CHIRI
The Child Health Insurance Research Initiative

ISSUE BRIEF No. 10
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What Has Been Learned About Expanding Children's Health Insurance? Highlights From CHIRI™

In 1999, the Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA) formed a unique public/private partnership to create the Child Health Insurance Research Initiative (CHIRI™). CHIRI™ was an effort to supply policymakers with information to help them improve access to, and quality of, health care for low-income children. CHIRI™ funded nine studies of public child health insurance programs and health care delivery systems.

This Issue Brief highlights some of the CHIRI™ findings on the State Children's Health Insurance Program (SCHIP), a Federal-State program implemented in 1997 and reauthorized in 2009 as the Children's Health Insurance Program (CHIP). CHIP provides insurance coverage to low-income children whose families earn too much to qualify for Medicaid but lack private insurance. While the CHIRI™ research primarily was conducted from 1999 to 2003, the findings remain instructive for policymakers and others interested in improving children's insurance coverage. Highlights include:

- Most SCHIP enrollees lived in families with a full-time worker and incomes equal to or below 150 percent of the Federal Poverty Level (FPL).
- Minority children and children with special health care needs (CSHCN) made up a significant proportion of SCHIP enrollees.
- SCHIP improved health care access and quality for low-income children generally; these gains were by and large shared by minority children and CSHCN.
- The design of coverage in States with separately administered SCHIP programs limited certain services for CSHCN.
- SCHIP retention was increased by a simplified renewal process that automatically reenrolled children in SCHIP unless their families submitted reenrollment forms indicating a change affecting their eligibility.
- More than three-quarters of SCHIP enrollees retained public insurance coverage more than a year after enrollment. However, others became uninsured and few obtained private insurance coverage.
- More than 70 percent of children enrolled in Oregon's premium assistance program lacked access to an employer-sponsored plan and thus purchased their coverage in the individual market.

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

WHAT WAS LEARNED

CHIRI™ funded two national and seven State-based (Alabama and Georgia, Florida, Indiana, Kansas, Michigan, New York, and Oregon) research projects. Researchers analyzed data collected between 1999 and 2002, including SCHIP administrative data, pre-enrollment and followup surveys of families of SCHIP enrollees, and focus group results, depending on the study. In some cases, CHIRI™ researchers collaborated to conduct analyses across the study States. (See CHIRI™ Issue Briefs listed in the Sources section for further information.)

Most SCHIP Enrollees Are from Near-Poor, Full-Time Working Families

Most SCHIP enrollees lived in families with a working adult (80 percent to 87 percent of enrollees, depending on the study State) who worked full time (63 percent to 74 percent). Although the study States permitted coverage for families with incomes up to as much as 250 percent of the FPL, nearly two-thirds to three-quarters of new enrollees lived in families with incomes equal to or below 150 percent of the FPL.

Most new SCHIP enrollees were white (55 percent to 78 percent), but a significant proportion of SCHIP enrollees were black or Hispanic. Compared with white enrollees, minority children enrolled in SCHIP had lower incomes and poorer health status. They also were more likely to have been uninsured the entire year prior to SCHIP enrollment.

SCHIP Is an Important Source of Coverage for Children With Special Health Care Needs

Children with special health care needs (CSHCN) made up a significant proportion of new SCHIP enrollees (17 percent to 25 percent). In fact, CSHCN made up a larger proportion of SCHIP enrollees than the proportion of CSHCN in the general population (12 percent to 15 percent). Although many SCHIP officials expected CSHCN to be enrolled in Medicaid or State programs instead of SCHIP, CSHCN enrolled in SCHIP due to family income or medical conditions that did not qualify them for other programs.

CSHCN had more unmet needs than other enrollees prior to SCHIP enrollment. Families of CSHCN enrolled in SCHIP were readily able to access primary care and routine specialty care services and were generally satisfied with this care. However, these families experienced some barriers to care for their children. For example, some experienced difficulty finding a participating primary care provider with expertise in serving CSHCN. In addition, families of children with severe chronic health conditions (e.g., spina bifida) experienced significant challenges in securing certain specialty services under SCHIP because of coverage limits. These specialty services included physical, occupational, and speech therapies; home-based health care; mental health and substance abuse services; and nonemergency transportation (e.g., transportation of a wheelchair-bound child).

