

# Improving Access to Health for Children The Roles of SCHIP and Medicaid

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# Health and Quality of Life

Many “good” alternative investments to improve health

- Public health
  - Smoking cessation programs
  - Healthy life styles
  - Obesity prevention
- Education
- Social capital
- Urban planning (renewal and good growth)

# Why Insurance?

1. Timely high quality care improves health outcomes.
2. Insurance can improve access to care.

Therefore, health insurance is thought to be important (perhaps essential) to improve health outcomes. Is it?



MANKOFF

*"Uh-oh, your coverage doesn't seem to include illness."*

# Why Medicaid and SCHIP?

Public Sector competing interests include:

1. The Iraq war
2. Security (terrorism)
3. Research
4. Social Security
5. Medicare
6. Medicaid and/or SCHIP

How many votes are swung by Medicaid/SCHIP?

# Increasing Health Care Costs

Health care costs continue to rise faster than inflation, making health insurance programs relatively more expensive over time.

This will continue to put public health insurance programs at risk.

We need strong evidence about the merits of public insurance programs.

# The Case for Medicaid and SCHIP

If Medicaid and/or SCHIP are valuable, they need to be defended.

If there are better ways to improve health, we need to know that too.

Can program innovations improve OUTCOMES or reduce COSTS?

**EVIDENCE!**

# SCHIP

## State Children's Health Insurance Program

- Evidence: SCHIP improves access to care and its benefits are shared broadly.
- Question:
  - (1) What role does it play in the patchwork system for children? Is it a long-term insurance solution, a transitional insurance program, or a band-aid?
  - (2) Do program characteristics matter?

# Study Objectives

Determine how SCHIP fits into the patchwork system

- Describe SCHIP-enrollment patterns
  - Duration of enrollment, insurance prior to and following enrollment, and their relationships
- Describe differences in these patterns by subgroups
  - Including special health care needs status and poverty level
- Relationship between enrollment patterns and health systems access and use measures
- Relationship between state program features and enrollment patterns

# Setting: Three States' Programs Florida, Kansas, New York

- Data from CHIRI™ (AHRQ/Packard) evaluations of three states
- Coordination in design, measures and methods
- Strong encouragement to collaborate across studies

## Program Characteristics

	<b>Florida</b>	<b>Kansas</b>	<b>New York</b>
<b>Program Name</b>	Healthy Kids	Health Wave	Child Health Plus
<b>Year SCHIP Operations or SCHIP Precursor Began</b>	1990 (Precursor)	1999	1991 (Precursor)
<b>2001 Enrollment</b>	298,705	34,241	590,000
<b>Income Eligibility as a Percent of FPL</b>			
<b>Children 0-1</b>	185%-200%	150%-200%	185%-250%
<b>Children 1-5</b>	133%-200%	133%-200%	133%-250%
<b>Children 6-18</b>	100%-200%	100%-200%	100%-250%
<b>Delivery System</b>	Capitated managed care, 15 commercial plans. Little enrollee choice among plans (at most 2 operating per country)	Capitated managed care, 1 commercial plan.	Capitated managed care, 32 commercial plans. Choice among plans (14 operating in New York City)
<b>CSHCN Policies</b>	Carve out for CSHCN with most severe conditions; others enrolled in SCHIP	No special policies	No special policies
<b>Guaranteed Eligibility</b>	No	12 months	No
<b>Re-certification Procedure</b>	Passive	Active	Active
<b>Re-certification Period</b>	6 months	12 months	12 months
<b>Premiums</b>	All Enrollees	Above 150% FPL	Above 160% FPL
<b>Waiting Period</b>	No	6 months	No

# Study Design

- Pre-post (T1-T2) longitudinal design.
- Newly enrolled children between July 2000 and March 2001, interviewed twice
  - Florida (T1 N = 1304, T2 N = 904) -- ages 12 to 17
  - Kansas (T1 N = 750, T2 N = 435) -- ages 1 to 17
  - New York (T1 N = 2531, T2 N = 2226) -- ages 1 to 17
- Administrative data: monthly SCHIP-enrollment status and (KS and FL only) Medicaid enrollment status

