

Who's Enrolled in the State Children's Health Insurance Program (SCHIP)? An Overview of Findings From the Child Health Insurance Research Initiative (CHIRI)

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ABSTRACT. *Background.* The State Children's Health Insurance Program (SCHIP) was enacted in 1997 to provide health insurance coverage to uninsured low-income children from families who earned too much to be eligible for Medicaid.

Objectives. To develop a "baseline" portrait of SCHIP enrollees in 5 states (Alabama, Florida, Kansas, Indiana, and New York) by examining: 1) SCHIP enrollees' demographic characteristics and health care experiences before enrolling in SCHIP, particularly children with special health care needs (CSHCN), racial and ethnic minority children, and adolescents; 2) the quality of the care adolescents received before enrollment; and 3) the changes in enrollee characteristics as programs evolve and mature.

Methods. Each of 5 projects from the Child Health Insurance Research Initiative (CHIRI) surveyed new SCHIP enrollees as identified by state enrollment data. CHIRI investigators developed the CHIRI common core (a set of survey items from validated instruments), which were largely incorporated into each survey. Bivariate and multivariate analyses were conducted to ascertain whether there were racial and ethnic disparities in access to health care and differences between CSHCN and those without. Current Population Survey data for New York State were used to identify secular trends in enrollee characteristics.

Results. Most SCHIP enrollees (65% in Florida to 79% in New York) resided in families with incomes $\leq 150\%$ of

the federal poverty level. Almost half of SCHIP enrollees lived in single-parent households. A majority of SCHIP parents had not had education beyond high school, and in 2 states (Alabama and New York) $\sim 25\%$ had not completed high school. The vast majority of children lived in households with a working adult, and in a substantial proportion of households both parents worked. Children tended to be either insured for the entire 12 months or uninsured the entire 12 months before enrolling in SCHIP. Private insurance was the predominant form of insurance before enrollment in SCHIP in most states, but 23.3% to 51.2% of insured children had Medicaid as their most recent insurance.

Health Care Use and Unmet Needs Before SCHIP. The vast majority of all SCHIP enrollees had a usual source of care (USC) during the year before SCHIP. The proportion of children who changed their USC after enrolling in SCHIP ranged from 29% to 41.3%. A large proportion of SCHIP enrollees used health services during the year before SCHIP, with some variability across states in the use of health care. Nevertheless, 32% to almost 50% of children reported unmet needs.

CSHCN. The prevalence of CSHCN in SCHIP (between 17% and 25%) in the study states was higher than the prevalence of CSHCN reported in the general population in those states. In many respects, CSHCN were similar to children without special health care needs, but CSHCN had poorer health status, were more likely to have had unmet needs, and were more likely to use the emergency department, mental health care, specialty care, and acute care in the year before enrolling in SCHIP than children without special health care needs.

Race and Ethnicity. A substantial proportion of SCHIP enrollees were black non-Hispanic or Hispanic children (Alabama: 34% and $<1\%$; Florida: 6% and 26%; Kansas: 12% and 15%; and New York: 31% and 45%, respectively). Minority children were poorer, in poorer health, and less likely to have had a USC or private insurance before enrolling in SCHIP. The prevalence and magnitude of the disparities varied among the states.

Quality of Care for Adolescents. Seventy-three percent of adolescent SCHIP enrollees engaged in one or more risk behaviors (ie, feeling sad or blue; alcohol, tobacco, and drug use; having sexual intercourse; and not wearing seat belts). Although almost 70% of adolescents reported having had a preventive care visit the previous year, a majority of them did not receive counseling in each of 4 counseling areas. Controlling for other factors, having a private, confidential visit with the physician was associated with an increased likelihood (2–3 times more likely) that the adolescent received counseling for 3 of 4 counseling areas.

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Trends Over Time. New York SCHIP enrollees in 2001, compared with 1994 enrollees in New York's SCHIP-precursor child health insurance program, were more likely to be black or Hispanic, older, from New York City, and from families with lower education, income, and employment levels. A greater proportion of 2001 enrollees was uninsured for some time in the year before enrollment, was insured by Medicaid, and lacked a USC. Secular trends in the low-income population in the state did not seem to be responsible for these differences. Program modifications during this time period that may be related to the shift in enrollee characteristics include changes to benefits, outreach and marketing efforts, changes in the premium structure, and the advent of a single application form for multiple public programs.

