Data Needs for the State Children's Health Insurance Program

Panel for the Workshop on the State Children's Health Insurance Program, Arleen Leibowitz and Earl S. Pollack, Editors, National Research Council

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PANEL FOR THE WORKSHOP ON THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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We would like to thank the state policy makers, who have been working creatively and tirelessly to make the SCHIP program a success, for sharing their knowledge. Thanks are also due to the researchers who are developing the new methods needed to understand this complex program and who are so willing to share not only their findings, but also their methods. The worskhop drew on excellent presentations by Vicki Grant, Southern Institute on Children and Families; Linda Bilheimer, The Robert Wood

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Evaluation, Massachusetts Department of Public Health; Lorraine V. Klerman, The Heller School for Social Policy and Management, Brandeis University; Trish Riley, National Academy for State Health Policy, Portland, Maine; and Nora Cate Schaeffer, Department of Sociology, University of Wisconsin.

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by Alan Zaslavsky, Department of Health Care Policy, Harvard Medical School. Appointed by the National Research Council, he was responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.

Finally, I am grateful to my fellow panel members for their generous contributions to both the Workshop and to the writing of this report. I am very appreciative of their willingness to apply their expertise and knowledge to efforts to use data more effectively to improve the State Children's Health Insurance Program. Their cooperation and congeniality made writing this report a pleasure.

Arleen A. Leibowitz, *Chair*
Panel for the Workshop on the State Children's
Health Insurance Program

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Executive Summary

The State Children's Health Insurance Program (SCHIP) was established by Congress to provide health insurance to uninsured children whose family income was too high for Medicaid coverage but too low to allow the family to obtain private health insurance coverage. The enabling legislation for SCHIP, included in the Balanced Budget Act of 1997, made available to states (and the District of Columbia) almost $40 billion over a 10-year period for this program. Like Medicaid, SCHIP is a joint federal-state program, with funding from both sources, but it is implemented by the states. Thus, there are SCHIP programs in all of the states and the District of Columbia.

States had the option of organizing their SCHIP program in the form of a new State Children's Health Insurance Program, expanding Medicaid coverage, or establishing a combination of these two approaches. As of December 2000, 17 states had established separate SCHIP coverage, 17 had expanded Medicaid, and 17 had a combination of these two approaches.

The National Research Council, through the Committee on National Statistics, was asked to explore some of the ways in which data analysis could be used to promote achievement of the SCHIP goal of expanding health insurance coverage for uninsured children from low-income families. To inform its work, the panel for this project held a workshop to bring together state SCHIP officials and researchers to share findings and methods that would inform the design, implementation, and evaluation of

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SCHIP at the state and national levels. In keeping with this charge, this report is limited to discussions at the workshop. It does not attempt to provide a summary of all the state programs nor a comprehensive review of the literature.

The panel concludes that data are insufficient in the individual states to provide a clear picture of the impact of SCHIP on the number of children who are eligible for the program, the rate at which eligible children are enrolled in the program, and the rate at which they are retained in the program once enrolled. This situation is due, in part, to the fact that sample sizes in national surveys are too small to provide detailed data for individual states. In addition, the great amount of movement of children among health insurance categories—Medicaid, SCHIP, private insurance, or no insurance at all—makes it difficult for states to count the number of children in specific categories at a particular point in time.

The panel specifies a number of practices that could be implemented to improve the overall functioning of SCHIP and the ability of policy makers to evaluate the program. Foremost among these are: (1) developing more uniform ways of estimating eligibility and health insurance coverage among the states; (2) sharing among the states effective methods for outreach; (3) taking qualitative information into account, in addition to quantitative information, in assessing variation among states in enrollment and disenrollment; and (4) implementing longitudinal studies to track the movement of children among the various insurance statuses.

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Background

In the mid-1990s there were more than 11 million children in the United States without any form of health insurance (Institute of Medicine, 1998). This situation led Congress to enact legislation to establish the State Children's Health Insurance Program (SCHIP) with an appropriation of $40 million over a 10-year period to be allotted to the states (U.S. Congress, 1997). Subsequent difficulties in estimating the size of the SCHIP eligible population, in bringing data to bear on the enrollment process, and in assessing disenrollment from the program led the Office of the Assistant Secretary for Planning and Evaluation, of the Department of Health and Human Services, to contract with the Committee on National Statistics of the National Research Council to organize and hold a workshop to explore some of the ways in which data analysis could be used to promote achievement of the SCHIP goals of expanding health insurance coverage for uninsured children from low-income families. The charge to the workshop was to bring together state SCHIP officials and researchers to share findings and methods that would inform the design, implementation, and evaluation of SCHIP at the state and national levels.