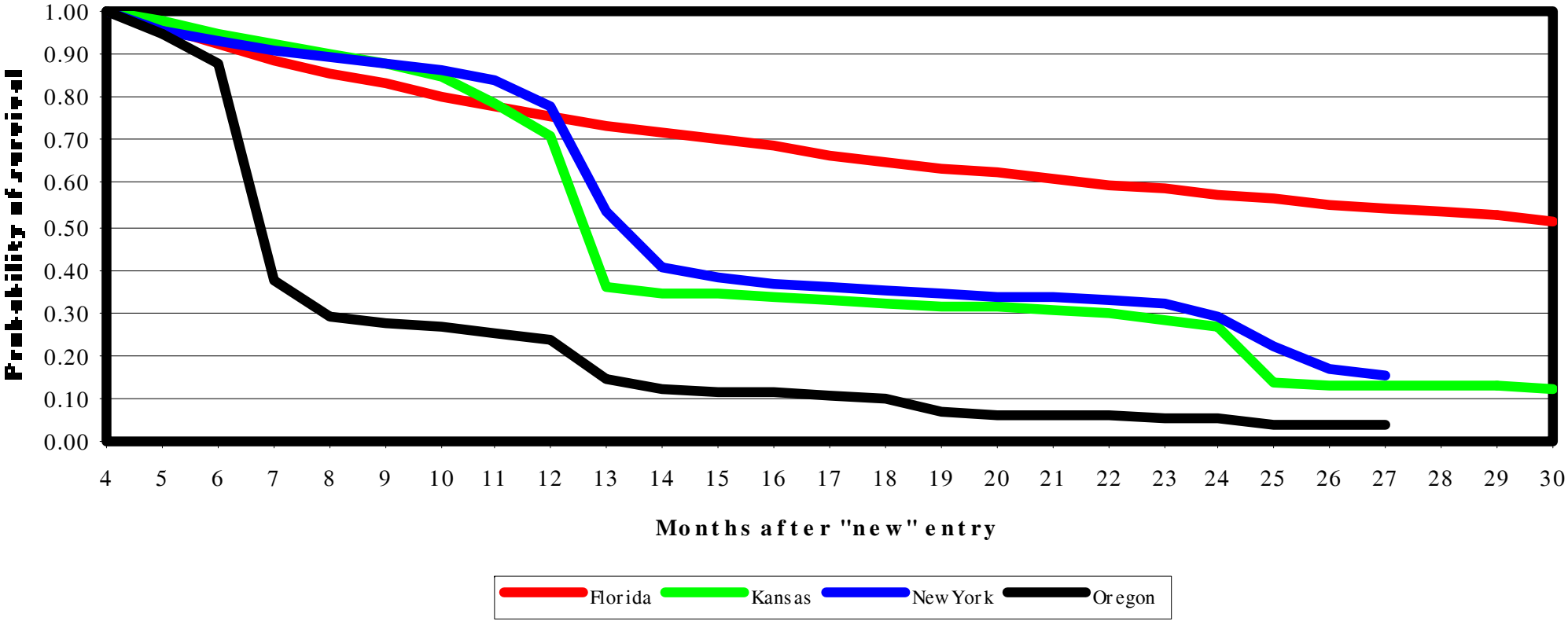
# Measures

- SES and demographic measures
- Access: Usual Source of Care (USC), type of USC, Unmet needs
- Use of care: Any, preventive, acute, specialty
- Pre-SCHIP Insurance: Medicaid, private, none
- Post-SCHIP Insurance: Public, private, none

