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The Challenge of Enrolling and Retaining Low-Income Children in SCHIP

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Research Brief

The State Children's Health Insurance Program (SCHIP) was enacted in 1997 to extend public health insurance coverage to children in families that had low incomes but did not qualify for Medicaid. The program's implementation contributed to a 25 percent decline between 1997 and 2005 in the portion of children who were uninsured.[1] By 2005, more than 6 million children had been enrolled in SCHIP.[2] Nevertheless, more than 8 million children remained uninsured throughout that year.[3]

While SCHIP has allowed more children to obtain health insurance, barriers have prevented many eligible children from enrolling and staying enrolled. Analysts estimate that about seven out of 10 uninsured children are eligible for coverage under Medicaid or SCHIP.[4]

The failure of SCHIP to enroll a large portion of eligible children is a serious policy concern because uninsured children face significant obstacles to receiving health care. Comparing Medicaid-eligible uninsured children to Medicaid-enrolled children with the same health status, family income and other characteristics, researchers found that uninsured children were almost three times as likely to have an unmet health need during a year, and were more than four times as likely to delay health care due to cost.[5] Nearly 25 percent of the uninsured children lacked a regular source of health care compared to 6 percent among Medicaid-enrolled children.[5] Out-of-pocket medical expenses were also higher for families of uninsured children. Almost 30 percent of uninsured children had medical costs exceeding $500 per year, while 13 percent of Medicaid-enrolled children spent this much.[5]

This issue brief will discuss the barriers to participation in SCHIP and how enrollment and renewal procedures have attempted to address these barriers. It also will present evidence suggesting that crowd-out (substituting private health insurance with public coverage) is less of a concern than previously thought.

Barriers to Participation

Surveys have identified the three main barriers that parents face to enrolling their children in SCHIP:

- **Insufficient knowledge.** Parents may not know that the program exists or that their child is eligible. In 1999, knowledge gaps were the primary reason that low-income uninsured children were not enrolled in Medicaid or SCHIP.[6]
- **Administrative hassle.** Enrollment procedures vary by state but frequently are cumbersome. For example, they may include face-to-face interviews, confusing application forms and onerous documentation requirements to verify income and assets. A new hurdle arose with the Deficit Reduction Act of 2005, which stipulates that Medicaid recipients and future applicants must prove their citizenship and identity.[7] In states that have a single application for Medicaid and SCHIP, these documentation requirements extend to SCHIP applicants as well, creating another administrative obstacle.[7]

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- **Not wanting public coverage or feeling it is not needed.** Surveys have found that some parents prefer not to receive public coverage, perhaps because of stigma.[6] Alternatively, they may feel that health insurance is not needed.[6] The uninsured children of parents who claimed that coverage was not needed were more likely than other uninsured children to be in good health, however, only 32 percent of these children had received well-child care in the past year.[6] This finding suggests that this group of children is not receiving proper preventive care.

Even after overcoming the barriers to achieving enrollment, participants face similar administrative barriers to retaining SCHIP eligibility. State officials believe that a large portion of participants fail to renew their enrollment because they are confused about SCHIP rules and procedures.[8]

Efforts to Improve Enrollment

States and community organizations have responded to underenrollment in SCHIP by providing outreach, simplifying eligibility procedures, using community-based application assistance, and eliminating procedural differences between Medicaid and separate SCHIP programs:[9]

- **Outreach.** At the time SCHIP was authorized, 22 percent of children eligible for Medicaid expansions had not enrolled and remained uninsured.[10] Recognizing that lack of participation would be a problem, the authors of the SCHIP legislation provided funding for outreach to encourage enrollment.[10] Philanthropic organizations, such as the Robert Wood Johnson Foundation, also have contributed by funding organizations to undertake outreach efforts. Such efforts have included nationwide information campaigns such as the Covering Kids & Families Back-to-School campaign, as well as community outreach events at which parents are educated and receive application assistance.
- **Simplification.** Some organizations have hired literacy experts to simplify the language on application forms. Other examples of simplification measures include accepting mail-in applications in place of face-to-face interviews, using self-reported income data and disregarding assets in determining eligibility.[9]
- **Community-based application assistance.** Some states and community organizations have employed outreach workers to inform the public about SCHIP and assist with the application process. In the example of school-based outreach programs, schools help identify uninsured children who may be eligible and then outreach workers screen their families for eligibility and assist them with the application process.[11] States have supported community-based application assistance by other types of organizations such as child-care providers, faith-based organizations, and health and human service providers.[9]
- **Elimination of procedural differences between Medicaid and SCHIP.** Many states have addressed the inconsistencies between SCHIP and Medicaid eligibility rules and enrollment procedures that often cause confusion. A majority of the states that have separate Medicaid and SCHIP programs have developed a common application form.[9] In addition, some states have created new electronic systems that screen for eligibility for both programs.[12] Virginia, for example, also implemented a No Wrong Door policy, allowing applicants to apply for either Medicaid or SCHIP at the Department of Social Services offices or the state's Family Access to Medical Insurance Security program offices (which previously accepted only SCHIP applications).[11]

