

# SCHIP DISENROLLMENT AND STATE POLICIES

The State Children's Health Insurance Program (SCHIP) was enacted in 1997 to provide health insurance coverage to previously uninsured children. States have flexibility in tailoring their SCHIP programs within broad Federal guidelines and have made significant progress in providing health care coverage to low-income children not eligible for Medicaid. In fiscal year 2001, approximately 4.6 million children participated in SCHIP. Many policymakers are concerned, however, that high rates of disenrollment from SCHIP threaten the gains made in many States.

Despite apprehension over disenrollment, little is known about the extent to which children are leaving SCHIP and how State policies impact the rates of disenrollment. This Issue Brief is the result of a study from the Child Health Insurance Research Initiative (CHIRI™). The study examined the relationship between disenrollment and State policies in four States where a third of all SCHIP enrollees resided at the time. It found that:

- A significant number of children were enrolled in SCHIP for at least 2 years, while many other enrollees had shorter (1 year or less) stays.
- State redetermination requirements generate large disenrollments; up to one quarter of disenrolled children return within 2 months.
- Requiring active eligibility redetermination every 6 months rather than every 12 months is accompanied by even higher levels of disenrollment over time.
- A passive reenrollment policy substantially reduces disenrollment at redetermination.



*The David and Lucile Packard Foundation*





“In some cases, States’ successes in enrolling children into SCHIP have been substantially eroded by disenrollments.”

## WHAT WAS LEARNED

Researchers investigated SCHIP disenrollment in four States with separate SCHIP programs – Florida, Kansas, New York, and Oregon. This CHIRI™ Issue Brief reports on how long children remain enrolled in SCHIP and the effect of State policies on disenrollment.

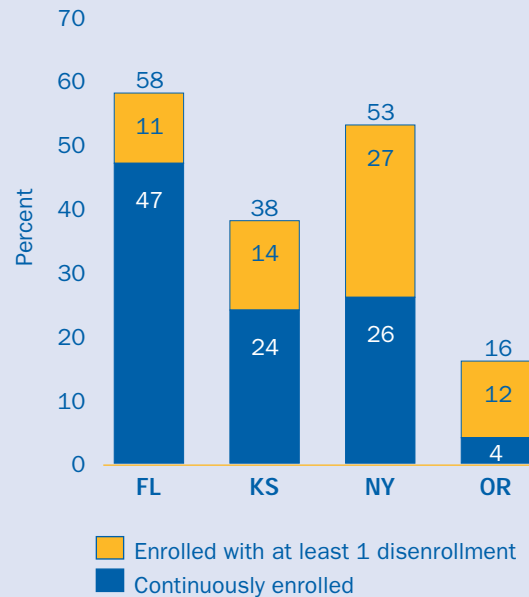
### Some Children Remain Enrolled for 2 or More Years, But Many Experience Disruptions

A significant number of children were enrolled in SCHIP at the 2-year anniversary of their initial enrollment (e.g., 58 percent in Florida and 53 percent in New York). Many of these children, however, were disenrolled from the program at least once during that time (see Figure 1).

#### Policy Definitions

- *Passive reenrollment* refers to a redetermination (renewal) process in which families do not have to return a renewal form unless changes have occurred that might affect eligibility.
- *Premiums* are a cost-sharing option that States can use, within specific federal requirements, to require families to pay a fee for participation. *Universal premiums* indicate that a fee is required of all participating families.
- *Presumptive eligibility* extends temporary coverage to SCHIP applicants who appear to be eligible while their eligibility is being determined.
- *Redetermination* is the point at which a family’s eligibility is reassessed. States have the option of determining how frequently eligibility will be reviewed (e.g., every 6 months, 12 months).

Figure 1. Children’s Enrollment in SCHIP at 24 Months



Note: FL and OR require redetermination of SCHIP eligibility every 6 months. KS and NY require redetermination every 12 months.

### States Vary as to Whether the Majority of Children Leave SCHIP Within 1 Year or Stay Longer

A substantial number of children were initially enrolled for relatively short periods of time and many did not return at a later date. In Oregon and Kansas, nearly 90 percent and 70 percent of SCHIP enrollees, respectively, did not remain in the program continuously for longer than 12 months. Even in Florida, where children remained enrolled for longer periods, 39 percent left SCHIP within 12 months (see Figure 2).