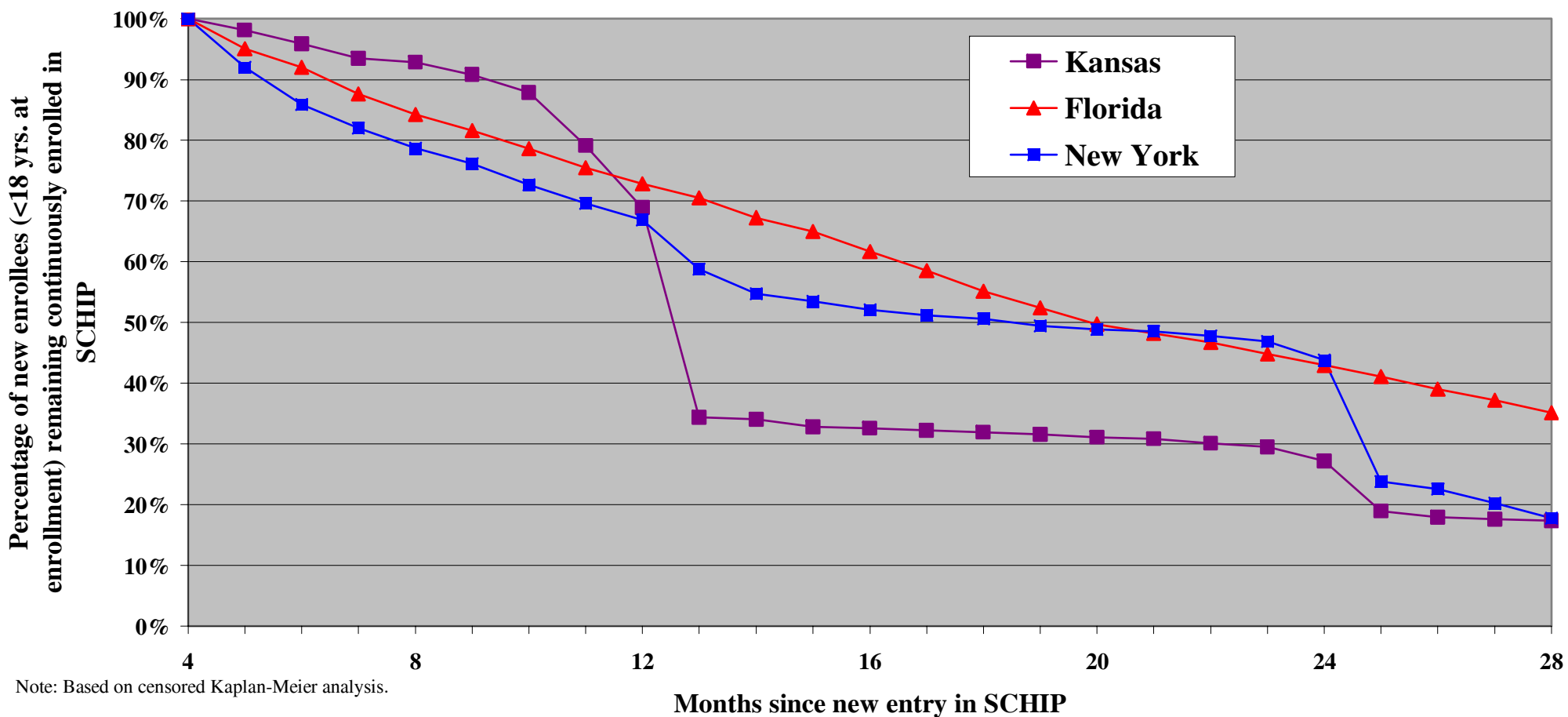
# Length of SCHIP Enrollment

- KM Empirical survivor functions
- Multivariate Models

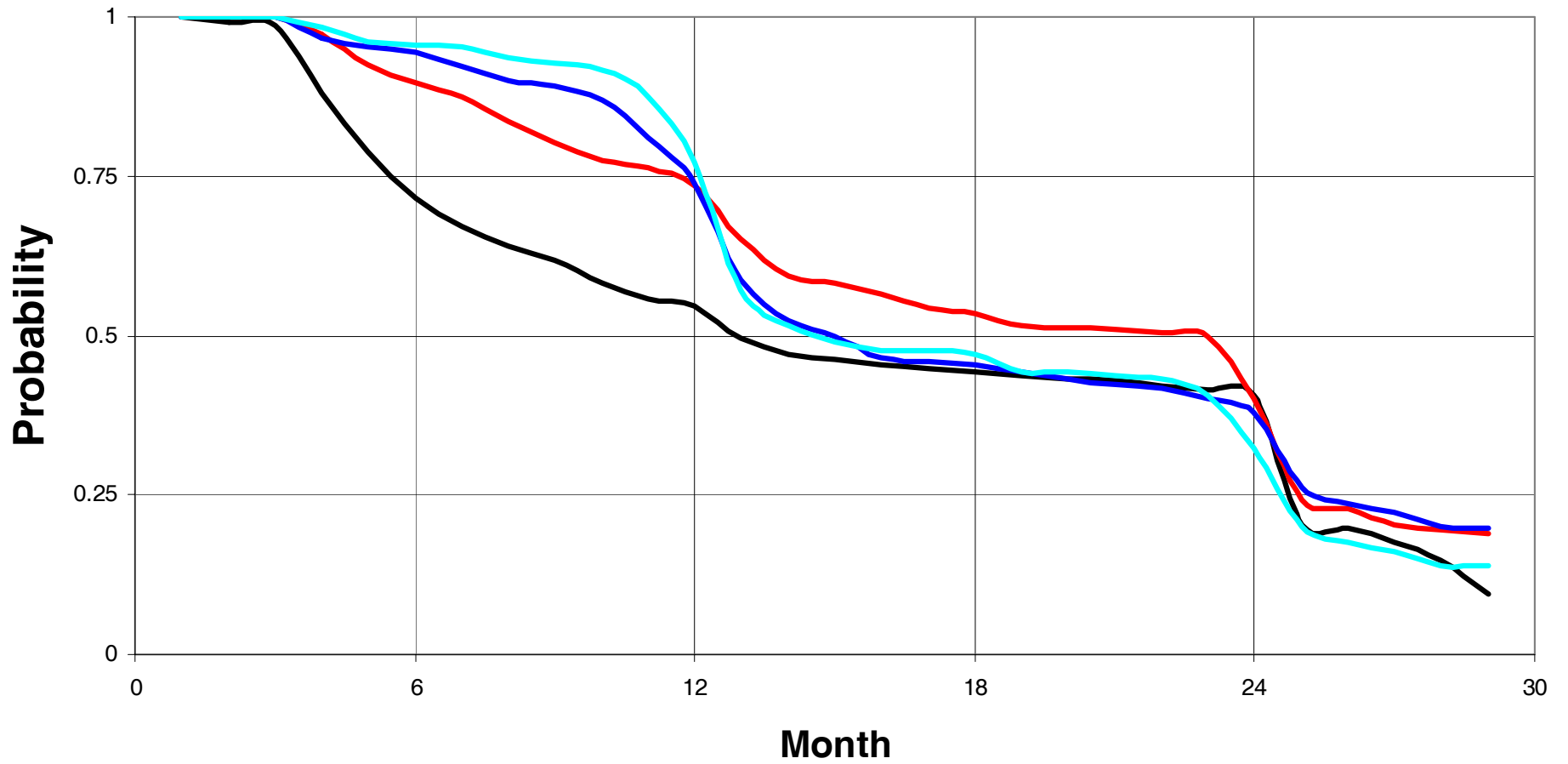
**Kaplan-Meier Empirical Survivor Functions  
(Conditional on Enrollment Until Month 4)**



## Percentage of Children Remaining Continuously Enrolled in SCHIP, Conditional Upon Survival Until the Fourth Month



# KM Survivor Functions By Region (New York)



— NYC — NYC Metro — Upstate Urban — Upstate Rural

# Prior Insurance Status

	Florida	Kansas	NY
Last insurance type (%)			
Medicaid	20	44	17
Private	15	26	23
None	65	30	60