Conclusions. SCHIP enrollees are a diverse group, and there was considerable variation among the 5 study states. Overall, SCHIP enrollees had substantial and wide-ranging health care needs despite high levels of prior contact with the health care system. A sizable minority of SCHIP enrollees has special health care needs. There is racial and ethnic diversity in the composition of enrollees as well, with racial and ethnic disparities present. The quality of care adolescents received before enrollment in SCHIP was suboptimal, with many reporting unmet health care needs and not receiving recommended counseling. The characteristics of SCHIP enrollees can be expected to change as SCHIP programs evolve and mature.

Policy Implications. 1) Benefits should be structured to meet the needs of SCHIP enrollees, which are comparable to Medicaid enrollees' needs in many respects. 2) Provider networks will have to be broad if continuity of care is to be achieved. 3) Multiple outreach strategies should be used, including using providers to distribute information about SCHIP. 4) The quality of care delivered to vulnerable populations (eg, minority children, CSHCN, and adolescents) should be monitored. 5) States and health plans should actively promote quality health care with the goal of improving the care received by SCHIP enrollees before enrollment. 6) States will have to craft policies that fit their local context. 7) Collecting baseline information on SCHIP enrollees on a continuous basis is important, because enrollee characteristics and needs can change, and many vulnerable children are enrolling in SCHIP. *Pediatrics* 2003;112:e499–e507. URL: <http://www.pediatrics.org/cgi/content/full/112/6/e499>; access, children, children with special health care needs, disparities, enrollment, ethnicity, insurance, Medicaid, minorities, quality, race, State Children's Health Insurance Program.

ABBREVIATIONS. CHIRI, Child Health Insurance Research Initiative; SCHIP, State Children's Health Insurance Program; CSHCN, children with special health care needs; USC, usual source of care; FPL, federal poverty level.

This supplement to *Pediatrics* presents findings from the Child Health Insurance Research Initiative (CHIRI) that shed light on the question, "Who is enrolled in the State Children's Health Insurance Program (SCHIP)?" SCHIP¹ was enacted in 1997 in response to a seemingly intractable problem: the lack of health insurance among children. Although a large public insurance program for low-income children, Medicaid, has been in effect since 1965, 14% of all children under 19 were uninsured in

1995.² Evidence had continued to accumulate that children without insurance had reduced access to health care and poorer health status.^{3–11} However, low-income children from families who earned too much to be eligible for Medicaid and did not have access to affordable dependent coverage from employers continued to fall between the cracks.¹² Congress responded to the plight of these uninsured children by sponsoring SCHIP, which made \$40 billion available as federal matching funds to states over a 10-year period.

Under the SCHIP legislation, states are given considerable latitude in designing and implementing their programs.¹³ They can expand Medicaid, create a separate program, or combine the 2 approaches. States also have control over setting the eligibility criteria, the delivery system, and, for states that opted for separate or combination programs, the benefit structure of their SCHIP programs. Although SCHIP is a small program compared with Medicaid (Medicaid serves 10 times as many children as SCHIP), it generated enthusiasm for the task of providing health insurance for children.¹⁴ Many were inspired by the flexibility offered under SCHIP to invest considerable energy into designing SCHIP programs.¹⁴ The autonomy given to states has resulted in the implementation of SCHIP programs with greatly varying features.

WHO'S INTERESTED IN WHO'S ENROLLED IN SCHIP?

Policy makers have an interest in knowing whether SCHIP is in fact serving the children it was intended to serve. SCHIP was designed to serve a specific segment of children: those who were not eligible for Medicaid and yet did not have "creditable coverage," that is, alternative health insurance that meets minimum standards.¹⁵ At the time of SCHIP's passage, policy makers balanced an interest in reducing the number of uninsured children against concern over creating an additional entitlement by further expanding Medicaid. Furthermore, SCHIP was passed during a time period in which the welfare system was reformed dramatically to encourage and reward work. As a result, beneficiaries of the SCHIP legislation were portrayed as children of working families who pay their taxes but could not afford health insurance.^{16–18}

State health agency administrators, public officials, and health plans also need information about who enrolls in SCHIP. Ideally, the SCHIP health care delivery system would be shaped by information regarding the characteristics and needs of enrollees. Because SCHIP was new, policy makers had to design their programs based on assumptions and estimates about how the SCHIP population may resemble or be dissimilar to other low-income children: those insured by Medicaid, those privately insured, and those uninsured. Data on SCHIP enrollees' demographics and prior health care experiences allow policy makers to reexamine their assumptions and make evidence-based decisions.

