sample size for this question is 6,167 children. Of the 29 states, 23 had SCHIP programs that were at least 18 months old as of the beginning of the survey period (October 17, 2000).

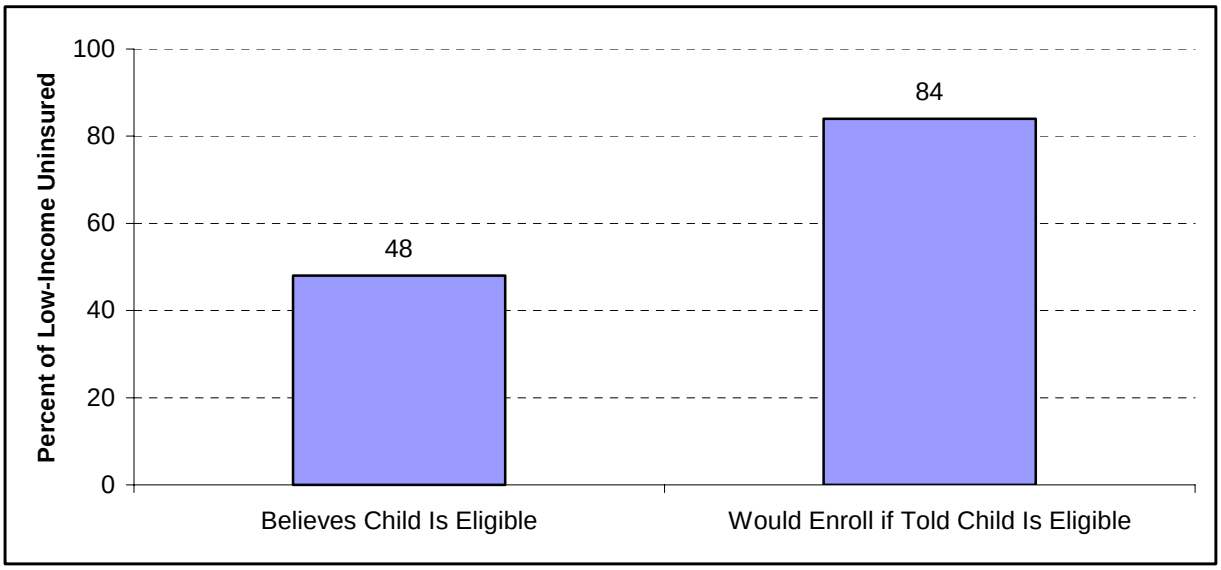
A final potential barrier was a perception among some families of low-income, uninsured children that the enrollment process was difficult. Just over one-half of those parents who were aware of SCHIP (54 percent) thought the application process for SCHIP was easy or somewhat easy, a minority (22 percent) thought it was difficult or very difficult, and nearly a quarter of families did not know how easy it was to enroll (23 percent) (Figure 4). However, among families who had enrolled a child in SCHIP, three-quarters thought the process was easy or somewhat easy. Approximately 68 percent of families who had applied but not enrolled thought the application was very or somewhat easy.

We now turn to a discussion of parents' experiences enrolling their children in SCHIP and Medicaid. Overall, parents reported they were able to enroll their child with relative ease.

States Made It Easy For Many Low-Income Parents to Enroll Their Children in SCHIP

As discussed earlier, states used extensive outreach to inform families of SCHIP availability, introduced simplified application forms, and took steps to make it easy for families to submit these forms. For example, all 10 study states permitted families to mail in applications, and 8 of the 10 states had no asset test for SCHIP. Additionally, states did not require families to provide formal documentation on all information required in the application, making it easier for families to assemble their applications.

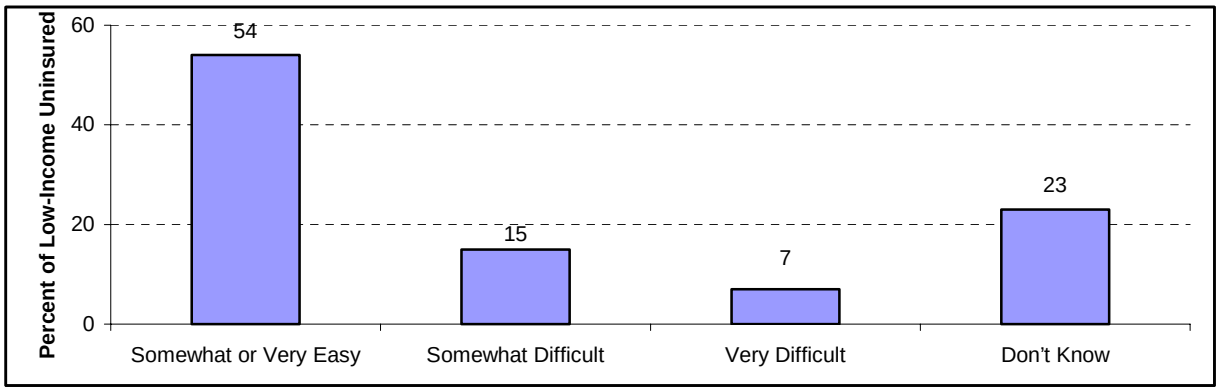
Figure 3. Perceptions of Medicaid/SCHIP Programs, Low-Income Uninsured Children, 2001



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. Perceptions of SCHIP Application Processes, Low-Income Uninsured Children, 2001

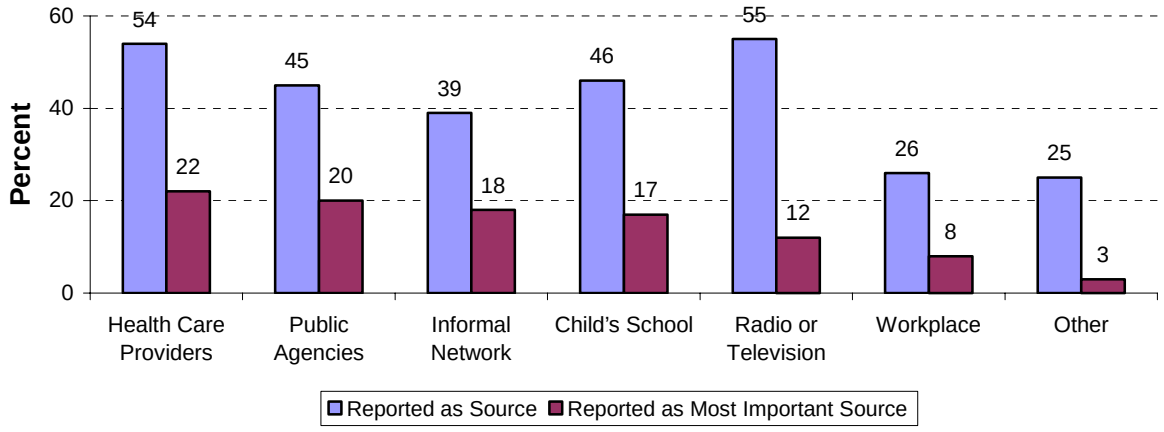


SOURCE: National Survey of Children with Special Health Care Needs, State and Local Integrated Telephone Survey, National Center for Health Statistics, 2001.