## Enrollment Duration

### Probability of remaining enrolled > 9 months

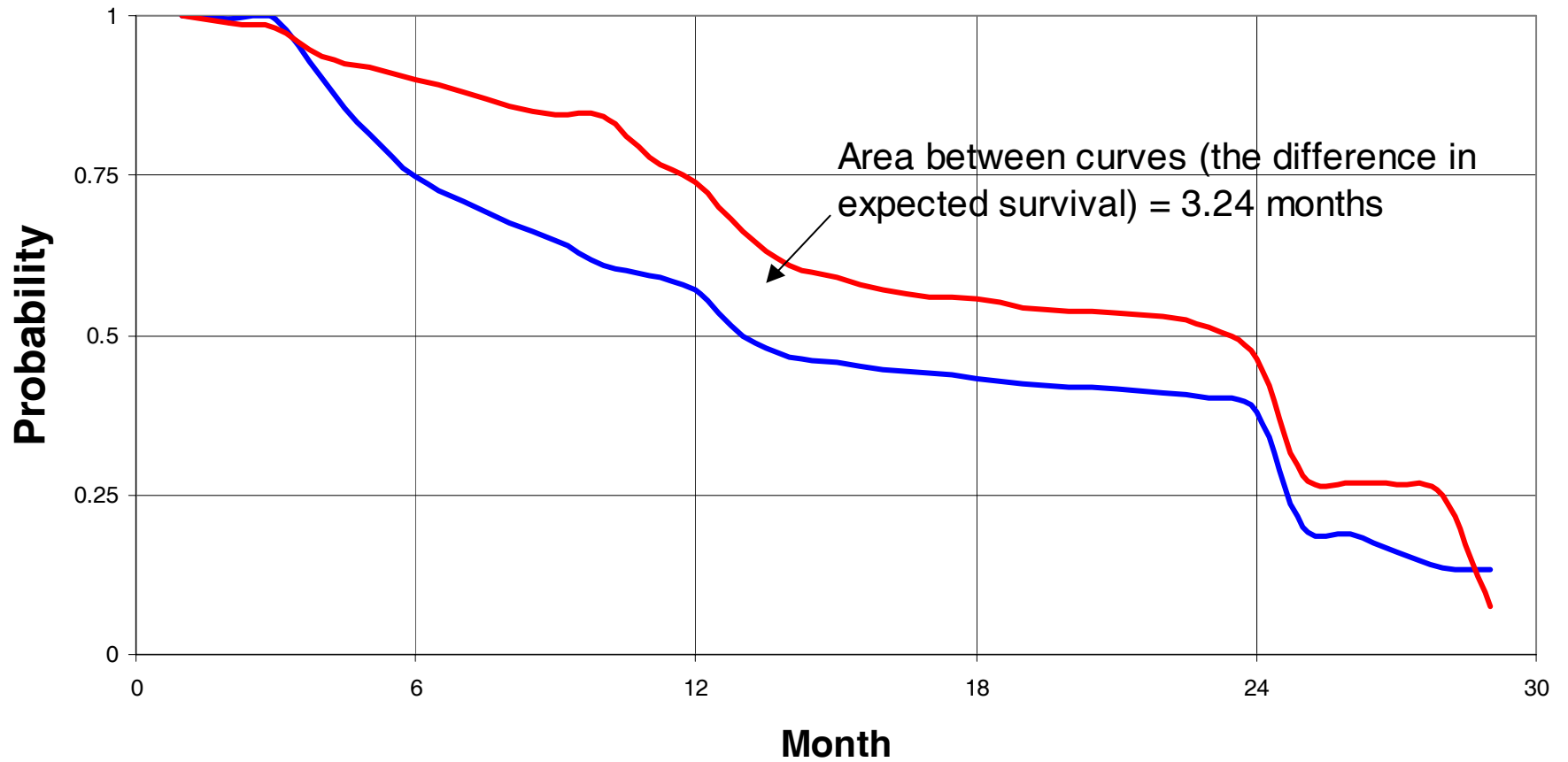
Odds Ratios

	New York	Kansas	Florida
<b>Income (vs &gt;150% FPL)</b>			
Income < 150% FPL	0.32 ***	0.94	0.63 ***
Income Unknown	1.58 **	0.59	