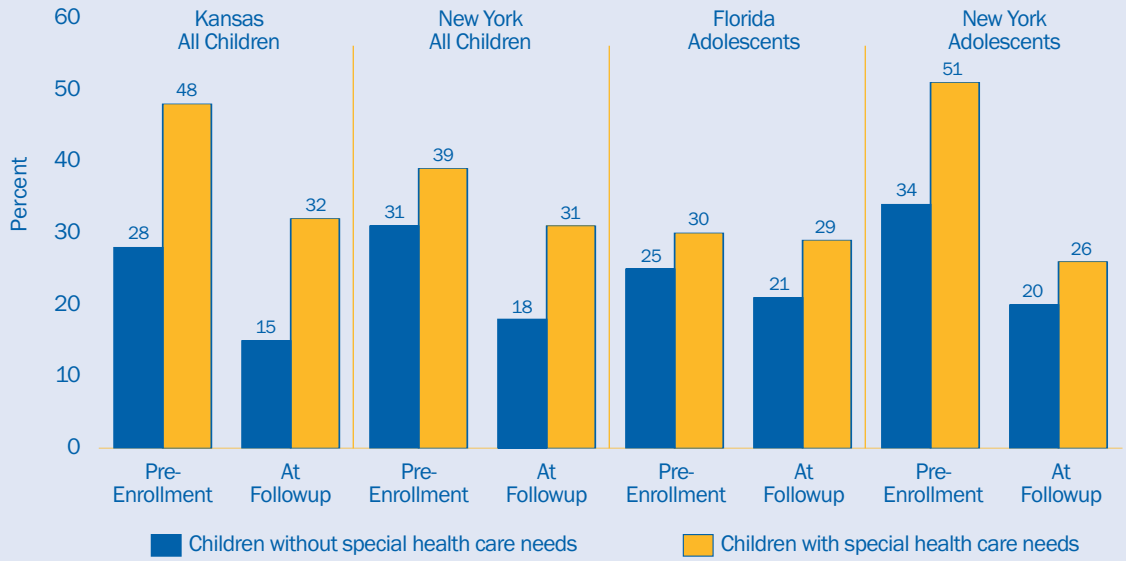
SCHIP Design and Enrollment

States had considerable flexibility in how they designed their SCHIP program. They could choose to expand Medicaid, create a separate program that may have eligibility rules and coverage different from Medicaid, or establish a combination program with both a Medicaid expansion and a separate program. Within some limits, States that established a separate program could choose to charge premiums and copayments for services, and they had flexibility in defining the benefits package for the program. Federal law required that States screen all SCHIP applicants for Medicaid eligibility but there was no equivalent requirement to screen SCHIP enrollees for Medicaid eligibility when they disenrolled from SCHIP. Similar program flexibility exists in the recent legislation that reauthorized SCHIP and changed the name of the program to CHIP.

SCHIP Improves Health Care Access and Quality for Low-income Children

Following enrollment in SCHIP, children were more likely to have a regular source of health care (88 percent before enrollment to 98 percent at followup) and to have a preventive care visit (8 percent to 13 percent more likely). Fewer children had unmet health care needs after SCHIP enrollment than in the year before enrollment (reductions of 12 percent to 43 percent) (see Figure 1). Families of new SCHIP enrollees were more satisfied with the health care their children received after SCHIP enrollment than before SCHIP.

Figure 1. Unmet Needs by Special Health Care Needs Status, at Pre-Enrollment and Followup



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

Vulnerable children (e.g., minority children, CSHCN) generally shared in SCHIP gains although some disparities remained after SCHIP enrollment. Some racial and ethnic disparities in access to health care were evident after SCHIP enrollment. In addition, a large proportion of CSHCN (almost one-third) still had unmet needs after SCHIP enrollment.