NOTE: These questions were asked only of respondents who had heard of the SCHIP program in the 29 states where the SCHIP program has a different name from the Medicaid program.

Families learned about SCHIP from many sources, especially radio and television advertisements (55 percent), health care providers (54 percent), and schools (46 percent). However, when asked which was the most important source of information in their families' decision to enroll their child, health care providers and public agencies were the two most important sources. Health care providers were the most important source of information (22 percent), public agencies were next most common source (20 percent), followed by friends and relatives (18 percent), and schools (17 percent). (See Figure 5.) Although many families learned about SCHIP from radio and television (55 percent), few said that these sources were important in their decisions to enroll their child (12 percent).

Figure 5. Sources of Information About SCHIP: Recent SCHIP Enrollees

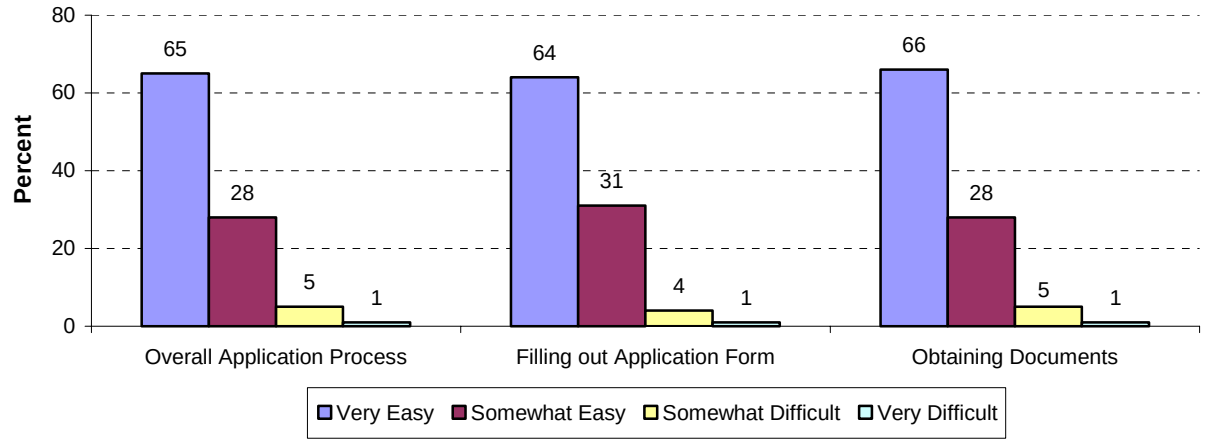


SOURCE: 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

NOTES: Respondents were asked to report all sources of SCHIP information, then to choose one important source.

Most families of children recently enrolled in SCHIP said enrollment was easy or very easy. Two-thirds of these families found the overall process very easy, and another 28 percent found it somewhat easy (Figure 6). Only 6 percent reported the process somewhat or very difficult. Similar experiences were reported by families for two other aspects of the enrollment process: completing the application form, and obtaining documents needed for the application.

Figure 6. Ease of Application Among Recent Enrollees in 2002



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

This relative ease of application was consistent across all 10 study states. Between 81 and 98 percent of recent enrollees' families found the process very or somewhat easy, depending on the state (see Table 17). The percentage of enrollees whose families found the process very or somewhat easy was highest in Louisiana (98 percent) and lowest in New Jersey (81 percent).

Table 17. SCHIP Enrollment Experience of Recent Enrollees, by State, in 2002 (Percent)

State	Reported Enrollment Was Easy	Received Help Applying	Knew When to Renew Enrollment
Separate Programs	%	%	%
California	93	63 **	56 *
Colorado	92 *	31	71 **
Florida	94	12 **	n.a.
New York	93	47	63
North Carolina	93	24 **	87 **
Texas	97 **	22 **	63 **
Combination Programs			
Illinois	95	22 **	46
New Jersey	81 *	25 **	33 **
Medicaid Programs			
Louisiana	98 **	11 **	70 **
Missouri	97 **	12 **	44 **
Total	**94**	**32**	**52**

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

NOTES: Tests of significance compare each state to the mean of all other states.
Number of enrollees varies from 555 to 669 per state.

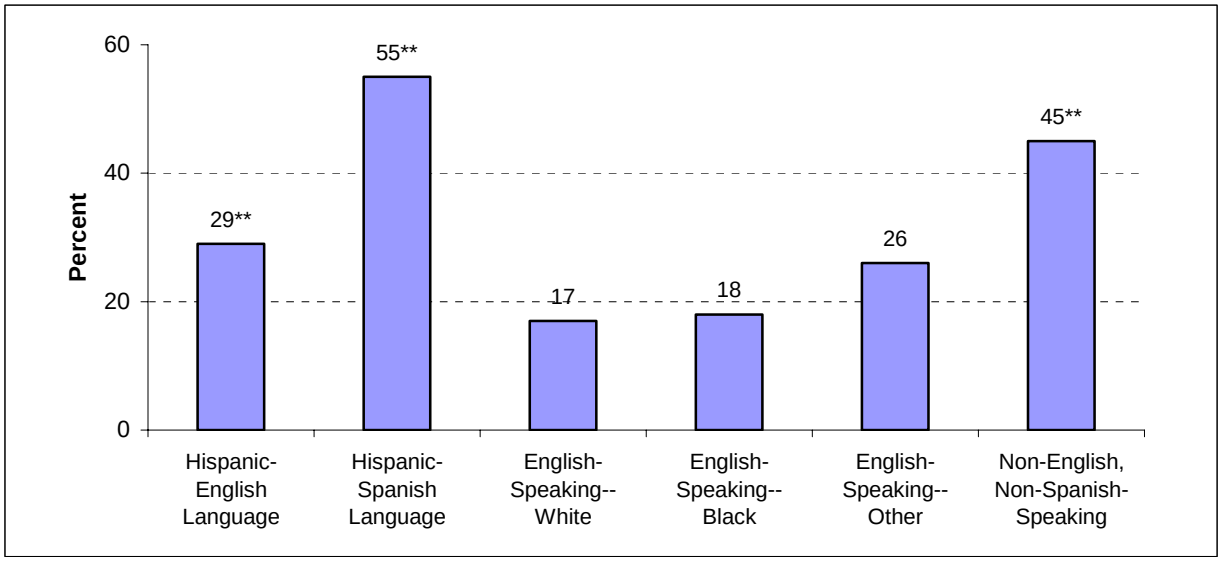
n.a. = not applicable (Florida has a passive renewal process).