### Probability of remaining enrolled > 12 months | 10 months

Income < 150% FPL	0.82	1.26	0.67
Income Unknown	1.02	0.72	

# KM Survivor Functions By Income

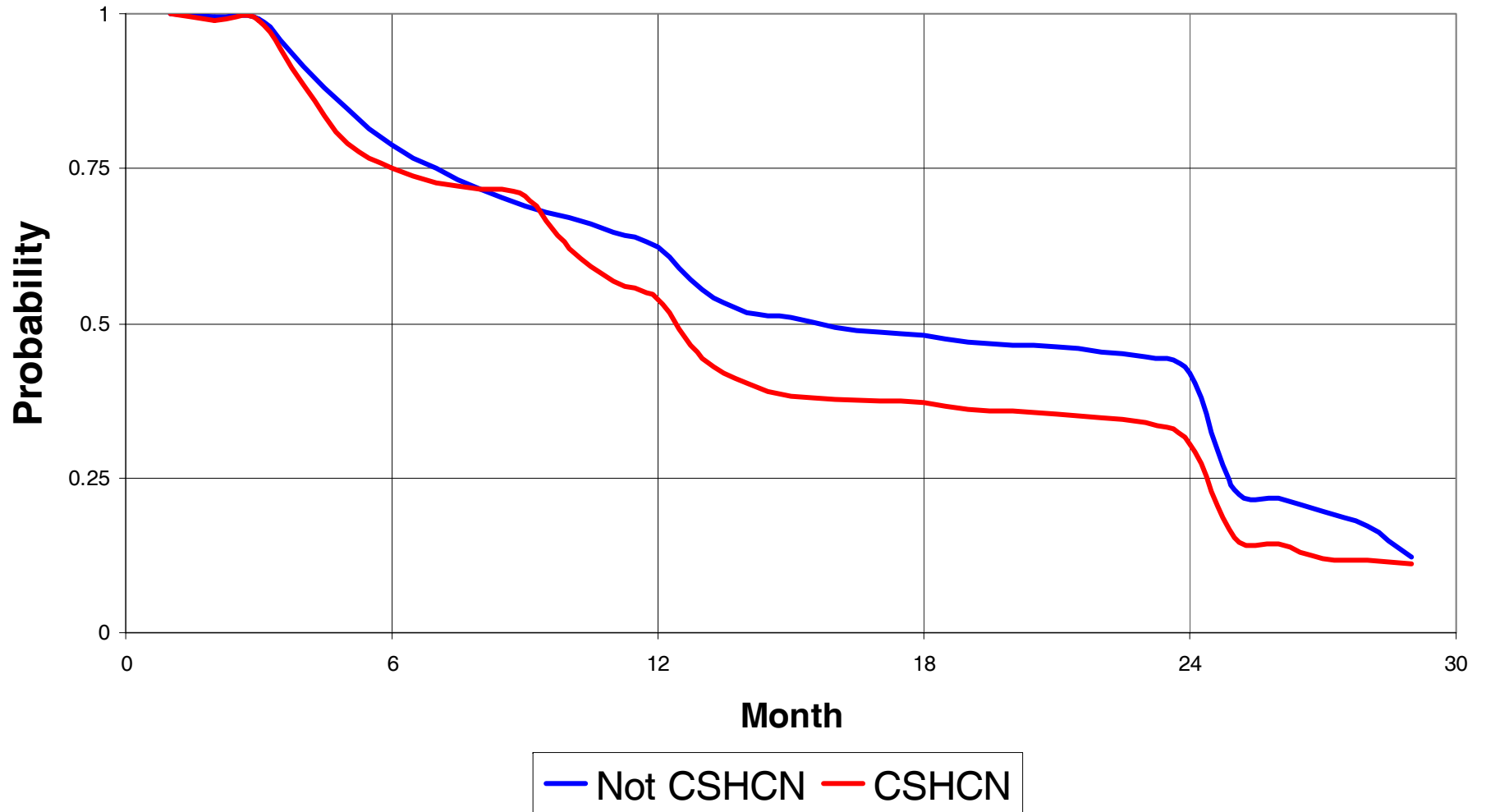


— < 150% FPL — > 150% FPL

## Enrollment Duration By Health Status and Use of Services

	Odds of Surviving > 9		Odds of Surviving > 12   10	
	New York	Kansas	New York	Kansas
<b>CSHCN</b>	0.89	0.70	0.47 **	1.40
<b>Acute Use Before SCHIP</b>	1.66 **	3.28 **	0.93	4.06 *

# KM Survivor Functions By CSHCN Status



# Enrollment Duration: Summary

## Recertification policies

- Big differences in nature of disenrollment at recertification versus before recertification (NY & KS)