On the other hand, another large group of children stayed on SCHIP continuously for more than 1 year (e.g., 61 percent in Florida and 48 percent in New York). States’ varied experiences with how long children were likely to remain enrolled in SCHIP, ranging from a median of 6 months in Oregon to 21 months in Florida, appear to be related to specific State policies.

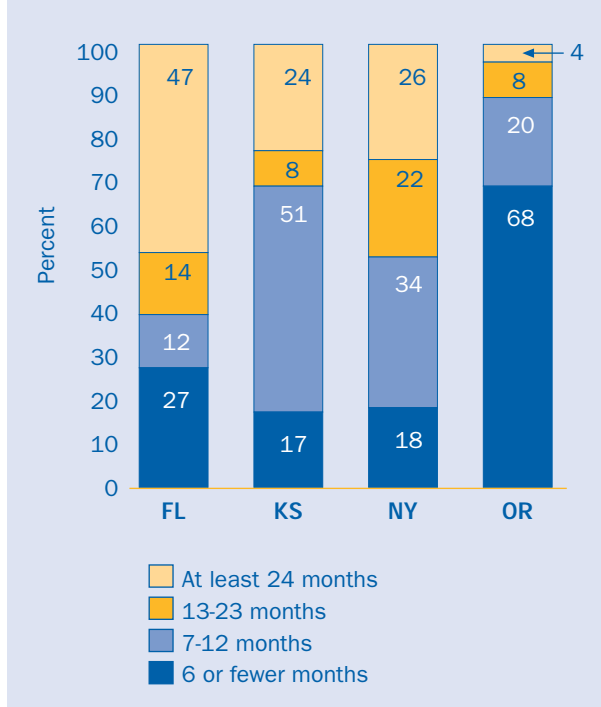


## Disruptions in Health Care Coverage Are Problematic

Research indicates that disruptions in health care coverage pose significant issues for children and families, providers, health plans, and States. Disenrollment can:

- Reduce continuity of care with primary care providers and thus affect quality of care for children and families.
- Place families at risk of paying for health care costs incurred during periods of disenrollment.
- Create a loss of anticipated revenues for providers and health plans and erode incentives to provide preventive care.
- Impose administrative costs on States and health plans.
- Result in adverse health outcomes for children who become uninsured.

**Figure 2. Percent of Children Continuously Enrolled in SCHIP**



### State Redetermination Policies Affect Disenrollment Rates

Large drops in enrollment occurred in Kansas, New York, and Oregon at redetermination. In these States, families must actively verify their eligibility. As Figure 3 shows, up to 50 percent of children were disenrolled at redetermination.

Some of these disenrollments represent transfers to Medicaid or children who obtained private coverage. A significant proportion of these children (up to 25 percent), however, returned within 2 months, which suggests that they had not obtained other coverage.

Other studies have shown that administrative errors, miscommunication, and families' difficulties complying with redetermination procedures are factors in redetermination-related disenrollment. Since these drops in enrollment occur at each redetermination, requiring active redetermination

every 6 months rather than every 12 months was accompanied by even higher levels of disenrollment over time.

On the other hand, passive reenrollment appears to sharply reduce disenrollments. In Florida, where a policy of passive reenrollment is used, disenrollments at redetermination were no greater than at any other time.