Policy makers and program administrators are also interested in the characteristics and needs of

vulnerable groups of SCHIP enrollees. Children with special health care needs (CSHCN), members of racial and ethnic minority groups, and adolescents constitute distinct populations whose health is of particular concern to policy makers. Their prevalence in SCHIP, characteristics, and prior health care experiences could influence future program adjustments.

Providers are also interested in knowing about the characteristics and needs of SCHIP enrollees. As SCHIP's front line, providers want to know about the types of children they are likely to see to deliver the most appropriate services. Providers also want to know about the care enrollees have received before SCHIP enrollment, which can serve as a benchmark for learning if their participation in SCHIP improves health care for enrolled children.

WHAT IS CHIRI?

Numerous child health services researchers and funders of research recognized that the implementation of SCHIP represented an unparalleled research opportunity.¹⁹ In response to this opportunity, CHIRI, a unique, multistate research program, was launched in the fall of 1999 by the Agency for Health Care Research and Quality, The David and Lucile Packard Foundation, and the Health Resources and Services Administration.²⁰ CHIRI's main purpose is to supply policy makers with information to help them improve access to and the quality of health care for low-income children.

CHIRI is a 3-year, \$9.7 million effort that includes 9 separate research projects, 7 of which are state-based and 2 of which are national in scope. Although the primary focus of most CHIRI studies is SCHIP, some projects include studies of Medicaid and the Title V Maternal and Child Health Services Block Grant program (a component of which serves CSHCN). The majority of the studies concentrate on the impact of public insurance programs on enrolled children, but some CHIRI projects examine impacts of public health insurance programs on communities and the health care system.

CHIRI places an emphasis on particularly vulnerable populations: CSHCN, racial and ethnic minority children, and adolescents. Little is known about the impact of changes in health care delivery systems on CSHCN, who have been found in general to have many needs.²¹⁻²⁴ Minority children are also of particular interest, because past research has shown that minority children can face greater barriers to care than nonminority children.²⁵⁻²⁷ Adolescents have also been identified as a third vulnerable population that is at risk of high morbidity and mortality but often goes underserved.²⁸ Thus, 7 CHIRI projects address CSHCN, 5 projects address disparities between minority and nonminority children, and 2 projects address adolescents. Furthermore, several CHIRI studies are longitudinal and are assessing SCHIP's impact both overall and on vulnerable populations.

Producing policy-relevant research has been a fundamental objective of CHIRI from its inception. CHIRI grantees are required to work with the state and local programs being studied to ensure that the

researchers are answering questions that policy makers are asking. Researchers are also required to ensure that public officials and other stakeholders continue to be involved throughout the studies. National stakeholders have also been given an opportunity to have input into CHIRI research.

Finally, CHIRI is a collaborative initiative that is able to harness the research skills, knowledge, and perspectives of multiple research entities. Although the 9 CHIRI studies were designed and funded separately, the researchers have engaged in a cooperative process that makes CHIRI truly an initiative rather than a collection of disparate studies. The principal investigators all participate in a coordinating committee and various work groups to facilitate research collaboration among projects. This *Pediatrics* supplement is an example of this collaboration. CHIRI researchers have joined forces to present comparable findings across several states, highlighting commonalities and dissimilarities of SCHIP enrollees.

WHAT IS CHIRI'S NEW CONTRIBUTION?

Despite researchers' interest in studying SCHIP, no national studies have yet been published that can answer the question, "Who's enrolled in SCHIP?" based on identified samples of program enrollees. Several researchers have modeled what the SCHIP-eligible population looks like by using population-based household surveys.^{29,30} Population-based surveys, however, cannot conclusively identify children who are enrolled in SCHIP because of confusion about which insurance coverage children possess. Moreover, models of income eligibility, even sophisticated ones, cannot take into account all states' complex eligibility rules. Even if SCHIP enrollees could be identified reliably, most national surveys would be limited by having few SCHIP enrollees in most states because of the relatively small number of SCHIP enrollees.

CHIRI analyses are based on surveys of children known to be enrolled in SCHIP and thus provide robust samples of SCHIP enrollees. Additionally, CHIRI surveys are able to capture SCHIP enrollees' experiences with insurance and health care before they enrolled in SCHIP as well as support analyses by race and ethnicity or CSHCN status and examinations of the quality of care received by adolescents.