## Premiums & guaranteed eligibility

- Unexpected results in NY

## Risk

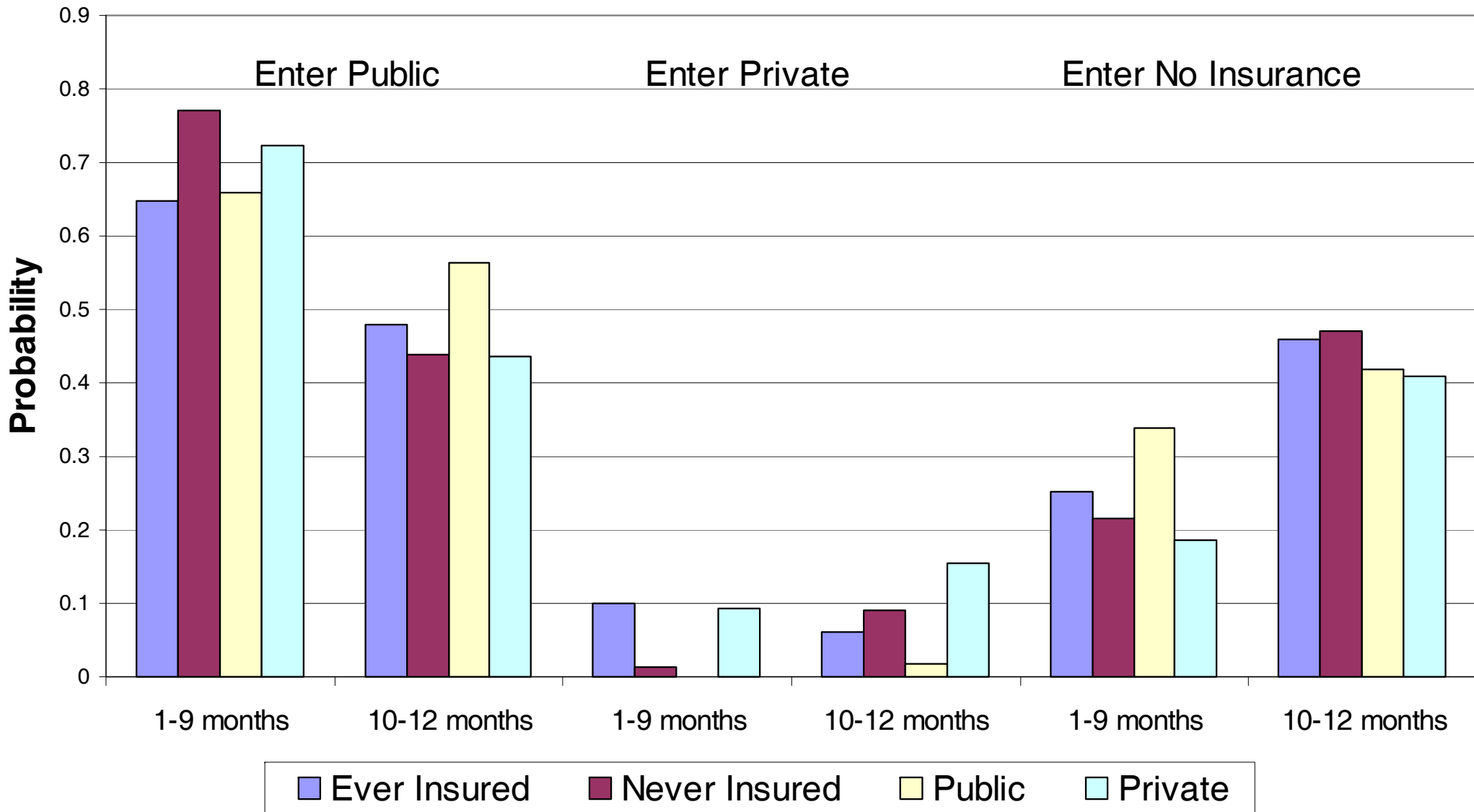
- Limited evidence that CSHCN leave more rapidly
- Stronger evidence that those with prior use are more likely to remain enrolled

