Enacted in 1997 as Title XXI of the Social Security Act, the State Children’s Health Insurance Program (SCHIP) offers significant potential for expanding health insurance for children and improving their access to care. According to the states, nearly 2 million children were enrolled by October 1999. Ultimately, 3 million uninsured children in low-income families, or about one third of all US uninsured children, could eventually gain coverage under SCHIP. Moreover, SCHIP outreach efforts may also lead to increased enrollment levels of children already eligible for Medicaid.

More than 2 years have now passed since enactment of the program and many of the components needed to monitor the program are now in place. These include a new template to assist states in meeting federal reporting requirements, an external evaluation funded by the Health Care Financing Administration (HCFA), several SCHIP research projects funded through the Agency for Healthcare Research and Quality.

The enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 further enhances the prospects for a comprehensive approach to monitoring. This act, incorporated in one of the final appropriations bills for fiscal year 2000 (Public Law 106-113), not only included new appropriations for data collection and evaluation as indicated above, but also expands Congressional oversight by specifying periodic audits by the Inspector General of the Department of Health and Human Services combined with monitoring reports from the General Accounting Office to assess progress in reducing the number of uninsured low-income children. The legislation also directs the federal Department of Health and Human Services to take an active role in coordinating and consolidating data and reports regarding children’s health.

In this commentary, we outline several elements of a comprehensive national monitoring program and discuss how these new data collection and evaluation initiatives fit within this framework. We start by providing some baseline data on the health needs of children in the SCHIP target population. This is followed by a discussion of the goals and objectives of a national SCHIP monitoring strategy. We then describe several critical elements of an effective national monitoring strategy and the potential contribution of the new data collection and evaluation efforts. Finally, we discuss the need for federal leadership in forging these elements into a cohesive monitoring strategy. Without a coordinated approach to monitoring, duplication and inefficiency are inevitable and potential synergies may be lost.

BACKGROUND

Congress designed SCHIP as a program to extend health insurance to children in low-income families (below 200% of the federal poverty level) who are otherwise uninsured and not eligible for Medicaid. Uninsured children in low-income families experience substantial difficulties in accessing care as indicated by absence of a usual source of care, absence of a regular clinician, presence of unmet health needs, and lack of a recent physician contact. Figure 1, based on previously unpublished data from the 1997 National Health Interview Survey (NHIS), illustrates the scope and magnitude of unmet needs and access barriers among low-income children during the year SCHIP was enacted. Figure 1 also shows differences between insured and uninsured children and thus SCHIP’s potential for improving access by expanding insurance coverage.

More than 1 in 4 uninsured children in low-income families lacked a usual source of care in 1997. Uninsured children in low-income families were also at high risk of going without needed medical services; nearly 1 in 10 were reported to have an unmet health need during the preceding year attributable to the costs of care. A large proportion of uninsured children in low-income fami-

Fig 1. Access to care and unmet health needs among children in families with incomes below 200% of poverty: United States, 1997.

MONITORING GOALS

An effective monitoring strategy should accomplish 2 main goals. First, it should provide information about the impact of the new state programs—both individually and collectively—in expanding health insurance coverage and in improving access to care in the short- and long-term. Second, an effective monitoring strategy should permit identification of features of state plans that contribute to success or act as barriers to enrollment, retention, and access to care.

Congress gave states substantial flexibility in designing their programs. For example, states can choose to use Medicaid or a separate state plan to expand insurance coverage. Within certain guidelines they can choose eligibility levels, benefit coverage, and other program characteristics. As a result, there is wide variation in the approaches taken across states. This creates a natural experiment of sorts that can be exploited with a well-designed monitoring strategy to help us identify and understand the most effective mechanisms for improving access for children in low-income families. That way, when creative outreach strategies and other innovations in enrolling and retaining children in the program are identified, they can be adopted by other states as midcourse corrections.