TIGHT BUDGETS HAVE LED SOME STATES TO IMPLEMENT SCHIP ENROLLMENT CAPS OR INCREASE THE PREMIUMS THEY CHARGE TO ENROLLEES.

For the families that succeed in submitting an application, approval is far from assured. One study found that in most states, fewer than 50 percent of SCHIP applications were approved and a large percentage of applicants were denied for procedural reasons.[13] Researchers examining three states with comparable data found that between one-half and three-quarters of the denied applicants either "failed to comply with procedures" or submitted incomplete applications. Omission of income verification appeared to be the leading cause of denial for a procedural reason. The researchers posit that a disadvantage of accepting mail-in applications is that applicants lose the opportunity to get face-to-face guidance from SCHIP administrative staff.[13]

Approximately 40 percent of denied SCHIP applications were referred to Medicaid because the applicants appeared eligible for that program.[13] Only a very small number of applicants were rejected because they already had health insurance coverage (less than 5 percent in four out of the six states examined).[13]

The Challenge of Retention

Renewal procedures for SCHIP have not been simplified to the extent that initial application procedures have been.[8] In four of the five states for which comparable data were available, only 26 to 48 percent of the children up for renewal were approved for continued eligibility.[8] Since the program's target population often experiences variable income, much of this type of attrition may be due to families' incomes rising above the threshold for eligibility or dipping below it so that they qualify for Medicaid instead–thus, it need not mean that children whose eligibility is not renewed go uninsured. Nevertheless, state officials are concerned about the 10 to 40 percent of parents who do not respond to renewal notices (which are sent out months before the child is due for renewal) or submit renewal applications. It is impossible to know whether the family moved, did not receive the notices, ignored the notices, or obtained private health insurance coverage. State officials feel, however, that a large portion of these cases are families that do not reapply because they are confused about SCHIP rules and procedures.[8]

Crowd-Out Concerns

When SCHIP was authorized, policy-makers were seriously concerned about the extent to which expanded public coverage would replace, or "crowd-out," private health insurance. They feared that parents might drop their private insurance to enroll for free or lower-cost coverage from SCHIP. To deter families who have or could obtain private health insurance from enrolling in SCHIP, many states require children to be uninsured for a waiting period before they are eligible. States also use cost-sharing measures in the form of premiums, enrollment fees and co-payments to weaken families' incentives to substitute SCHIP for private coverage.[14]

As SCHIP was implemented, however, crowd-out concerns diminished at the state and local levels. One study found that SCHIP and Medicaid officials in 18 states reported little to no concern about crowd-out.[14] Researchers found that only 3.7 percent of applicants had coverage through an employer within 90 days prior to their application in California.[14] Similarly, Colorado and Texas rejected just 3 percent and 3.4 percent of applications, respectively, because the applicants had private coverage.[14]

Early on in the program, some states actually loosened restrictions intended to limit crowd-out in order to boost enrollment.[14] For example, New Jersey lawmakers reduced the state's waiting period from 12 months to 6 months and eliminated it for families

with incomes less than 200 percent of the federal poverty level.[14] In 2000, Mississippi eliminated its waiting period altogether.[14]

Conclusion

While most states have succeeded in making enrollment easier, some have lost ground in recent years. Tight budgets have led some states to implement SCHIP enrollment caps or increase the premiums they charge to enrollees.[12] Going forward, it will be important to ensure that funding shortages do not undermine the goal of enrolling all eligible but uninsured children.

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3 U.S. Census Bureau Current Population Survey (2005 data): *http://pubdb3.census.gov/macro/032006/health/h01_001.htm*.
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