# Insurance Status Following Disenrollment from SCHIP (New York)

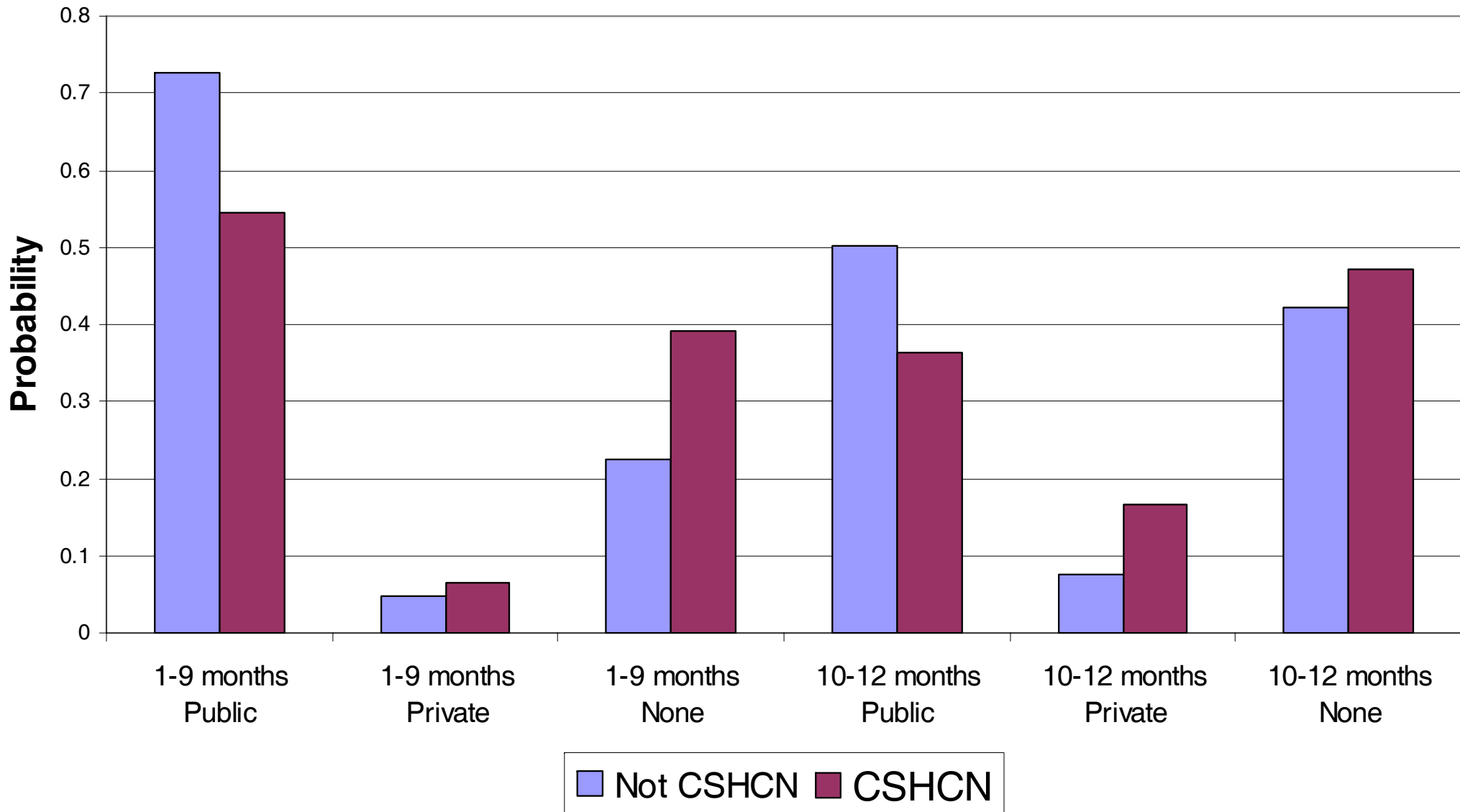
By duration and

- By prior insurance
- By CSHCN status
- By access and use *during* SCHIP

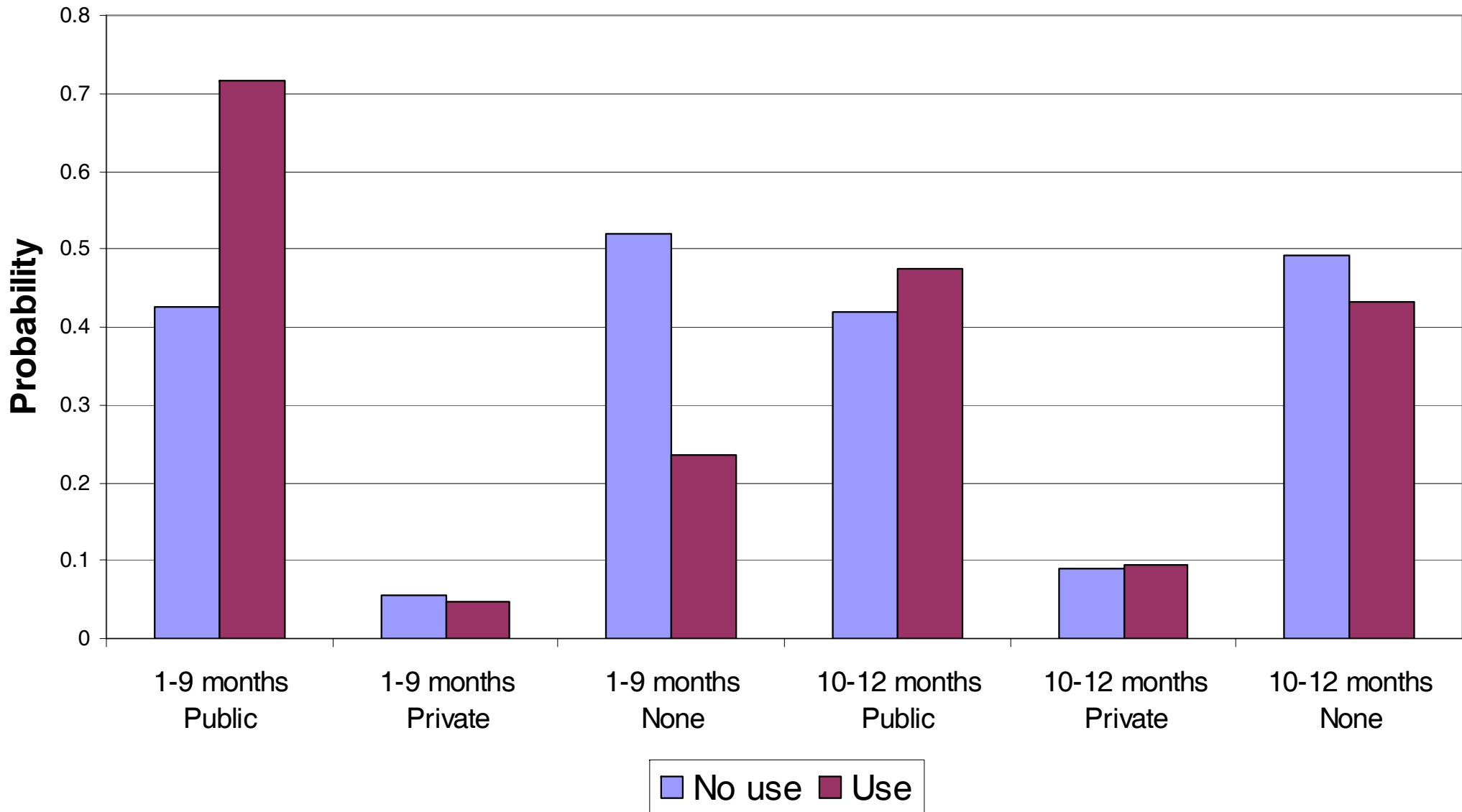
# Insurance Status Following SCHIP Disenrollment By Length of Enrollment