A handful of researchers have collected data for single-state evaluations of SCHIP programs,³¹⁻³³ but these studies have not included the breadth of analyses found in the CHIRI research. Although not national in scope, the CHIRI data in this supplement encompass 5 states that collectively accounted for almost 30% of SCHIP enrollment in 2001. CHIRI includes states that are large and had SCHIP-like programs before the passage of the SCHIP legislation as well as relatively small states that implemented new programs as a result of SCHIP. This range provides more breadth than studies of single states.

METHODS

The specific methods of the CHIRI projects are described in detail in the articles and technical appendices included in this

supplement.^{24,28,34–38} Each CHIRI project represented in this supplement conducted a survey of new enrollees of separate, free-standing SCHIP programs as identified by state enrollment data. (Indiana sampled only CSHCN new enrollees in both their free-standing and Medicaid expansion SCHIP programs, and Florida sampled only adolescents.) Table 1 summarizes the SCHIP program characteristics in the study states. Each project was responsible for the design of its own survey to meet its objectives.

To maximize the ability to compare findings across states, a number of CHIRI investigators formed a work group to coordinate key survey questions. Working with a variety of existing validated survey instruments, the investigators developed a set of survey items that have come to be known as the CHIRI common core. In addition to items assessing children's health care experiences before enrollment, the CHIRI common core includes the Child and Adolescent Health Measurement Initiative CSHCN screener, a set of screening items for identifying CSHCN, and questions to identify both the race and ethnicity of enrollees.

The CHIRI common core served as the basis of collaboration for the 2 articles in this supplement that drew on data from several states.^{24,37} Different schedules for fielding the surveys, constraints on survey length, and the need to maintain consistency with prior work done in a state meant that not all CHIRI projects could adopt the full set of CHIRI common core questions exactly as constructed. Nevertheless, the collaborative process resulted in a much higher level of comparability across data sets than would otherwise have been the case. In addition to CHIRI surveys, data from a previous study of enrollees in a New York SCHIP precursor program, as well as 1992 to 1994 and 1999 to 2001 Current Population Survey data for New York State, are used to analyze how the population of enrollees in 2001 differed from enrollees in 1994.

RESULTS

Demographics, Health Care Use, and Needs of SCHIP Enrollees

Although children living in the study states can qualify for SCHIP with family incomes up to 200% or 250% of the federal poverty level (FPL) (see Table 1), most SCHIP enrollees (from 65% in Florida to 79% in New York) resided in families with incomes \leq 150% of the FPL. Almost half of SCHIP enrollees lived in single-parent households. A majority of SCHIP parents did not have any education beyond high school, and in 2 states (Alabama and New York) \sim 25% had not completed high school. The vast majority of children lived in households with a working adult (80% in Florida and New York to 87% in Kansas), and in a substantial proportion of households both parents worked.

Two patterns of prior insurance emerged: children tended to be either insured for the entire 12 months (ie, they enrolled in SCHIP immediately after their previous coverage ended) or were uninsured the entire 12 months before enrolling in SCHIP. The proportion of SCHIP enrollees uninsured the entire year before enrollment was greatest in the 2 states that had SCHIP precursors, with 62% and 73% uninsured all year in New York and Florida, respectively. Private insurance was the predominant form of prior insurance in most states, but 23.3% to 51.2% of insured children had Medicaid as their most recent insurance. The major reasons for loss of prior insurance were: change of parent's employment; the high costs of the prior insurance; the perception that there would be better benefits from SCHIP compared with their prior insurance; and a life change such as loss of Medicaid because of income change, aging out, divorce, or death.

The vast majority of all SCHIP enrollees (75% to $>$ 90%) had a usual source of care (USC) during the year before SCHIP. The most common type of prior USC was a doctor's office outside of the hospital, followed by community health centers and hospital clinics. Common reasons for not having a USC were lack of health insurance, child never being sick, and having recently moved into the area, although reasons varied across the study states. The proportion of children in each state who changed their USC after enrolling in SCHIP ranged from 29% to 41.3%.

A large proportion of SCHIP enrollees used health services during the year before SCHIP, which includes a high proportion using the emergency department and more than two-thirds having a preventive visit. More than half of SCHIP enrollees had a dental visit in the prior year. There was some variability across states in the use of health care, and not all visit types were assessed by all the studies.