SCHIP was established to provide health insurance to uninsured children whose family income was too high for Medicaid coverage but too low to allow the family to obtain private health insurance coverage. Like Medicaid, SCHIP is a joint federal-state program, with funding from both sources but administered by the states. Thus, in the states and the District of Columbia there are 51 different programs.

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The SCHIP authorizing legislation set out criteria that all programs must meet yet left the states a great deal of latitude in determining the structure of the program, eligibility criteria for children, and program implementation. States had the option of organizing their SCHIP program in the form of a new state children's health insurance program, expanding Medicaid coverage, or establishing a combination of these two approaches. As of December 2000, 17 states had established separate SCHIP coverage, 17 had expanded Medicaid, and 17 had a combination of these two approaches (Smith and Rousseau, 2001). In addition, within federal guidelines, states set eligibility criteria for enrollment. The legislation requires that the states maintain the Medicaid eligibility they had in place on June 1, 1997; thus SCHIP could only be used to expand eligibility for health insurance to those who would not have been eligible under the preexisting Medicaid program. On one hand, if a state chose to implement a Medicaid expansion, it was required to offer those who would be newly covered the same Medicaid benefits package that was already in place. On the other hand, if a state chose to establish a separate SCHIP, it was required to meet the standards laid out by the act that established the program.

The program went into effect on October 1, 1997, but before states could enroll children in SCHIP, they were required to obtain approval of the plan for their program from the secretary of the U.S. Department of Health and Human Services. The plan was required to detail what the state was already doing in insuring children of low-income families, to estimate the number of uninsured children in the state, to describe proposed SCHIP eligibility requirements and benefits, and to describe how the plan would be coordinated with Medicaid and how outreach would be conducted.

By 6 months after the program went into effect, 6 states had obtained approval for their plans; this number increased to 33 by the end of the first year and to 49 by the end of the second year. Two states did not get started until fiscal year (FY) 2000 (Rosenbach et al., 2001). One reason that states were delayed in obtaining approval for their SCHIP plans was the difficulty they had in estimating the numbers of uninsured children who would meet income eligibility criteria for the program in their state and the distribution of eligible children within the state. The Current Population Survey (CPS) is used to allocate federal funds for SCHIP to the states, but the size of the sample is too small to estimate numbers of eligible children for all but the largest staes, let alone for geographic areas within states and to estimate the total number of eligible children in many states reliably. Estimates of the

numbers of uninsured children will also be needed to evaluate the success of the program in reducing the uninsurance rate among children. States encountered a variety of impediments: available data on insurance often defined "uninsured" as lacking insurance at a point in time, while some states set a 6-month period without health insurance as a requirement for inclusion in the program; furthermore, family income data in available surveys was often categorized in a way that made it difficult to determine whether a child would meet the income eligibility criteria for SCHIP.

Once they had an approved program, states also encountered difficulties in enrolling children in SCHIP as rapidly as they had predicted. A paucity of good information on the characteristics of uninsured children whose family income fell in the range specified by the state made it difficult to target the program to eligible families. During the first three years of the program, most states were unable to enroll as many children as their funding allotment would allow. However, the allotment was based on the unreasonable assumption that each state would have complete enrollment on the day the SCHIP legislation went into effect. Even though states were allowed to spend funds allotted in a given fiscal year over a 3-year period, only 45 percent of the $4 billion allotted in FY 1998 had been spent by the end of FY 2000. This left $1.9 billion to be distributed among the states that had spent all of their FY 1998 allotment (Kenney et al., 2000). The SCHIP program covered between 2 and 3 million previously uninsured children each year during its first three years; even so, there were an estimated 11 to 12 million uninsured low-income children at the end of that time, an unknown number of whom were eligible for SCHIP.

As states increased the numbers of children enrolled in SCHIP, many also documented low retention rates in the program. However, there was uncertainty about whether children were leaving SCHIP because their families had obtained other insurance for them, either Medicaid or private; because of failure to complete the paperwork requirements for reenrollment; or because their families were dissatisfied with the program.

The workshop was designed to provide a forum for substantive interaction among state policy makers and analysts, federal policy makers, and researchers and academics. The presentations provided opportunities for states to share their experiences in making innovative use of data to target enrollment and improve and monitor the success of their programs. Researchers examining SCHIP, often using nationally representative databases, presented their analyses and suggested ways that states might adapt the research methods to better understand state-level SCHIP issues. The work-

shop agenda is included in Appendix A, and the presentations are summarized briefly in Appendix B. Appendix C contains a brief description of each of the national surveys mentioned in this report.