**p-value (of difference) <0.01 level based on two-tailed t-tests on bivariate tabulations.

*p-value (of difference) <0.05 level based on two-tailed t-tests on bivariate tabulations.

Many SCHIP programs funded application assistance in local communities. One-third of families reported receiving help with their applications (Table 17). Over one-half of Spanish-speaking, Hispanic enrollees' families received help with their applications—38 percentage points higher than among white, English-speaking families (Figure 7). Moreover, many families also reported receiving help with understanding eligibility criteria, benefit features, and program requirements, as well as with translation (data not shown). California families received an exceptionally high level of help (63 percent of enrollees, see Table 17), most likely reflecting the high proportion of Hispanic children among enrollees in that state.

Figure 7. Receipt of Help Applying for SCHIP Among Recent Enrollees, by Language and Ethnicity, in 2002



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

**p-value (of difference between focal group and reference group) <0.01. "White" (English-speaking non-Hispanic) is the reference category for the significance test.

Not surprisingly, families with the least-educated parents were most likely to receive help applying (data not shown). Nearly one-half of the parents who had not graduated from high school had help applying (46 percent) compared to one-third of parents with a high school education and one-quarter of parents with some college education. This is consistent with a finding among families of low-income, uninsured children that the least-educated parents were more likely to perceive that the application process was difficult (Kenney, Haley, and Tebay 2004), which, in turn, was likely to make them more prone to need and use help when it was available.

One-half of the families knew when to renew their child's SCHIP coverage. As shown in Table 17, 52 percent of families knew when they needed to renew their child's coverage in SCHIP (either 6 months or 12 months after enrollment, assuming there was no change in family income). Families' knowledge of when to renew their child's coverage varied widely across states. Most notably, in Florida, only 9 percent of parents of enrolled children accurately reported the renewal period. However, Florida used a passive renewal process until 2004, which makes knowledge about when to renew less salient to families.

Medicaid Families also Found Enrollment Easy, but Less so than SCHIP Families

Both California and North Carolina (the two states where Medicaid and SCHIP surveys were conducted) adopted a joint application form and simplified enrollment for SCHIP and Medicaid, so that the application procedures were similar. However, families might have experienced differences enrolling in the two programs as the result of differences in the families themselves, differences in their perceptions of the programs, remaining differences between the enrollment processes (the processes are not identical), or other factors.

Most parents of recent Medicaid enrollees in these two states reported that applying to Medicaid was easy, although they were slightly less likely to do so than parents of recent SCHIP enrollees. In California, 83 percent of parents of recent Medicaid enrollees reported that enrollment had been very or somewhat easy, compared to 94 percent of recent SCHIP enrollees' parents; while in North Carolina, 89 percent of recent Medicaid enrollees' parents revealed that enrollment in Medicaid had been very or somewhat easy, compared to 93 percent of recent SCHIP enrollees' parents (see Table 18). Parents who recently enrolled their children in Medicaid were less likely to report that the process was very easy than parents who recently enrolled their children in SCHIP (38 percent compared to 59 percent in California, and 52 percent compared to 64 percent in North Carolina).

Table 18. Experience Enrolling in Medicaid and SCHIP in California and North Carolina, 2002

Percentage Reporting the Following Enrollment Experience:	California		North Carolina	
	Medicaid	SCHIP	Medicaid	SCHIP
Enrollment in the program is	%	%	%	%
Very easy	38	59 **	52	64 *
Somewhat easy	45	35 **	37	29 *
Received help applying	44	62 **	46	25 **

SOURCE: 2002 congressionally mandated survey of SCHIP enrollees in 10 states and Medicaid enrollees in 2 states.

NOTES: Tests of significance are based on two-tailed t-tests of the difference between Medicaid and SCHIP programs within each state.

**p-value (of difference) < 0.01level in two-tailed t-tests of Medicaid versus SCHIP within each state;

*p-value (of difference) < 0.05 level in two-tailed t-tests of Medicaid versus SCHIP within each state.

In both states, close to one-half of recent Medicaid enrollees' parents reported receiving help applying (44 percent in California and 46 percent in North Carolina). The rate of receiving help was quite different from that reported by the parents of SCHIP enrollees. In California, parents of Medicaid enrollees were 18 percentage points *less* likely to report they had received help applying, whereas in North Carolina, parents of Medicaid enrollees were 21 percentage points *more* likely to report they had received help applying than SCHIP enrollees.

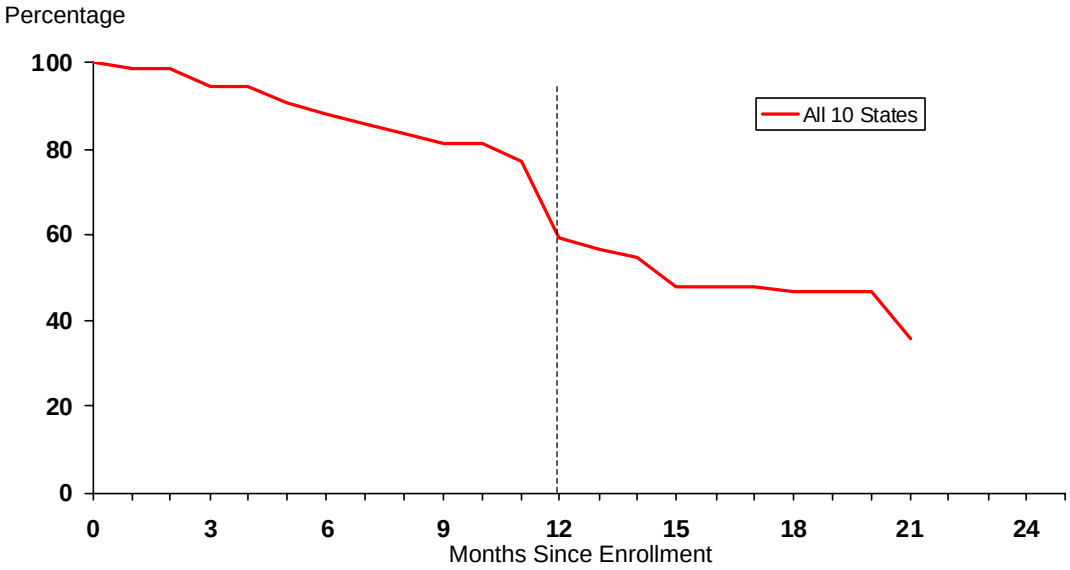
VIII. THE MAJORITY OF ENROLLEES STAY IN SCHIP FOR 12 MONTHS OR MORE, BUT MANY WHO LEAVE SCHIP BECOME UNINSURED