These findings suggest that SCHIP tends to enroll a population of children who were already connected to some degree with the health care system and were not predominantly disenfranchised children who lacked prior contact with the health care system. Nevertheless, a high proportion of all SCHIP enrollees (32.6% to nearly 50%, depending on the state) reported some kind of unmet health care need during the year before SCHIP. These included unmet needs for mental health care, specialty care, dental and vision care, and prescription medications.

Vulnerable Populations

Three vulnerable populations of children are analyzed in this collection of articles: children who have special health care needs, minority children, and adolescents. These children have traditionally been underserved by the health care system. Because their health care needs are somewhat different from those of other children, insight may be gained from examining each group in some detail.

CSHCN

Szilagy et al²⁴ used CHIRI data from 4 states to examine CSHCN enrolled in SCHIP. By using the CSHCN screener,³⁹ researchers found that the prevalence of CSHCN in SCHIP (between 17% and 25%) was higher than the most recent estimates of prevalence of CSHCN in those states from the National Survey of Children with Special Health Care Needs.⁴⁰

A broad spectrum of CSHCN was identified. In some respects CSHCN did not differ significantly from other SCHIP enrollees. The demographic characteristics of CSHCN were similar to those of children without special health care needs. Preenrollment insurance rates and types of insurance also did not differ significantly between the 2 groups of children. Similar to other SCHIP enrollees, most CSHCN had a USC before enrollment in SCHIP and between 23.5% and 38% of CSHCN changed their USC on enrollment in SCHIP. Although CSHCN had poorer health status than those without special health care needs, many CSHCN were reported to be in good health.

TABLE 1. SCHIP Characteristics

Characteristic	Alabama	Florida	Indiana	Kansas	New York
Program name	ALL Kids	Healthy Kids	Hoosier Healthwise	HealthWave	Child Health Plus
Program structure*	Combination†	Combination‡	Combinations§	Separate, free-standing	Combination
Year SCHIP operations or SCHIP precursor began	1998	1990 (Precursor)¶	1998	1999	1991 (Precursor)¶¶
2001 enrollment#	66 179	298 705	56 986	34 241	590 000
Income eligibility as a percent of FPL**					
Children 0–1	133–200%	185–200%	150–200%	150–200%	185–250%
Children 1–5	133–200%	133–200%	133–200%	133–200%	133–250%
Children 6–18	100–200%	100–200%	100–200%	100–200%	100–250%
Presumptive eligibility	No	No	No	No	60 days
Required waiting period for separate free-standing program	3 months	None	3 months	6 months††	None
Premiums	\$50/child/year, with a maximum of \$150/family/year	\$15/family/month	151–175% FPL \$11/child, with a maximum of \$16.50/two or more children; 176–200% FPL-\$16.50/child with a maximum of \$24.75/two or more children	151%–175% FPL; \$10/family/month; 176%–200% FPL; \$15/family/month	160%–222% FPL: \$9/child/month with a maximum of \$27/family/month; 223%–250% FPL: \$15/child/month with a maximum of \$45/family/month
Delivery system	Fee-for-service	Primary care case management and capitated managed care	Primary care case management and capitated managed care	Capitated managed care	Capitated managed care

Sources: National Conference of State Legislatures,^{49–51} Ross and Cox,⁵² and Centers for Medicare and Medicaid Services.^{53,54}

* This table reflects program characteristics in 2001. Characteristics may have changed since then. With the exception of Indiana, where the Medicaid expansion portion of SCHIP represents a significant proportion of SCHIP enrollees, the studies described in this supplement included only new enrollees of separate, free-standing SCHIP programs (ie, Medicaid expansion SCHIP enrollees were not included).

† Alabama's Medicaid expansion covered children 14–18 years old up to 100% of the FPL who were not otherwise eligible for Medicaid.

‡ Florida's Medicaid expansion covered children under 1 and 17–18 years old to 100% of FPL who were not otherwise eligible for Medicaid.

§ Indiana's Medicaid expansion covered all children up to 150% of FPL who were not otherwise eligible for Medicaid.

¶ New York's Medicaid expansion covered children 15–18 years old to 100% FPL who were not otherwise eligible for Medicaid.

¶¶ Florida and New York had state-specific SCHIP precursor programs that became their respective SCHIP programs after the passage of Title XXI of the Social Security Act.

Entries on this row represent the total number of enrollments during federal fiscal year 2001.