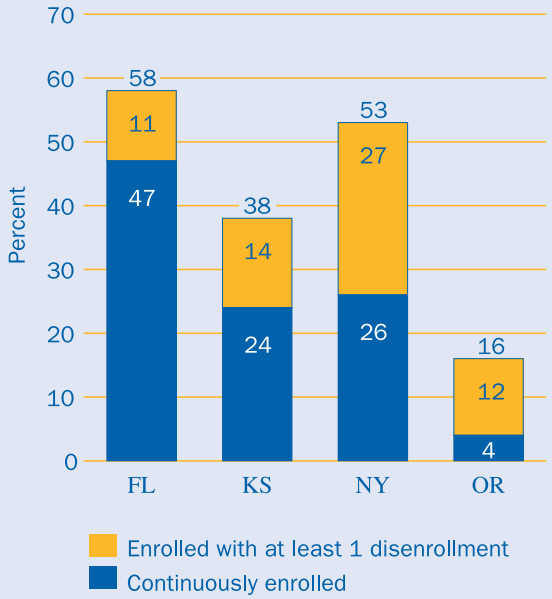
State SCHIP Design Can Affect Continuity of Coverage and Access to Care

SCHIP provides long-term coverage for some enrollees. A significant number of children were enrolled in SCHIP at the 2-year anniversary of their initial enrollment. Many of these children, however, were disenrolled from the program at least once during that time period (see Figure 2). Some disenrollments from SCHIP were the result of transfers to Medicaid (because of a change in the family's circumstances) or private insurance coverage. However, State redetermination policies that created barriers to renewal also had a significant impact on disenrollment.

Active renewal policies that required families to submit documentation to verify their continued eligibility were associated with substantial disenrollment. Requiring active eligibility redetermination every 6 months rather than every 12 months resulted in even higher levels of disenrollment over time. Up to one-quarter of children who disenrolled at renewal returned to SCHIP within 3 months (18 percent to 27 percent). A simplified renewal process that automatically reenrolled children in SCHIP unless their families submitted reenrollment forms indicating a change affecting their eligibility substantially reduced disenrollment at SCHIP renewal.

In some States with separate SCHIP programs, SCHIP design limited coverage for certain specialty services that are needed by CSHCN. This was done directly by limiting the scope of the benefit package or indirectly through ambiguous language in the definition of medical necessity in the State's SCHIP plan or contracts with health plans. This lack of clarity gave health plans considerable leeway to deny certain services to children. These restrictions are not allowable by Federal law under Medicaid or in SCHIP programs that are Medicaid expansions.

Figure 2. Children's Enrollment in SCHIP at 24 Months



OR requires redetermination of SCHIP eligiblity every 6 months.

FL, KS, and NY require redetermination every 12 months

SCHIP Is an Essential Component of Public Insurance Coverage for Children

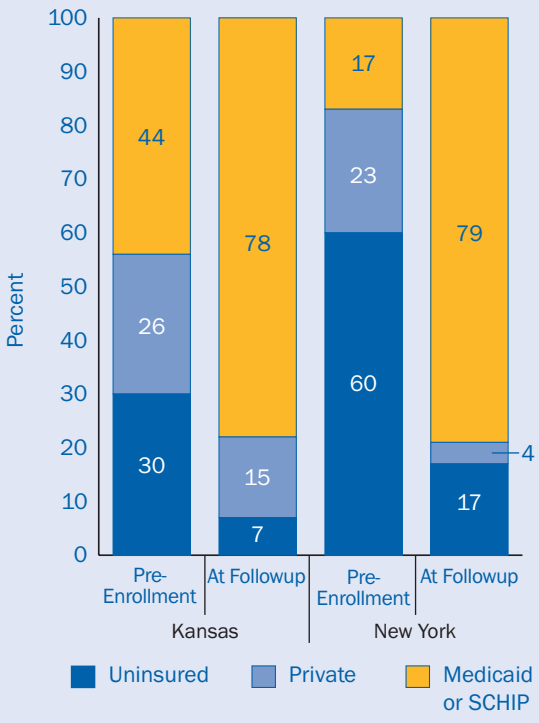
Many SCHIP enrollees were uninsured the entire year prior to SCHIP enrollment (30 percent to 60 percent). A substantial proportion of enrollees (17 percent to 44 percent) were previously insured by Medicaid and approximately one-quarter were covered by private insurance.