As the SCHIP program matured, states began to pay more attention to simplifying renewal of enrollment and retaining eligible children. They hoped to minimize the number of children leaving SCHIP who remain eligible. This chapter draws on a combination of state administrative records and the surveys of recent SCHIP enrollees and disenrollees to examine how long families stayed in SCHIP, the coverage they obtained when they left the program, and the factors that relate to these outcomes.[28]

Most Enrollees Stayed in SCHIP at Least a Year

Nearly 60 percent of recently enrolled children stayed in SCHIP for at least 12 months (Figure 8). Lengths of enrollment varied little by enrollee demographic characteristics, but varied widely across states.

Figure 8. Percentage of Children Enrolled in SCHIP, by Time Since Enrollment



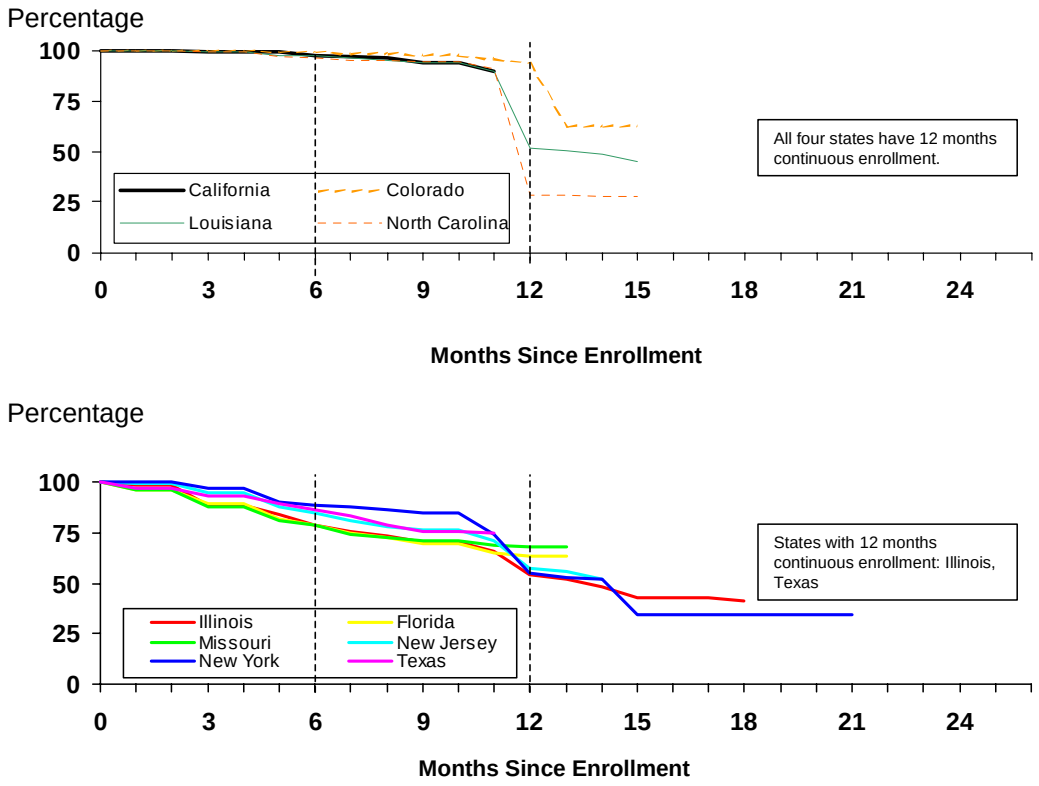
Source: SCHIP Enrollment Files and 2002 congressionally mandated survey of SCHIP enrollees and disenrollees in 10 states.

Two patterns of lengths-of-stay emerged across the 10 study states. In four states, few children left SCHIP until about 12 months after enrollment, at which time continued enrollment dropped sharply (upper panel of Figure 9). In the other six states, children left SCHIP at a fairly constant rate during the first 12 months, with a gradual falloff after 1 year (lower panel of Figure

[28]This chapter draws on data on findings presented in the detailed report on the analysis of the congressionally mandated survey of SCHIP enrollees and disenrollees (Kenney, Trenholm, et al. 2005; see Chapter IV, Moreno, L. and W. Black, and Chapter V, Trenholm, C.).

9). We do not know if SCHIP enrollee characteristics or differences in program features across the states explain these different patterns. However, all four states in the upper panel of Figure 9 offer 12 months of continuous coverage, consistent with the pattern of steady enrollment until the 12th month, followed by a rapid decline. In contrast, of the six states in the lower panel, only two (Illinois and Texas) offer 12 months of continuous coverage.

Figure 9. Percentage of Recent Enrollees Still Enrolled in SCHIP, by Time Since Enrollment, by State



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

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

Close to one-half (48 percent) of the children who left SCHIP lacked coverage after they were no longer in the program, and one-third were still uninsured 6 months later (Table 19). However, a number of these children no longer appear to be SCHIP eligible. For example, among the children uninsured immediately after leaving SCHIP, close to half (23 percent of all disenrolled children) reportedly left the program because the child was too old, the family's income had changed, or for some other reason that suggested the child is no longer eligible. This leaves a smaller fraction, 25 percent of all disenrolled children, who were uninsured upon

Table 19. Insurance Coverage of SCHIP Disenrollees, by Time Since Leaving SCHIP (Percent)

Time	Uninsured	Medicaid	SCHIP	Private	Other	Total
When Child Left SCHIP	**48**	**34**	**--**	**14**	**4**	**100**
Unlikely SCHIP eligible[a]	23	34	--	14	4	**75**
Possible SCHIP eligible[b]	25	--	--	--	--	**25**
6 Months After Child Left SCHIP	**33**	**35**	**14**	**16**	**2**	**100**
Unlikely SCHIP eligible[a]	17	35	--	16	2	**70**
Possible SCHIP eligible[c]	16	--	14	--	--	**30**

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

[a]Includes disenrolled children who have obtained other (non-SCHIP) coverage, or who are uninsured and whose parents reported leaving SCHIP for a reason that would make them ineligible, such as reaching age 19 or a change in family income. Children who reach age 19 account for close to one-third of the uninsured who fall in this group after leaving SCHIP (7 of 23 percent) and over one-third of the uninsured who fall in this group after 6 months (7 of 17 percent).