** Children with incomes below the lower bounds stipulated in this table are covered by Medicaid, with exceptions noted in Florida's and New York's combination programs. In New York and Florida, children with incomes above the upper bounds stipulated in this table are eligible for SCHIP, but families must pay the full cost for the coverage.

†† Kansas repealed its 6-month waiting period provision in April 2001, after the study sample was selected.

Although there was variability among the states, CSHCN were more likely than other children to use the emergency department, mental health care, specialty care, and acute care in the year before enrolling in SCHIP. A high proportion (44%–62%) of CSHCN reported unmet health care needs. CSHCN were more likely to have had unmet needs than children without special health care needs despite the fact that CSHCN tended to be more likely to have had health care visits during the prior year. Nevertheless, CSHCN, similar to children without special health care needs, rated the quality of their medical care highly.

Children from Racial and Ethnic Minority Groups

Racial and ethnic disparities in health care have been well documented⁴¹ and are a public policy concern.^{42,43} Shone et al³⁷ examined baseline disparities in access to health care among different racial and ethnic groups in SCHIP in 4 states.

The researchers found that a substantial proportion of SCHIP enrollees were black non-Hispanic or Hispanic children (Alabama: 34% and <1%; Florida: 6% and 26%; Kansas: 12% and 15%; and New York: 31% and 45%, respectively). Minority children differed from their white non-Hispanic counterparts on sociodemographic as well as health care and health measures despite the fact that all families had incomes that fell within the narrow band of SCHIP eligibility. More minority children came from single-parent and lower-income families. Minority children were less likely to have had a USC before enrolling in SCHIP. Minority children, particularly Hispanic children, were reported to be in poorer health than white children. Among children who had insurance in the year before SCHIP enrollment, minority children were more likely to have had Medicaid and less likely to have been covered by employer-sponsored health insurance compared with white children.

The prevalence and magnitude of the disparities varied among the states. Differences in state health care system infrastructures, SCHIP program features, and characteristics of the minority populations that reside in the various states all could be factors contributing to this variance. What seems clear is that there are disparities in every state and racial and ethnic differences manifest themselves differently depending on where one lives. Shone et al³⁷ conclude that appropriate policy alternatives in one locale may not be salient options in another locale.

Adolescents

Shenkman et al²⁸ examined Florida adolescent SCHIP enrollees' risk behaviors and receipt of preventive care and counseling in the year before enrollment. Their findings are compelling; 73% of new adolescent SCHIP enrollees engaged in one or more risk behaviors (ie, feeling sad or blue; alcohol, tobacco, and drug use; having sexual intercourse; and not wearing seat belts) before enrollment. Although almost 70% of adolescents reported having a preventive care visit the previous year, a majority of them did not receive counseling in each of 4 counseling areas (ie, general risk behaviors; sexual activity, sex-

ually transmitted diseases, and birth control; diet and exercise; and emotional health and relationships).

The incidence of risk behaviors and rates of receipt of preventive visits were not uniform across subgroups of adolescents. Hispanic adolescents were 30% less likely to have engaged in risk behaviors than were white non-Hispanic adolescents. Hispanic and black Hispanic adolescents, however, were half as likely to have had a preventive visit than their white non-Hispanic counterparts. Adolescents with special health care needs were almost twice as likely to have had a preventive visit compared with their healthier counterparts.

Counseling rates also differed by subgroup. Males were significantly less likely than females to receive counseling related to sexual activity. Adolescents with special health care needs were more likely than adolescents with no special health care needs to receive counseling on diet and exercise and emotional health. Hispanic and black non-Hispanic adolescents who had a preventive visit were at least as likely to receive counseling as white non-Hispanic adolescents, and on some topics they were more likely to receive counseling.

Two factors were related to receipt of counseling by adolescents who had preventive visits. First, having a private, confidential visit with the physician, controlling for other factors, was associated with an increased likelihood (2–3 times more likely) that an adolescent would receive counseling for 3 of the 4 counseling areas. Older adolescents and those with special health care needs were more likely to report a private, confidential visit, but having a USC made no difference in whether adolescents had a private, confidential visit or got counseling. Adolescents with risk behaviors were almost 50% less likely to have private, confidential visits. Second, controlling for other factors, adolescents with risk behaviors who had a preventive visit were 1.45 to 2 times more likely to receive counseling than those without risk behaviors.

Do Enrollee Characteristics Change Over Time?