Most SCHIP enrollees continued to be insured at least one year after enrollment. More than three-quarters were publicly insured. Few enrollees (4 percent to 15 percent) obtained private insurance coverage after leaving SCHIP. Some enrollees became uninsured (7 percent to 17 percent) (see Figure 3). More than half the children were enrolled in SCHIP at the 2-year anniversary of their initial enrollment.

Most Families Enrolled in Oregon's Premium Assistance Program Lacked Employer-Sponsored Health Insurance

At the time of the study (2002), the Oregon Family Health Insurance Assistance Program (FHIAP) was a State-funded program that provided premium subsidies to families at up to 170 percent of FPL. Oregon's premium assistance program was unusual in that families who chose to enroll in FHIAP could use the subsidy to purchase employer-sponsored insurance or to buy individual coverage directly from insurers. Seventy percent of FHIAP families did not have access to employer-sponsored health insurance and therefore purchased their coverage in the individual market.

Figure 3. Insurance Status of SCHIP Enrollees at Pre-Enrollment and Followup



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

Eligibility requirements for FHIAP and SCHIP were identical and eligible families could choose to enroll in either program. Those who chose FHIAP, however, were more likely than their SCHIP counterparts to have parents who were highly educated and employed and to have prior experience with private health insurance coverage and paying premiums. FHIAP and SCHIP enrollees reported similarly high levels of health care access and satisfaction after enrollment.

More than half of low-income children who disenrolled from FHIAP and SCHIP no longer qualified for the program. Families cited increases in income as the primary reason for disenrollment. Almost half of FHIAP disenrollees and more than two-thirds of SCHIP disenrollees became uninsured after leaving public insurance. More than 85 percent of disenrolled families reported that they would have kept their children in SCHIP or FHIAP if possible.

Definitions

Children with special health care needs are children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Premium assistance programs subsidize the purchase of employer-sponsored or other private health insurance coverage for eligible low-income families.

Redetermination or renewal is the point at which a family's eligibility for coverage is reassessed. States have the option of determining how frequently eligibility will be reviewed (e.g., every 6 months, every 12 months).

Simplified renewal refers to a process in which families do not have to return a renewal form unless changes have occurred in their income or family status that might affect eligibility.

CONCLUSION

Low-income working families, including those with CSHCN, relied on SCHIP as an essential source of health insurance coverage for their children. The vast majority of the program's resources were spent on the poorest of eligible families. Given the income distribution of uninsured children, future children's health insurance expansions are likely to continue serving the neediest families.

After enrollment in SCHIP, more children had a regular source of care and used preventive care, fewer children had unmet health care needs, and families experienced higher satisfaction with care. Improvements in health care access and satisfaction were largely shared by vulnerable groups of enrollees. States achieved these results using a variety of program designs, including subsidizing insurance offered in the individual as well as group market. Nevertheless, opportunities remain to improve the quality of health care provided under SCHIP, especially for CSHCN and members of minority groups.

SCHIP's success is contingent on children remaining insured. SCHIP has not, however, served as a bridge to private insurance coverage for children in the short term. Few low-income children have access to affordable private insurance. The vast majority of SCHIP enrollees remained insured because they continued to participate in public insurance. At followup, nearly 80 percent of SCHIP enrollees were enrolled in Medicaid or SCHIP.

Some SCHIP enrollees, however, became uninsured. CHIRI™ research has shown that SCHIP coverage is frequently interrupted and that State renewal policies had a strong effect on a child's likelihood of disenrollment. Provisions under CHIPRA (see box on next page) encourage States to continue simplifying State renewal policies similar to the way States have streamlined the enrollment process. In addition, States can increase income eligibility, thereby ensuring that there is no gap between where CHIP eligibility ends and access to affordable coverage begins.