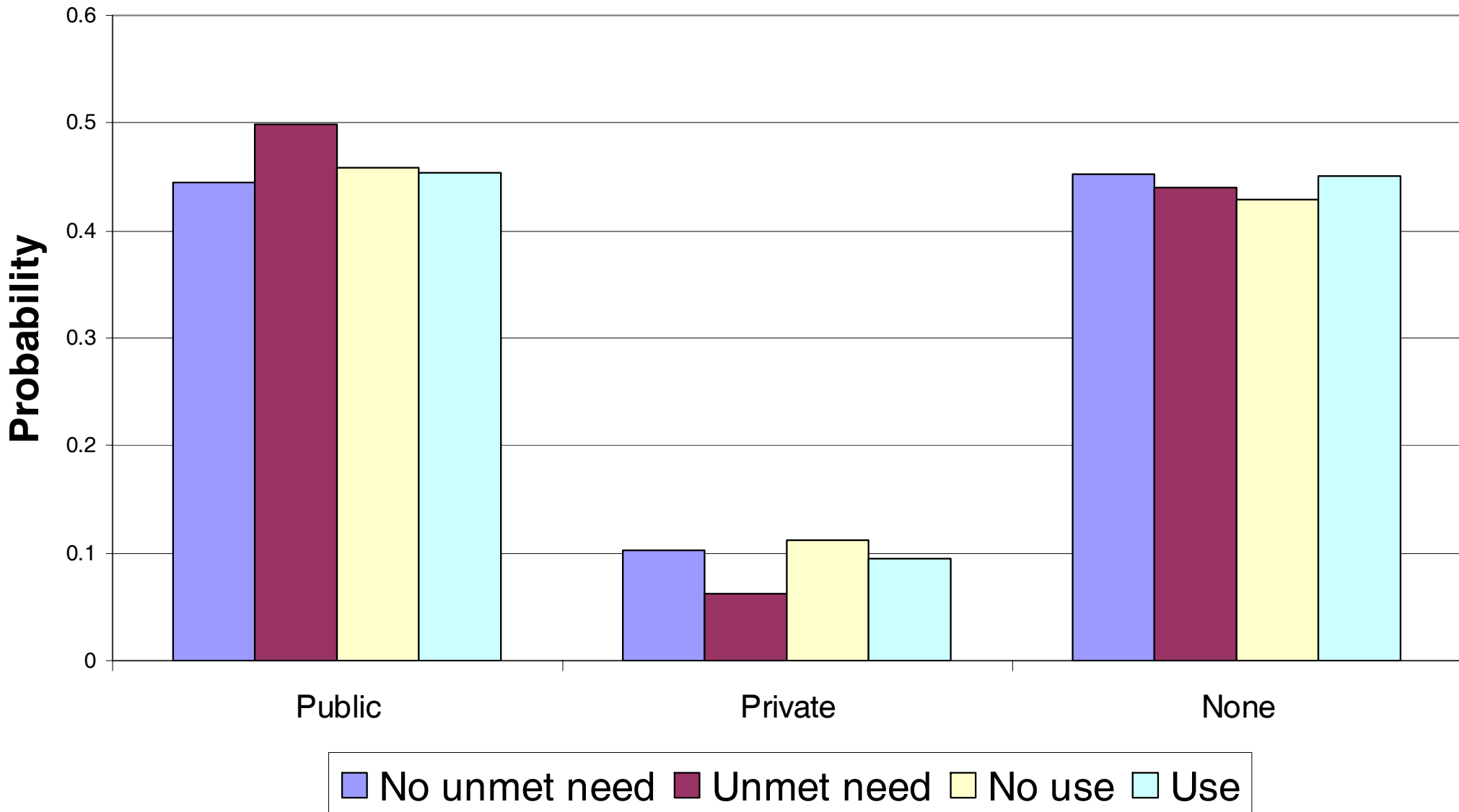
# Insurance Status Following SCHIP Disenrollment By Special Needs Status



# Insurance Status Following SCHIP Disenrollment By Use of Services



# Insurance Status Following SCHIP Disenrollment By Access *During* SCHIP



# Insurance Disposition: Summary

- Not a bridge to private insurance
- Potentially large amount of confusion about enrollment status and Medicaid versus SCHIP
- Weak evidence that where you come from predicts where you go
- No evidence that experiences during enrollment affect disenrollments
- CSHCN more likely to become uninsured
- Children with prior use less likely to become uninsured  
(especially for short duration spells)

# Conclusions

- Policies matter -- especially regarding recertification
  - children who disenrolled at recertification were much more likely to become uninsured
- Many children are enrolled for a long time, esp. in NY and FL where nearly 50% were still enrolled after 20 months
- SCHIP is not a bridge to private insurance
  - a substantial fraction of children who disenroll became uninsured; few enrolled in private insurance
- CSHCN may be particularly at risk
  - shorter spells and greater probability of becoming uninsured
- No evidence that access *during* enrollment affects disenrollment

# What about health outcomes? Costs?

This study provides important results regarding access and dynamics, but...

1. Expensive
2. No outcomes data
3. No cost data

Why?

Lack of systematic outcomes data and cost data sets!

# Increasing Health Care Costs and Access

Increasing health care costs put pressure on access.

- Private insurance → rapidly increasing economic burden passed back to “insured” through higher copayments and deductibles.
- Public insurance → narrowing of eligibility, reductions in reimbursements, increases in premiums, or more drastic reductions in programs.

We need evidence to defend valuable programs, and we need to maintain a focus on health care costs.