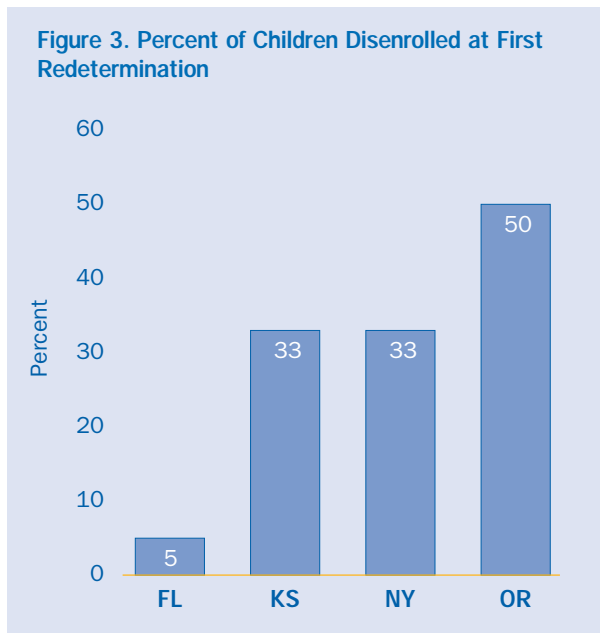
States with passive reenrollment, particularly those that prepay health plans, may wish to implement some type of mechanism that lets the SCHIP system know when a family no longer wants SCHIP coverage. In Florida, a universal premium policy of \$15 per family per month is used. Families who obtain other coverage, move out of State, or do not wish to continue SCHIP coverage for other reasons stop paying their premiums and the State stops their coverage after a 3-month grace period.

The overall impact premiums have on disenrollment is not known from this study. However, the net effect of Florida's combination of universal premiums and passive reenrollment was a lower rate of disenrollment at redetermination and a higher proportion of children remaining continuously enrolled for 2 or more years than other study States.

“Passive reenrollment appears to sharply reduce disenrollments at redetermination.”



Figure 3. Percent of Children Disenrolled at First Redetermination



## CONCLUSION

Results from this study show that children in SCHIP can experience fragmentation in their health care coverage. Redetermination policies that require families to actively verify their eligibility generate spikes in disenrollment. Requiring active redetermination more frequently (i.e., every 6 months rather than every 12 months) is associated with higher levels of disenrollment.

Disenrollment from SCHIP does not necessarily mean loss of health coverage, as children may be moving to Medicaid or private insurance. Children who have maintained coverage, however, may experience disruptions in continuity of care if they have to change providers when they change insurance. Oregon eliminated this problem for SCHIP-Medicaid transitions by having identical delivery systems.

## Policy Implications

These States' experiences provide important insights into SCHIP enrollment patterns and ways to minimize disenrollment in both SCHIP and Medicaid programs.

- *Broadening provider networks and synchronizing health care delivery systems may minimize discontinuity of care due to brief stays on SCHIP.* Some families may need SCHIP temporarily as they move among insurance programs. Making SCHIP and Medicaid systems parallel each other and private insurers' networks as much as possible minimizes the chances that children will have to change physicians when transferring from one type of coverage to another.
- *Collecting information on why children disenroll from SCHIP is critical to strengthening SCHIP systems.* Information on whether disenrollees are successfully moving to private health insurance, moving to Medicaid in a timely and efficient way, or becoming uninsured may help determine how concerned to be about disenrollment and what to do about it.
- *Implementing passive reenrollment may minimize disenrollment.* Passive reenrollment appears to sharply reduce the level of disenrollment that occurs when families are required to *actively* verify their eligibility at redetermination.
- *Reducing the frequency of eligibility redetermination may lessen the impact of redetermination-related disenrollment.* If a State chooses not to adopt a passive reenrollment policy but still wants to minimize disenrollment, redetermining eligibility at 12 months instead of 6 months may help children maintain coverage.

## STUDY METHODOLOGY

This CHIRI™ Issue Brief is based on a study that used State SCHIP administrative records in four States with freestanding SCHIP programs – Florida, Kansas, New York, and Oregon. All new enrollees – those who had not been enrolled in SCHIP for at least the previous 12 months – whose enrollment began in January 1999 or later were included in the study.

SCHIP enrollment and disenrollment experiences in the four States were characterized by three sets of statistics. The researchers calculated:

- How likely children were to leave SCHIP in any given month and how likely children were to remain continuously enrolled in SCHIP for a given period of time.
- How quickly children who had disenrolled returned to SCHIP (if at all).
- How likely children were to be enrolled in any given month during the 2 years following initial enrollment, regardless of whether they had been disenrolled from the program.