In addition, a well-designed monitoring strategy can help strengthen our ability at the national level to monitor the health care of all children. That is, the need to evaluate SCHIP can be used as an opportunity to bolster existing national and state level data systems so they do a better job of tracking access to care for children. These include administrative data systems located primarily at the state level, such as enrollment and claims management systems, and population-based surveys at the national level, such as the NHIS and the Medical Expenditure Panel Survey. Moreover, a well-planned strategy can help foster better measurement of children’s access to care. In recent years, much effort has been devoted to improving children’s measures of access and satisfaction with care through initiatives such as the Consumer Assessment of Health Plans Study. Although designed for evaluating performance of managed care plans, many of the measures developed through the Consumer Assessment of Health Plans Study initiative could be used for evaluating SCHIP. The need to monitor SCHIP provides a unique opportunity to implement these measures across the states in order to understand how SCHIP and other changes in federal policies affecting low-income families impact health insurance and access to care.

COMPONENTS OF AN EFFECTIVE MONITORING STRATEGY

Achieving these goals requires a multifaceted monitoring strategy. A number of recent reports have addressed SCHIP monitoring and evaluation. These reports include an evaluation tool developed in 1998 by the American Academy of Pediatrics. This tool, composed of 30 indicators to measure the impact of SCHIP, was developed by experts in the field using a consensus process. The Institute of Medicine also sponsored a Committee on Health Insurance and Children’s Access to Care. This committee’s report contains a series of recommendations concerning accountability under SCHIP. These recommendations emphasize the need to improve data systems to support SCHIP monitoring. More recently, the National Academy of State Health Policy (NASHP) released a framework to help states meet federal reporting requirements for Title XXI. This voluntary tool was developed by a task force nominated by the National Governors Association, the American Public Human Services Association, and key federal agencies. In addition, several articles on strategies for monitoring SCHIP have appeared in leading academic and health policy journals.

Several important themes and ideas concerning monitoring were raised across these reports. Together these themes and ideas provide a foundation for an effective national monitoring strategy. Four key elements of such a strategy stand out: 1) taking...
a comprehensive approach to monitoring; 2) collecting comparable data across states; 3) making effective use of existing data sources, and; 4) sponsoring new data collection efforts where needed. Each of these elements is discussed below.

**Taking a Comprehensive Approach to Monitoring**

A dual focus on assessing both the enrollment process and the health care utilization process is critical to understanding the program's impact. In enacting SCHIP, Congress was primarily interested in how effective the program would be in enrolling eligible children. There was also concern that the program might displace or crowd out private insurance provided by employers. Hence, most of the federal reporting requirements focus on counting newly insured children. However, because insurance alone does not guarantee access to care, the process of accessing and obtaining care must also be evaluated.

In addition, a comprehensive monitoring approach should focus broadly on the low-income population of children, not just those eligible under the new SCHIP initiatives. Indeed, SCHIP’s impact is likely to extend beyond the targeted eligible population. For example, SCHIP outreach efforts targeted at low-income communities may lead to increased enrollment of children already eligible for Medicaid. Anecdotal evidence from the states suggests this is in fact occurring. A broad focus on the entire low-income population has the advantage of helping to detect such important but indirect effects.

These goals will be facilitated by a provision of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 that includes an appropriation of $10 million to conduct a 10-state evaluation of SCHIP. The legislation specifies that the evaluation is to include surveys of the target population, evaluation of effective and ineffective outreach and enrollment practices for children under both SCHIP and Medicaid, an assessment of the degree to which Medicaid and SCHIP enrollment and outreach practices are coordinated, and an assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

Another source of potentially rich state level contextual data will be generated through several new grants jointly funded by the Agency for Healthcare Research and Quality, the David and Lucile Packard Foundation, and the Health Resources and Services Administration. These studies are aimed at providing new information on the impact of SCHIP on access and quality of care. Most of these research projects are focused on particular states and the impact of SCHIP on specific subpopulations, such as children with special health care needs, within those states.

**Collecting Comparable Data Across States**

Use of a uniform set of core indicators on health insurance coverage, access and utilization is essential to making valid comparisons across states. If different data elements are collected from one state to the next, or if disparate methods are used to collect those data, it will be difficult to identify program characteristics that serve children well. Ideally, a core dataset would be collected in a uniform fashion across all states. In addition, supplemental data items unique to each state could also be collected. To support collection of comparable data, an evaluation template consisting of a standardized set of data elements as well as definitions, formats, and protocols for collecting them is needed. A major step in this direction occurred recently when the NASHP released its framework to help states meet Title XXI reporting requirements. Subsequently, the HCFA endorsed the NASHP template and encouraged the states to use it in meeting federal reporting requirements for SCHIP.