[b]Includes disenrolled children who are uninsured and whose parents reported leaving SCHIP for a reason that might still make them eligible, such as failure to pay premium or difficulty with renewal.

[c]Includes disenrolled children who resume SCHIP coverage, or who remain uninsured but whose parents reported leaving SCHIP for a reason that might still make them eligible, such as failure to pay premium or difficulty with renewal.

leaving SCHIP *and* who left for reasons unrelated to their eligibility, such as failure to pay premium or problems with paperwork. Over the next 6 months, many of these children then returned to SCHIP, leaving only 16 percent of all disenrolled children both uninsured and possibly SCHIP-eligible.

Roughly one-third (34 percent) of all children leaving SCHIP obtained Medicaid coverage, underscoring the importance of coordination between SCHIP and Medicaid This is more than twice the percentage of disenrolled children who obtained private coverage (14 percent). Six months later, these percentages increased only slightly, to 35 percent and 16 percent, respectively. Private coverage was concentrated among children in families with higher incomes, with two working parents, and who were white and English-speaking (data not shown).

The fairly modest rate of private coverage among children leaving SCHIP sheds additional light on the results presented in Chapter V on potential substitution of SCHIP for private coverage. Those results found that as many as 36 percent of SCHIP enrollees had some option to enroll their child in employer coverage; however, the modest share who actually obtained this coverage after leaving SCHIP suggests that many families do not take up such options, possibly for cost and other unknown reasons. Thus, the actual extent of substitution of SCHIP for private coverage may be well below this upper-bound estimate of 36 percent.

Lack of Family Awareness That Their Child Had Been Disenrolled May Contribute to Cycling On and Off SCHIP

Of the 14 percent of disenrollees who returned to SCHIP within 6 months, most (75 percent) had parents who reported that their child had never left the program. This lack of awareness could have been problematic if the child had needed care during the period without coverage. It

also raises questions as to why families report having coverage when states indicate they do not and how such situations can be prevented.

Coverage After Disenrolling Varied by Child's Age and Whether the Child Had Ever Left Because the Family Did Not Pay Premium

The percentage of children remaining uninsured after leaving SCHIP was reasonably consistent across most demographic groups, typically ranging from 30 to 40 percent 6 months after leaving the program (including both SCHIP-eligible and ineligible children). A notable exception was among children aged 18 years or more; after they left SCHIP, 65 percent were uninsured, largely due to their loss of eligibility for SCHIP (and in some states they would also no longer be eligible for Medicaid). Young adults typically have very high rates of being uninsured and the 18 year-olds leaving SCHIP are no exception.

While it is not possible to assess the impact that premiums are having on coverage patterns after children leave SCHIP, insurance coverage was less likely among children whose families reported ever having left SCHIP due to a failure to pay premiums.[29] Among this group, close to one-half (48 percent) were uninsured 6 months after they left SCHIP, compared to only 31 percent of those who had never left the program for this reason. Many factors might contribute to the high rate of being uninsured among this group. Examples include: (1) the use of blackout periods before these families can return to SCHIP; (2) a lack of referral to Medicaid (because these children may leave SCHIP at any time, their eligibility for Medicaid is less likely to be reviewed); and (3) even a decision by some families to leave SCHIP (and thereby avoid premiums) until the child is sick or otherwise needs care. Disentangling these factors is not possible given the small number of states in the study and a lack of information on disenrollees' eligibility for SCHIP and Medicaid coverage. Notably, however, Medicaid coverage among children in this group is quite low, just 18 percent, which may point to a lack of Medicaid referral as a contributing factor.

Program Coordination May Be a Key to Expanding Coverage of Children after Leaving SCHIP

As indicated in Chapter III, the 10 case studies found that states with separate and combination programs often reported having problems coordinating their SCHIP and Medicaid programs. In contrast, Medicaid expansion programs do not have coordination problems because the SCHIP and Medicaid components function seamlessly with one another. Findings across the states suggest that this variability in program coordination has contributed to important cross-state differences in coverage of SCHIP disenrollees.

A relatively small percentage of children who left Medicaid-expansion SCHIP programs became uninsured (Table 20). In the six states with separate programs, 37 percent of children

[29]Of the children whose families reported that the child had ever been terminated for failure to pay a premium, 82 percent had only been enrolled once, and thus this reason for termination related to the disenrollment period that is the focus of the study. This group reflects abut 20 percent of the sample in the seven states that charge premiums for some or all disenrollees.

Table 20. Coverage of Disenrollees 6 Months After Leaving SCHIP, by Program Type (Percent)

State Program Type	Uninsured	Medicaid	SCHIP	Private	Other
Separate Programs	**37 ****	**29 ****	**16 ****	**17**	**1**
Unlikely SCHIP eligible[a]	19	29	--	17	1
Possible/certain SCHIP eligible[b]	18	--	16	--	--
Medicaid Expansion Programs	**22 ****	**54 ****	**13**	**9 ****	**2**
Unlikely SCHIP eligible[a]	15	54		9	2
Possible SCHIP eligible[b]	7	--	13	--	--
Combination Programs	**24 ****	**50 ****	**9 ****	**16**	**1**
Unlikely SCHIP eligible[a]	10	50	--	16	1
Possible SCHIP eligible[b]	14	--	9	--	--

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

NOTES: Study states with separate programs include California, Colorado, Florida, New York, North Carolina, and Texas; states with Medicaid expansion include Louisiana and Missouri; states with combination programs include Illinois and New Jersey. Tests of significance compare each program model to the mean of the other two models. Based on multivariate analyses controlling for enrollees' demographic characteristics. Number of disenrollees in the study sample varies from 290 to 402 per state.

** p-value (of difference) <0.01 level; * p-value (of difference) <0.05 level.

[a]Includes disenrolled children who have obtained other (non-SCHIP) coverage, or who are uninsured and whose parents reported leaving SCHIP for a reason that would make them ineligible, such as reaching age 19 or a change in family income.

[b]Includes disenrolled children who resume SCHIP coverage, or who remain uninsured but whose parents reported leaving SCHIP for a reason that might still make them eligible, such as failure to pay premium or difficulty with renewal.

were reportedly uninsured 6 months after leaving SCHIP, of whom about half were still possibly eligible for SCHIP. By comparison, in the two states with Medicaid-expansion programs, 22 percent of children were reportedly uninsured by this time and only 7 percent of disenrolled children were uninsured and possibly eligible for SCHIP. In the two combination programs, the percentage of children uninsured after 6 months was similarly low, 24 percent, a result due entirely to very low rates of uninsurance among children leaving the Medicaid-expansion component of these programs (not shown).