Calculations were made using very large numbers of enrollees, ranging from 40,572 in Kansas to 792,111 in New York. The study controlled for a number of factors including children who might be disenrolled from SCHIP because they were aging out of the program. The study also took into account New York's policy of presumptive eligibility. Presumptive eligibility artificially inflated New York's disenrollment rates because it results in temporary coverage and subsequent disenrollment of children who would not have otherwise been enrolled. While the study focused on separate SCHIP programs, the results have bearing on Medicaid-expansion SCHIP and Medicaid programs alike.

## RELATED STUDIES OF INTEREST

Allison RA, LaClair B, St. Peter RF. Dynamics of HealthWave and Medicaid enrollment: into, out of, and between two state programs. Topeka: Kansas Health Institute. March 2001.  
<http://www.khi.org/transfers/brief.pdf>.

Bachrach D, Tassi A. Coverage gaps: the problem of enrollee churning in Medicaid managed care and Child Health Plus. A report of the New York State Coalition of PHSPs. New York: Kalkines, Arky, Zall & Bernstein. June 2000.

Hill I, Lutzky AW. There's a hole in the bucket...understanding SCHIP retention. Report to the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. In preparation.

Lin CJ, Lave JR. Duration in and pattern of utilization under children's health insurance programs. *Health Care Financing Review*; 19 (4):101-16; Summer 1998.

Riley T, Pernice C, Perry M, Kannel S. Why eligible children lose or leave SCHIP: findings from a comprehensive study of retention and disenrollment. National Academy for State Health Policy. February 2002.

Rosenbach ML, Ellwood M, Czajka JL, et al. Implementation of the State Children's Health Insurance Program: momentum is increasing after a modest start. Cambridge, MA: Mathematica Policy Research, Inc. Contract No: 500-96-0016 (03). MPR Ref No. 8644-102. January 2001.  
<http://www.mathematica-mpr.com>.

For information on the U.S. Department of Health and Human Services' SCHIP Evaluation, see <http://aspe.os.dhhs.gov/health/schip/schiphome.htm>.

## ABOUT CHIRI™

The Child Health Insurance Research Initiative (CHIRI™) is an effort to supply policymakers with information to help them improve access to, and the quality of, health care for low-income children. Nine studies of public child health insurance programs and health care delivery systems were funded in the fall of 1999 by the Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA). Additional support was provided for the Kansas project by the Kansas Health Foundation, the United Methodist Health Ministry Fund, and the Prime Health Foundation. These studies seek to uncover which health insurance and delivery features work best for low-income children, particularly minority children and those with special health care needs.

Four CHIRI™ projects contributed to this Issue Brief: “Access and Quality of Care for Low-Income Adolescents (Principal Investigator: Elizabeth Shenkman, University of Florida); “Evaluation of Kansas HealthWave” (Principal Investigator: Robert St. Peter, Kansas Health Institute); “New York’s SCHIP: What Works for Vulnerable Children” (Principal Investigator: Peter Szilagyi, University of Rochester); “Medicaid SCHIP vs. Premium Subsidy: Oregon’s Health Insurance Alternatives for Low-Income Children” (Principal Investigator: Janet Mitchell, Center for Health Economics Research).

**Credits:** This CHIRI™ Issue Brief was written by Karen VanLandeghem and Cindy Brach, based on an article by Andrew W. Dick, R. Andrew Allison, Susan G. Haber, Cindy Brach, and Elizabeth Shenkman. See Dick et al., “The Consequences of States’ Policies for SCHIP Disenrollment,” *Health Care Financing Review*, 23(3), Spring 2002.

## For More Information

More information on CHIRI™ projects can be found at [www.ahrq.gov/chiri/chiri.htm](http://www.ahrq.gov/chiri/chiri.htm). Reprints of the *Health Care Financing Review* article on which this Issue Brief is based can be obtained from AHRQ’s Publications Clearinghouse by phone (800-358-9295) or E-mail ([ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov)). Request by title of article (see “Credits,” below).

Topics of future CHIRI™ Issue Briefs include:

- Characteristics of SCHIP enrollees.
- Adolescents’ quality of care prior to enrolling in SCHIP.
- Dental care of publicly insured children.

## 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 science, children, families and communities, population, conservation, and the arts.

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.