POLICY IMPLICATIONS

CHIRI™ findings point to strategies that States can use to strengthen SCHIP design, improve continuity of care, and increase access to care. These strategies are described in greater detail in the CHIRI™ Issue Briefs and include the following:

- Improve enrollment, renewal, and transition policies.
  - Simplify and facilitate eligibility and renewal processes, including reducing the frequency of eligibility redeterminations.
  - Improve "Screen and Renew" policies at renewal of SCHIP and Medicaid.
  - Educate families about the importance of obtaining and maintaining coverage for their families, as well as the children's insurance coverage options available to them.
  - Monitor the effectiveness of retention and transition policies (e.g., conduct surveys to determine reasons for disenrollment).
- Ensure appropriate coverage for children with special health care needs.
  - Define medical necessity broadly in SCHIP plans and in contracts with health plans.
  - Require that health plans identify and contract with primary care providers with expertise in serving CSHCN.
  - Involve families, particularly families of CSHCN, in the design of SCHIP (e.g., simplified enrollment and reenrollment forms, benefit packages).
- Implement quality improvement activities to improve services provided to enrollees, especially members of minority groups.
- Continue to explore creative ways to provide children with insurance coverage, such as allowing families to purchase individual coverage through premium assistance programs.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), thereby reauthorizing SCHIP. The Act includes a number of provisions to provide coverage to uninsured children and extends the program through September 30, 2013. It also officially renamed the State Children's Health Insurance Program (SCHIP) to the Children's Health Insurance Program (CHIP).

CHIRI™ STUDY METHODOLOGY

The findings highlighted in this summary document are drawn from CHIRI™ Issue Briefs that were developed based on research conducted by seven of the nine CHIRI™ projects (one national and six State based: Alabama/Georgia, Florida, Indiana, Kansas, New York, and Oregon). In the case of State research projects, findings were produced for each State and then compared across the States. In general, CHIRI™ research involved surveys of SCHIP enrollees at baseline and followup, reviews of SCHIP administrative records, focus groups, and State case studies, depending on the study. Data were collected from 1999 to 2002.

Survey interviewers spoke with the adult in the household, most often a parent who was most knowledgeable about the child's health insurance and medical care (one child per family). Data from the surveys typically involved demographics (e.g., child's age, gender, race/ethnicity), prior health insurance status, health care access, utilization, and quality of care before, during, and after SCHIP enrollment. Bivariate and multivariate analyses were conducted to determine any differences by demographic characteristics, health status, health care experiences, and health care needs. The presence of special health care needs was determined by the Children With Special Health Care Needs Screener©.

Individual CHIRI™ study methodologies are described in greater detail in the CHIRI™ research papers. References can be found on the CHIRI™ Web site at: www.ahrq.gov/chiri.

SOURCES

This CHIRI™ Issue Brief summarizes research findings from the following Issue Briefs. References to the original research articles on which these CHIRI™ Issue Briefs were based, as well as additional CHIRI™ findings, can be found on the CHIRI™ Web site at: www.ahrq.gov/chiri.

VanLandeghem K, Brach C. SCHIP disenrollment and State policies. CHIRI™ Issue Brief No. 1. Rockville, MD: Agency for Healthcare Research and Quality; June 2002. AHRQ Pub. No. 02-0017.

VanLandeghem K, Brach C. Who's enrolled in SCHIP? CHIRI™ Issue Brief No. 3. Rockville, MD: Agency for Healthcare Research and Quality; December 2003. AHRQ Pub. No. 04-0015.

VanLandeghem K, Brach C. Does SCHIP benefit all low-income children? CHIRI™ Issue Brief No. 4. Rockville, MD: Agency for Healthcare Research and Quality; November 2004. AHRQ Pub. No. 05-0010.