**Making Effective Use of Existing Data**

There are several useful data sources for SCHIP monitoring at the national level including the Current Population Survey (CPS), the NHIS, and the Medical Expenditure Panel Survey. These surveys are excellent sources for monitoring national trends in insurance coverage, access, and utilization. Unfortunately, none of these surveys has sufficient sample size at present to support state level analyses, except in the largest states. Nevertheless, there are creative ways to combine elements of these data sources in a fashion that can provide insights not possible when the datasets are used in isolation. The contractor for the HCFA’s new $4.2 million SCHIP evaluation contract, Mathematica Policy Research, has proposed such a strategy.

There are also existing state and local data sources that can be tapped for monitoring SCHIP. These include the Urban Institute’s National Survey of America’s Families. This survey was originally designed to assess the impact of welfare reform in 13 selected states. The Robert Wood Johnson Foundation has given the Urban Institute supplemental funds to assess the impact of SCHIP in those states. Another data source is the Community Tracking Survey. This is another Robert Wood Johnson Foundation funded survey designed to assess health care system change in 60 selected communities. It is designed for local analyses but the local samples can be aggregated to conduct SCHIP monitoring in certain states.

Even with these data sources, our capacity to conduct comparative analyses across states is very limited. In fact, it is currently impossible to examine changes in insurance coverage or access to care in a uniform fashion across all states with existing data sources. To do this we need to invest in new data collection efforts capable of providing state level data.

**Sponsoring New Data Collection Efforts Where Needed**

There are 2 possible approaches to generating needed state level data. One approach is to augment existing national surveys so they are capable of providing reliable state level estimates. For example, adding sample children in small and me-
medium size states would greatly increase the utility of national surveys like the CPS and the NHIS.

The other approach is to implement the State and Local Area Integrated Telephone Survey (SLAITS). SLAITS is a rapid turn-around telephone survey designed by the National Center for Health Statistics. If funded, it would be capable of providing reliable state level data on access, utilization and other characteristics of the SCHIP target population for all 50 states. Special provisions are built into the SLAITS methodology to account for the potential bias from excluding households without telephones. The National Center for Health Statistics has designed a version of SLAITS specifically for the purpose of monitoring SCHIP.

Given these options, Congress, through the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, chose to appropriate $10 million annually for augmenting the CPS to improve state level estimates for children. This action should result in more precise estimates of insurance coverage characteristics for SCHIP’s target population.

PUTTING THE PIECES TOGETHER
During the 2 years since enactment of SCHIP, several new and potentially very valuable data collection and evaluation activities have been funded and, in some cases, implemented. Taken together, the ingredients for an effective national monitoring strategy are now largely in place. What is missing still is strong federal leadership in drawing the pieces together in an effective and efficient fashion. Without that we are likely to miss important opportunities to learn about what works and what doesn’t in meeting the health care needs of low-income children. Moreover, absent effective leadership, duplication and inefficiency are inevitable. For example, even though the HCFA contracted for a $4.2 million national SCHIP evaluation during the spring of 1999, Congress appropriated $10 million for a new multistate evaluation just before it recessed in the fall of 1999. How will these potentially duplicative evaluations be coordinated?

In part, the absence of strong federal leadership reflects the minimal evaluation requirements contained in the original enabling legislation for SCHIP. In addition, there has existed a reluctance in the federal Executive Branch to impose additional information requirements on the states. SCHIP has been largely viewed as a state program by high level policymakers in the Clinton Administration. As a result there has been something of a hands off attitude at the top levels of government. This is partly a response to resistance by the states to anything other than minimal reporting requirements.

Without federal leadership, evaluation activities are being conducted in an ad hoc and uncoordinated fashion across the states. Although these activities have already led to some very useful information for individual states,13,17–19 without a more comprehensive and integrated approach to monitoring the implementation and impact of SCHIP our capacity to make state comparisons, and thus the ability to identify program features that lead to successful outcomes, will be compromised. An integrated monitoring program that combines population-based data with contextual information from state-specific evaluations could go a long way toward enhancing the ability of SCHIP and Medicaid to meet the health needs of children in low-income families.

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