This difference in rates of coverage after leaving SCHIP between the Medicaid-expansion and separate program models appears linked to the coordination between SCHIP and Medicaid. In the two study states with Medicaid-expansion programs (where coordination is seamless), Medicaid coverage reached 54 percent among children 6 months after they left SCHIP. This is nearly twice the percentage of children who were covered by Medicaid in the separate programs (29 percent) and explains entirely the difference in overall coverage seen between the two program models.

One possible explanation for these differences is that disenrollees from separate programs are less inclined to enroll in Medicaid due to negative perceptions of the program. However, even among the separate programs, there is substantial variation in Medicaid coverage of SCHIP disenrollees that appears linked with coordination between the two programs. For example, among the six separate programs in the study, North Carolina was the only one to use a highly coordinated renewal process that jointly reviewed eligibility for Medicaid and SCHIP. In turn, it had by far the highest rate of Medicaid coverage among its SCHIP disenrollees (48 percent; not shown) and one of the lowest rates of uninsurance (31 percent; not shown), further suggesting the importance that coordination may have for extending coverage of children who leave SCHIP.

PART 3: SUMMARY

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

This congressionally mandated evaluation found that states were quick to implement their SCHIP programs and take advantage of the enhanced federal funding for SCHIP. Program designs were selected by states 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 under age 19 whose family income was under the poverty level who would, by 2002, have mandatory Medicaid coverage (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

During fiscal 2004, 6.1 million children were enrolled in SCHIP at some point during the year (CMS 2005). Of these children, 62 percent were in the 10 states that were the focus of the evaluation. 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. 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.

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. 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.

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. For example, 91 percent of SCHIP enrollees had a usual source of medical care, and the parents of 81 percent of enrollees were very or somewhat 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. In particular, 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. In addition, 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 Appear to Improve Access to Care

SCHIP had a positive effect 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. 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 a large variety of different types of children, 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 SCHIP is leading to access improvements across the board for the children who enroll.

Medicaid programs also have positive impacts on children who enroll. A parallel study of Medicaid impacts in California and North Carolina found results for the Medicaid programs similar to those for the SCHIP programs in those 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, and 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), and this was consistent across the 10 study states. 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). The most important sources of information in families' decisions to enroll their children were 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.

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 survey was conducted in 2001). Most parents of uninsured, low-income children reported they would enroll their child if they were told that the 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). 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 a full 12 months. While longer stays were found in states that offered 12 months of continuous eligibility, we cannot say with certainty that this program policy was the cause of the longer stays.

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. Of the children who were uninsured, nearly half (23 percent of all disenrolled children) appear to no longer be eligible for SCHIP due primarily 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.

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 the target population of low-income children who would have otherwise 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 stay-lengths vary 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 where there is more coordination between SCHIP and Medicaid more children transition to Medicaid from SCHIP and fewer children remain uninsured. In short, SCHIP plays an important role in insuring low-income children and improving their access to care.

REFERENCES

Blumberg, Stephen J., Lorayn Olson, Martin R. Frankel, et al. 2003. "Design and Operation of the National Survey of Children with Special Health Care Needs, 2001." Hyattsville, MD: National Center for Health Statistics. Vital and Health Statistics 1(41).

Centers for Medicare & Medicaid Services 2004. Accessed December 2004 [http://www.cms.hhs.gov/schip] state fact sheets.

Centers for Medicare & Medicaid Services 2005. Accessed September 20, 2005 [http://www.cms.hhs.gov/schip/enrollment/].

Congressional Budget Office. "Expanding Health Insurance Coverage for Children Under Title XXI of the Social Security Act." February, 1998. Accessed October 27, 2004 [http://www.cbo.gov].

Damiano, P.C., J.C. Willard, E.T. Momany, and J. Chowdhury. "The Impact of the Iowa SCHIP Program on Access, Health Status, and the Family Environment." *Ambulatory Pediatrics*, vol. 3, no. 5, September/October 2003, pp. 263-269.

Davidoff, Amy. "Health Insurance Coverage of Special Needs Children." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. Publication No. 2166. March 2003.

Dick, Andrew W., Cindy Brach, R. Andrew Allison, Elizabeth Shenkman, Laura P. Shone, Peter G. Szilagyi, Jonathan D. Klein, and Eugene M. Lewit. "SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare?" *Health Affairs*, vol. 23, no. 5, 2004, pp. 63-75.

Dubay, Lisa. Genevieve Kenney, and Jennifer Haley. "Children's Participation in Medicaid and SCHIP Early in the SCHIP Era." Washington, D.C.: The Urban Institute. *Assessing New Federalism* Policy Brief (B-40), March 2002.

Hill, Ian, Corinna Hawkes, and Mary Harrington, with Ruchika Bajaj, William Black, Nancy Fasciano, Embry Howell, Heidi Kapustka, and Amy Westpfahl Lutzky. "Congressionally Mandated Evaluation of the State Children's Health Insurance Program. Final Cross-Cutting Report on the Findings from Ten State Site Visits." Princeton, NJ: Mathematica Policy Research, Inc. and The Urban Institute, December 2003.

Hill, Ian, Mary Harrington, and Corinna Hawkes. "Interim Cross-Cutting Report on the Findings from Six State Site Visits." Princeton, NJ: Mathematica Policy Research, Inc., November 25, 2002.

Kenney, Genevieve, Jennifer Haley and Alexandra Tebay. "Awareness and Perceptions of Medicaid and SCHIP Among Low-Income Families with Uninsured Children: Findings from 2001." Washington DC: The Urban Institute and Mathematica Policy Research Inc., April 2004.

Kenney, Genevieve, Christopher Trenholm, Lisa Dubay, Myoung Kim, Lorenzo Moreno, Jamie Rubenstein, Anna Sommers, and Stephen Zuckerman. "The Experiences of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation." Final Report. Mathematica Policy Research, Inc. and The Urban Institute, October 2005.

Chapter I. Kenney, Genevieve, Christopher Trenholm, Lisa Dubay, Myoung Kim, Lorenzo Moreno, Jamie Rubenstein, Anna Sommers, and Stephen Zuckerman. "Characteristics and Experiences of SCHIP Enrollees and Disenrollees in Ten States."

Chapter II. Kim, Myoung. "Analysis of Recent Enrollees: Variations in the Experience of Families Enrolling in SCHIP."

Chapter III. Kenney, Genevieve, Jamie Rubenstein, Anna Sommers, and Grace Ko. "Analysis of Established Enrollees: "Variation in Coverage Among Children Who Leave SCHIP."