Since 1991, New York State has operated a child health insurance program for low-income children whose family income is too high to qualify for Medicaid. The existence of an SCHIP precursor program provides an opportunity to explore whether SCHIP enrollee characteristics change over time as program features evolve. Dick et al³⁸ described how the population of SCHIP enrollees in 2001 differs from enrollees in New York's SCHIP precursor program in 1994.

Characteristics of enrollees in the New York SCHIP program in 2001 were quite different from the 1994 SCHIP precursor enrollees.³⁸ SCHIP enrollees in 2001 were more likely to be black non-Hispanic or Hispanic, older, from New York City, and from families with lower education, income, and employment levels. Furthermore, a greater proportion of 2001 enrollees were uninsured for some time in the year before enrollment and lacked a USC. Those who were insured for some time in the prior year were

more likely to have had Medicaid coverage than their 1994 counterparts. How families learned about the health insurance programs also changed over the years, with a larger proportion of families reporting that they heard about the program from outreach workers in 2001 than in 1994. Doctors' offices, clinics, and hospitals were important sources at both time periods, second only to learning about SCHIP from neighbors, friends, or relatives.

Examination of changes in the low-income population in New York State by using the Current Population Survey confirmed that secular trends in the characteristics of low-income children were not responsible for the change in enrollee characteristics. However, during the same time period the program changed. These changes included an expansion of the benefit package to include hospitalization, mental health, and dental benefits; an increase in outreach culminating with a well-financed and multi-pronged marketing campaign; a change in the premium structure; and the advent of a single application form for a variety of public programs (ie, Medicaid; SCHIP; the Prenatal Assistance Program; and the Special Supplemental Nutrition Program for Women, Infants, and Children). These program changes may have contributed to the differences observed in the characteristics of enrollees. These findings underscore the dynamic nature of states' SCHIP programs and SCHIP populations. As SCHIP programs evolve and mature, enrollees' demographic characteristics and prior experiences with the health care system will likely change.

CONCLUSIONS

This collection of studies indicates that SCHIP is insuring the population Congress intended it to serve: children from low-income working families who either were ineligible for Medicaid, lost private insurance, or had been uninsured for a period of time. Despite the fact that SCHIP has been described as "a 'not Medicaid' law,"⁴⁴ SCHIP enrollees are not dramatically different from children covered by the Medicaid program in that they have substantial and wide-ranging health care needs. In addition, although most had a USC and prior health care utilization, many of these children did not attain recommended levels of preventive and dental visits and anticipatory guidance in the year before enrollment in SCHIP. SCHIP seems to be filling a gap in the patchwork of private and public child health insurance coverage and has the potential to improve access to and quality of health care.

The articles in this supplement that drew on data from several states show that SCHIP enrollees are a diverse group with considerable variation among the states. Studying SCHIP enrollees across states presented challenges when findings diverged but at the same time permitted researchers to have greater confidence in the trends that did emerge. This article has focused on CHIRI findings that transcended differences in SCHIP programs (see Table 1) and state contexts, findings that seem to represent commonalities that can be extrapolated elsewhere.

A sizable minority of SCHIP enrollees have special

health care needs. Although in many respects these CSHCN did not differ from other SCHIP enrollees and were overall in good health, a larger percentage of CSHCN were reported to be in fair or poor health, and unmet needs were very high among CSHCN. There are racial and ethnic disparities as well, with minority children more likely to be poorer, in poorer health, and less likely to have had a USC or private insurance before enrolling in SCHIP, even within the relatively narrow band of SCHIP income eligibility. Furthermore, minority adolescents were less likely to have had a preventive visit, and most adolescents did not receive preventive counseling before enrollment. Finally, characteristics of SCHIP enrollees were found to be as dynamic as the SCHIP programs themselves, and SCHIP was shown to be able to enroll populations traditionally thought of as "hard to reach."

Policy Implications

Providing insurance coverage is the first step to meeting the health care needs of low-income children, but policy makers also need to pay attention to what covered children receive as a result of having coverage.⁴⁵ This research provides information that policy makers can use as they address access and quality concerns in Medicaid as well as SCHIP programs.

First, benefits should be structured to meet the needs of enrollees, which are comparable to Medicaid enrollees' needs in many respects. Most states operating free-standing separate SCHIP programs have selected benefit packages that resemble commercial insurance and include coverage limitations that would be impermissible under Medicaid.⁴⁶ CHIRI research shows that SCHIP enrolls many CSHCN and children who have a wide range of unmet health care needs. Limitations on the type and quantity of services covered, without well-coordinated programs to supplement SCHIP coverage, could adversely affect the health of SCHIP enrollees with the greatest needs.