VanLandeghem K, Bonney J, Brach C, et al. SCHIP enrollees with special health care needs and access to care. CHIRI™ Issue Brief No. 5. Rockville, MD: Agency for Healthcare Research and Quality; August 2006. AHRQ Pub. No. 06-0051.

VanLandeghem K, Brach C, Bonney J, et al. Who enrolls in Oregon's premium assistance program and how do they fare? CHIRI™ Issue Brief No. 6. Rockville, MD: Agency for Healthcare Research and Quality; March 2007. AHRQ Pub. No. 07-0022.

VanLandeghem K, Brach C. Do SCHIP enrollees stay insured? CHIRI™ Issue Brief No. 7. Rockville, MD: Agency for Healthcare Research and Quality; May 2008. AHRQ Pub. No. 08-0057.

RELATED STUDIES OF INTEREST

Dubay L, Guyer J, Mann C, et al. Medicaid at the ten-year anniversary of SCHIP: looking back and moving forward. Health Aff 2007;26(2):370-81.

Hill I, Lutzky AW. Is there a hole in the bucket? Understanding SCHIP retention. Washington, DC: The Urban Institute; 2003.

Holohan J, Cook A, Dubay L. Characteristics of the uninsured: who is eligible for public coverage and who needs help affording coverage? Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2007.

Horner D, Guyer J, Mann C, et al. The Children's Health Insurance Program Reauthorization Act of 2009 overview and summary. Washington, DC: Center for Children and Families, Georgetown University Health Policy Institute; March 2009.

Kaye N, Pernice C, Cullen A. Charting SCHIP III: An analysis of the third comprehensive survey of State SCHIP programs. Washington, DC: National Academy for State Health Policy; 2006.

Rosenbaum S, Markus A, Sonosky S. Public health insurance design for children: the evolution from Medicaid to SCHIP. J Health Biomed Law 2004;1:1-47.

Ryan J, Shirk C. Reauthorizing SCHIP: a summary of selected issues. Washington, DC: National Health Policy Forum; January 2009.

Shirk C. Premium assistance toolbox for States: assisting States to develop premium assistance programs. Portland, ME: National Academy for State Health Policy; 2004.

VanLandeghem K, Brach C. Children's dental care access in Medicaid. The role of medical care use and dentist participation. CHIRI™ Issue Brief No. 2. Rockville, MD: Agency for Healthcare Research and Quality; June 2003. AHRQ Publication No. 03-0032.

Wooldridge J, Hill I, Harrington M, et al. Interim evaluation report: congressionally mandated evaluation of the State Children's Health Insurance Program. Cambridge, MA: Mathematica Policy Research; February 2003.

CHIRI
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For More Information

More information on CHIRI™ projects can be found at www.ahrq.gov/chiri/. Let us know how you use CHIRI™ research findings by contacting chiri@ahrq.gov.

CHIRI™ STUDIES

Analysis of Fee-for-Service vs. Managed Care for Children With Special Health Care Needs. Principal Investigator: Elaine Beane, Michigan Public Health Institute

Provider Participation and Access in Alabama and Georgia. Principal Investigator: Janet Bronstein, University of Alabama at Birmingham

Impact of Publicly Funded Programs on Child Safety Nets. Principal Investigator: Peter Budetti, Northwestern University

Medicaid SCHIP vs. Premium Subsidy: Oregon's SCHIP Alternatives. Principal Investigator: Janet B. Mitchell, RTI International

Responsiveness of SCHIP to Children With Special Health Care Needs. Principal Investigator: Sara Rosenbaum, George Washington University

Evaluation of Kansas Healthwave. Principal Investigator: Robert St. Peter, Kansas Health Institute

Access and Quality of Care for Low-Income Adolescents. Principal Investigator: Elizabeth Shenkman, University of Florida

Health Care Access, Quality, and Insurance for Children With Special Health Care Needs. Principal Investigator: Nancy Swigonski, Indiana University School of Medicine

New York's SCHIP: What Works for Vulnerable Children. Principal Investigator: Peter Szilagyi, University of Rochester

CHIRI™ FUNDERS

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

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

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

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