Chapter IV. Moreno, Lorenzo and Will Black. "Analysis of Length of SCHIP Enrollment and Length of Time Out of SCHIP After Disenrolling."

Chapter V. Trenholm, Christopher. "Variation in Coverage Among Children Who Leave SCHIP."

Chapter VI. Sommers, Anna, Stephen Zuckerman, and Lisa Dubay. "The Relationship Between SCHIP and Private Coverage Among SCHIP Enrollees."

Chapter VII. Kenney, Genevieve. "The Impacts of SCHIP on Access and Use of Care."

Chapter VIII. Kenney, Genevieve, Jamie Rubenstein, Anna Sommers, Stephen Zuckerman, Myoung Kim, and Frederic Blavin. "Experiences of Medicaid and SCHIP Enrollees in Two States."

Lave, Judith R., Christopher R. Keane, Chyongchiou J. Lin, Edmund M. Ricci, Gabriele Amersbach, and Charles P. LaVallee. "Impact of a Children's Health Insurance Program on Newly Enrolled Children." *Journal of the American Medical Association,* vol. 179, no. 22, June 10, 1998, pp. 1820-1825.

Pettibone, Kristianna, Joanna Shoffner, Jamie Chriqui, Raedell Wallace, Mathew Dunn, and Carissa Baker. Final Report on the National Survey of SCHIP Administrators for the Congressionally Mandated Evaluation of the Children's Health Insurance Program." Final Report. Princeton NJ: The MayaTech Corporation and Mathematica Policy Research, Inc., February 2005.

Smith, Vernon K., David M. Rousseau, and Molly O'Malley. *SCHIP Program Enrollment: December 2003 Update.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2004.

Szilagyi, Peter G., Jane L. Holl, Lance E. Rodewald, Laura Pollard Stone, Jack Zwanziger, Dana B. Mukamel, Sarah Trafton, Andrew W. Dick, and Richard F. Raubertas. "Evaluation of Children's Health Insurance: From New York State's Child Health Plus to SCHIP." *Pediatrics,* vol. 105, no. 3, March 2000, pp. 687-691.

Van Dyck, Peter C., Merle McPherson, Bonnie B. Strickland, Kerry Nesseler, Stephen J. Blumberg, Marcie L. Cynamon, and Paul W. Newacheck. 2002. "The National Survey of Children with Special Health Care Needs." *Ambulatory Pediatrics* 2 (1): 29-37.

Wooldridge, Judith, Ian Hill, Mary Harrington, Genevieve Kenney, Corinna Hawkes, and Jennifer Haley. "Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program." Princeton, NJ: Mathematica Policy Research, Inc., February 26, 2003.

APPENDIX A

SUPPLEMENTAL TABLES

TABLE A.1: Fiscal 2003 Fourth Quarter - SCHIP Enrollment Last Day of Quarter by State

State	Program Type	Program Enrollment		Point in Time FY 2003 Fourth Quarter Total
		Last Day of the Fourth Quarter		
		Separate Child Health Program	Medicaid Expansion	
Alabama	Separate	62,449	--	62,449
Alaska	Medicaid expansion	--	12,353	12,353
Arizona	Separate	50,845	--	50,845
Arkansas	[a]			
California	Combination	660,150	55,057	715,207
Colorado	Separate	43,312	-	43,312
Connecticut	Separate	14,640	--	14,640
Delaware	Separate	5,121	--	5,121
District of Columbia	Medicaid expansion	--	3,767	3,767
Florida	Combination	320,982	1,490	322,472
Georgia	Separate	189,966	--	189,966
Hawaii	Medicaid expansion	--	14,492	14,492
Idaho	Medicaid expansion	-	10,954	10,954
Illinois	Combination	N/R	N/R	0
Indiana	Combination	15,091	42,997	58,088
Iowa	Combination	15,431	10,033	25,464
Kansas	Separate	30,072	--	30,072
Kentucky	Combination	19,729	32,115	51,844
Louisiana	Medicaid expansion	--	93,194	93,194
Maine	Combination	4,883	8,047	12,930
Maryland	Combination	6,131	98,919	105,050
Massachusetts	Combination	17,270	41,986	59,256
Michigan	Combination	35,775	17,766	53,541
Minnesota	Combination	N/R	13	13
Mississippi	Separate	N/R	--	0
Missouri	Medicaid expansion	-	86,143	86,143
Montana	Separate	9,641	--	9,641
Nebraska	Medicaid expansion	-	23,066	23,066
Nevada	Separate	24,128	--	24,128
New Hampshire	Combination	N/R	147	147
New Jersey	Combination	63,097	33,952	97,049
New Mexico	Medicaid expansion	--	10,171	10,171
New York	Combination	369,485	N/R	369,485
North Carolina	Separate	109,236	--	109,236
North Dakota	Combination	N/R	N/R	0
Ohio	Medicaid expansion	--	123,616	123,616
Oklahoma	Medicaid expansion	--	53,258	53,258
Oregon	Separate	20,366	--	20,366
Pennsylvania	Separate	124,808	--	124,808
Rhode Island	Combination	563	10,052	10,615
South Carolina	Medicaid expansion	--	45,666	45,666
South Dakota	Combination	1,992	7,502	9,494
Tennessee	[a]			
Texas	Separate	507,281	-	507,281
Utah	Separate	30,347	--	30,347
Vermont	Separate	N/R	--	0
Virginia	Combination	35,469	23,246	58,715
Washington	Separate	8,106	--	8,106
West Virginia	Separate	22,410	--	22,410
Wisconsin	Medicaid expansion	-	37,048	37,048
Wyoming	Separate	3,494	--	3,494
TOTALS		**2,822,270**	**897,050**	**3,719,320**

Source: Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/schip/enrollment/2003pit4qt.pdf (dated and downloaded 7/30/04).

Note: N/R - Indicates that state has not reported data via the Statistical Enrollment Data System (SEDS)

[a]Arkansas and Tennessee ceased to operate their SCHIP programs during fiscal 2002.