Second, provider networks will have to be broad if continuity of care is to be achieved. SCHIP enrollees have prior insurance experiences with both the commercial health insurance and Medicaid systems. Others were uninsured and relied on safety-net providers. Some have special health care needs that would qualify them for programs that serve CSHCN (eg, Title V Maternal and Child Health Services Block Grant). Networks constructed to include providers that serve Medicaid enrollees, low-income commercial and uninsured populations, and CSHCN (including specialists) will preserve continuity of care as children move among the various types of coverage. Between 29% and 41.3% of SCHIP enrollees changed their USC after enrollment in SCHIP. Although we do not know if that shift represented an improvement (ie, switching to USCs that afford better access and quality), the large proportion of children that switched their USC should alert program administrators to the need for monitoring continuity of care carefully. It also suggests that providers should pay attention to the transitions children are

making and take steps to ensure that they are as smooth as possible.

Third, multiple outreach strategies should be used. For health care providers, CHIRI findings in New York offer clear lessons. Many families first learned about SCHIP from doctors' offices, clinics, and hospitals both when the SCHIP program was relatively new and when it was mature. Providers are an important source of information about SCHIP and should be encouraged to continue their efforts to reach out to potential SCHIP enrollees.

Fourth, monitoring the quality of care delivered to vulnerable populations is critical. Few states actively considered CSHCN when policy makers debated the design of their separate SCHIP programs, although some states did make special provisions for CSHCN.⁴⁷ The research findings suggest that an important minority of SCHIP enrollees are CSHCN. States and health plans therefore need to adopt screening tools to identify these children and develop quality measures that are sufficiently sensitive to detect quality differences in areas specific to the needs of CSHCN. Similarly, SCHIP programs and health plans should collect baseline data by race and ethnicity and by age breakdowns that capture adolescents and monitor and report on SCHIP effectiveness and outcomes for vulnerable populations. Currently, few states with separate, free-standing SCHIP programs routinely collect and analyze data to ensure that enrollees receive covered services.⁴⁸

Fifth, in addition to monitoring quality, states and health plans will want to promote quality actively. CHIRI research in Florida indicates that the majority of adolescents are not receiving recommended anticipatory guidance before SCHIP enrollment. SCHIP enrollees will benefit if SCHIP programs communicate with provider networks, either directly or through health plans, the importance of: 1) conducting outreach to get all adolescents seen for preventive care, particularly Hispanic and black adolescents and those with risk behaviors; 2) assuring private, confidential visits for adolescents of all ages; and 3) providing counseling in all recommended areas to all adolescents regardless of gender, ethnicity, and risk profile. Educating SCHIP adolescents and their families about the importance of preventive care and private visits is also likely to aid SCHIP programs in achieving their goal of providing quality health care to low-income adolescents. States and health plans should also ensure that providers are aware of and educated about state minor consent and confidentiality laws,²⁸ which may influence providers' willingness to see adolescents privately.

Sixth, states will have to craft policies that fit their local context. By analyzing 5 states' SCHIP enrollees, we found that although commonalities exist across the states, there are also substantial differences. These differences are a product of many factors including varying demographic patterns, health care systems, and historic state public health policy as well as the features of the SCHIP programs themselves (see Table 1). State policies on eligibility, outreach, enrollment, benefits, health plan and provider

contracting, and quality improvement will have to build on existing infrastructures.

Seventh, collecting baseline information on SCHIP enrollees on a continuous basis is important. The characteristics of SCHIP enrollees can be expected to change over time, at least as long as a substantial proportion of the eligible population remains unenrolled. Policy makers will want to consider the characteristics of SCHIP enrollees as they make budget decisions and fine-tune the program each year and recognize that their decisions are likely to affect who becomes enrolled in SCHIP. Only with baseline data can the effectiveness of SCHIP in providing quality health care for diverse populations be truly assessed over time. Measures used in the CHIRI studies may be a useful guide for states that have not undertaken such data collection previously. Future CHIRI findings will shed light on the impact of SCHIP on enrollees and the health care delivery system and provide information about what aspects of child health insurance programs improve access and quality.

Feedback on CHIRI Research

Feedback on how CHIRI research findings are being used is important to this initiative. If you are willing to provide feedback, please contact chiri@ahrq.gov to describe briefly how you are using the CHIRI findings.

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