Table A.2: Successful Outreach Strategies Identified

State	Schools	Paid media ads	Kick-off press conference	Mini-grants	Face-to-face/local/ grassroots	Health fairs	Word-of-mouth	RWJ F initiatives	Web site	Training sessions	Targeted outreach	Difficult to measure
Alabama (S)	X	X	X									
Alaska (M)					X							
Arizona (S)	X				X							
Arkansas (M)		X										
California (C)	X				X							
Colorado (S)												
Connecticut (S)		X			X							
Delaware (S)[1]												
District of Columbia (M)		X										
Florida (C)		X					X					
Georgia (S)	X											
Hawaii (M)						X						
Idaho (M)		X										
Illinois (C)					X							
Indiana (C)		X					X					
Iowa (C)	X	X										
Kansas (S)[1]												
Kentucky (C)							X					
Louisiana (M)[1]												
Maine (C)					X			X				X
Maryland (C)					X							
Massachusetts (C)				X								
Michigan (C)		X					X					
Missouri (M)					X							
Minnesota (M)								X	X			
Mississippi (S)	X									X		
Montana (S)												
Nebraska (M)	X											
Nevada (S)								X				
New Hampshire (C)	X											
New Jersey (C)	X											
New Mexico (M)		X										X
New York (C)		X			X						X	
North Carolina (S)											X	
North Dakota (C)												
Ohio (M)	X											
Oklahoma (M)[1]												
Oregon (S)												
Pennsylvania (S)												
Rhode Island (C)					X							
South Carolina (M)	X											
South Dakota (C)[1]												
Tennessee (M)[1]												
Texas (S)	X				X							
Utah (S)		X			X							
Vermont (S)	X				X							
Virginia (C)	X											
Washington (S)					X							
West Virginia (S)					X						X	
Wisconsin (M)							X					
Wyoming (S)[1]												
Program Type Subtotals												
Medicaid Expansion	3	4	0	0	2	1	1	1	1	0	0	1
Separate State Program	6	3	1	0	7	0	0	1	0	1	2	0
Combination	5	5	0	1	6	0	4	1	0	0	1	1
Totals	14	12	1	1	15	1	5	3	1	1	3	2

Table A.2 *(continued)*

Source: SCHIP Administrator Survey, 2003.

Notes:
Categories are not mutually exclusive, so total equals more than 44.
(M) indicates a Medicaid expansion program, (S) indicates a separate state program, and (C) indicates a program that implemented both a Medicaid expansion program and a separate state program.

[1] Highlighted states did not participate in the interviews so no responses are provided.

Table A.3. Differences or Similarities in Between Medicaid and SCHIP Delivery Systems

State	No differences	Differences
Alabama (S)		Fee for service is used in the separate state program, but not in Medicaid. SCHIP enrollees have more access to networks and there are payment differences between the separate state program and Medicaid. The separate state program uses discounted private fees for providers while Medicaid does not.
Alaska (M)	X	
Arizona (S)	X	
Arkansas (M)	X	
California (C)		SCHIP uses a closed HMO model and exclusive provider organization, which does not require a primary care physician while Medicaid uses a combination of fee-for-service and managed care.
Colorado (S)	X	
Connecticut (S)	X	
Delaware (S)[1]		
District of Columbia (M)	X	
Florida (C)		Children enrolled in the Medicaid expansion program or the Medikids program (a part of the separate state program) may choose between managed care, primary care case management, or fee-for-service, depending on the delivery systems available in their county. Enrollees in Healthy Kids are predominantly in managed care, with the exception of a small percentage who are enrolled in primary care case management.
Georgia (S)	X	
Hawaii (M)	X	
Idaho (M)	X	
Illinois (C)	X	
Indiana (C)	X	
Iowa (C)		The two programs use different capitation systems and networks.
Kansas (S)[1]		
Kentucky (C)	X	
Louisiana (M)[1]		
Maine (C)	X	
Maryland (C)	X	
Massachusetts (C)	X	
Michigan (C)		The state reported that there were differences between the delivery systems, but did not describe the differences.
Minnesota (M)	X	
Mississippi (S)		Primary care case management is used in Medicaid and not the separate state program.
Missouri (M)	X	
Montana (S)		The two programs use different capitation systems and networks.
Nebraska (M)	X	
Nevada (S)	X	
New Hampshire (C)	X	
New Jersey (C)	X	
New Mexico (M)	X	
New York (C)		The two programs use different capitation systems and networks.
North Carolina (S)		Primary care case management is used in Medicaid and not the separate state program.
North Dakota (C)	X	
Ohio (M)	X	
Oklahoma (M)[1]		
Oregon (S)	X	
Pennsylvania (S)	X	
Rhode Island (C)		Some fee-for-service is used in Medicaid, but only for disabled children, adults, and the elderly. The separate program uses managed care only.
South Carolina (M)	X	
South Dakota (C)[1]		

State	No differences	Differences
Tennessee (M)[1]		
Texas (S)		The state reported that there were differences between the delivery systems, but did not describe the differences.
Utah (S)[2]	X	
Vermont (S)	X	
Virginia (C)	X	
Washington (S)	X	
West Virginia (S)[2]	X	
Wisconsin (M)	X	
Wyoming (S)[1]		
Program Type Subtotals		
Medicaid Expansion	12	0
Separate State Program	11	5
Combination	10	6
Totals	33	11

Source: SCHIP Administrator Survey, 2003

Notes:

(M) indicates a state with a Medicaid expansion program, (S) indicates a state with a separate state program and (C) indicates a state that implemented both a Medicaid expansion program and a separate state program.

[1] Highlighted states did not participate in the interviews so no responses are provided.

[2] Utah and West Virginia reported that the systems are primarily the same, but that the use of fee-for-service and managed care varies depending on geographic location.

APPENDIX B

ENABLING LEGISLATION FOR THE SCHIP EVALUATION

ENABLING LEGISLATION FOR THE SCHIP EVALUATION

Public Law 106-113

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Introduced in the House)

SEC. 703. IMPROVED DATA COLLECTION AND EVALUATIONS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(b) **FEDERAL EVALUATION, OF STATE CHILDREN'S HEALTH INSURANCE PROGRAMS-** Section 2108 (42 U.S.C. 1397hh) is amended by adding at the end the following:

(c) **FEDERAL EVALUATION**

(1) **IN GENERAL-** The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

(2) **SELECTION OF STATES-** In selecting States for the evaluation conducted under this subsection the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic areas (including a mix of rural and urban areas) and contain a significant portion of uncovered children.

(3) **MATTERS INCLUDED-** In addition to the elements described in subsection (b)(1). the evaluation conducted under this subsection shall include each of the following:

(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this title).

(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the Medicaid program under title XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been enrolled previously in the Medicaid program under that title.

(C) Evaluation of the extent to which State Medicaid eligibility practices and procedures under the Medicaid program under title XIX are a barrier to the

enrollment of children under that program and the extent to which coordination (or lack of coordination) between that program and the program under this title affects the enrollment of children under both programs.

(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

(4) **SUBMISSION TO CONGRESS-** Not later than December 31, 2001, the Secretary shall submit to Congress the results of the evaluation conducted under this subsection.

(5) **FUNDING-** Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002.