Following the meeting, the panel met to summarize the workshop discussions and to draw conclusions about ways to enhance data collection and analysis in order to strengthen and target enrollment and retention efforts and to support evaluation of the SCHIP program. This report contains the panel's summaries of the workshop discussions around three issues: determining the size of the eligible population (Chapter 2), enrollment (Chapter 3), and disenrollment (Chapter 4). Chapter 5 discusses several cross-cutting themes that affect multiple program goals. At the end of each of Chapters 2-5, the panel lists conclusions focused on the capacity to evaluate and monitor the SCHIP program. Reviewing the SCHIP activities of the states not included in the workshop was beyond the scope of the panel's charge. The conclusions are those of the panel and do not necessarily reflect the opinions of either the workshop participants or the sponsors of the workshop. Although the panel sometimes based its conclusions directly on suggestions made by workshop participants, the conclusions evolved from subsequent discussion and synthesis of the issues, and some were not explicitly discussed in the workshop itself. The final chapter is a summary of the highlights of the workshop.

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Estimating Eligibility

Since SCHIP was established as a state program, each state has developed its own approach in attempting to reduce the number of uninsured children, taking into account its programs that were already in existence through Medicaid and private insurance when they implemented the program. However, SCHIP funds are allocated to the states on the basis of a formula that depends on the proportion of all uninsured children from low-income families who are residents of a given state. Thus, eligibility data for each state are important for at least four purposes: (1) to allocate the total national funding for SCHIP to the states; (2) to measure the success, or lack thereof, of enrollment and reenrollment efforts within a given state; (3) to allocate SCHIP funds across areas (e.g., counties) within a given state; and (4) to present the state legislature with valid estimates of the numbers of children who are eligible for coverage. The latter is critical, since state legislatures must match federal SCHIP funding and be persuaded that the program is effectively meeting its goals. If the program underestimates the number of eligible children, it may be difficult to persuade the legislature to appropriate the matching funds needed to pay for the insurance for the eligible children. Given the way in which the system currently operates, such a deficit cannot be addressed until the following year.

The SCHIP allotments to states for a given year are based on a complex formula that uses the average of the number of low-income children from the March supplement of the Current Population Survey for the previous three years, adjusted to take into account factors accounting for dif-

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ferences in health care costs among the states. Several other surveys, including the National Health Interview Survey and the State and Local Area Integrated Telephone Survey, have been used to estimate the number of children eligible for both SCHIP and Medicaid. Differences in methodology and in question format make for substantial variations in these estimates. In his presentation at the workshop, Thomas Selden concluded that each of the national surveys has positive and negative attributes and there is no single benchmark against which to compare results. The challenges include having to estimate eligibility from income data that do not map directly to state eligibility criteria, either in terms of the eligibility criteria for the state's Medicaid program, the definition of insurance, the definition of countable income, or the length of the reference period for measuring income or insurance coverage; respondents' difficulties in accurately responding to survey questions on income; differences in income thresholds across the states; nonresponse to the survey; and inadequate sample sizes to estimate the number of eligible children in all but the largest states, even when multiple years of survey data are combined.[1]

SCHIP is a state program with only general guidelines from the federal government, thus eligibility criteria vary from state to state. In particular, states were required to maintain Medicaid eligibility for all children who were eligible prior to June 1997 and to use SCHIP to provide insurance for children whose family income exceeds the level for Medicaid but whose income falls below the level set by the state as the income ceiling for SCHIP. The assessment of eligibility for SCHIP is complicated by the relationship between family income and the ceiling for Medicaid eligibility and SCHIP eligibility. The income band for eligibility for SCHIP is sufficiently narrow (in some states, for example, between 100 percent and 140 percent of the federal poverty level) that its boundaries are very difficult to identify from survey data, particularly in view of the difficulty in allocating survey responses to income questions and the difficulty that respondents have in supplying the information with the precision needed to accurately model eligibility. In most states, when family income changes only slightly, eligi-

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[1]Beginning in the year 2001, the sample size of the March Supplement was increased to provide much more reliable estimates for the smaller states, in many cases more than doubling the sample size for the state. Since the state estimates for determining SCHIP allocations are based on a three-year average, the full effect of this change will not be realized until the year 2003.

bility can shift from SCHIP to Medicaid, or on the other end of the scale, to private insurance or to none at all.

MEASURING INCOME AND PRIOR INSURANCE

In many states the income eligibility rules for SCHIP are so complicated that survey respondents have difficulty supplying the information needed to determine eligibility. For example, some states attempt to more closely approximate disposable income by allowing applicants to deduct such expenses as child care and child support in calculating income for purposes of determining eligibility. Survey responses are further complicated by respondents giving inconsistent answers to questions about the time period during which they have been uninsured. This creates a problem, because in some states SCHIP requires at least a 6-month period without insurance for eligibility. All of these problems make it difficult to obtain reasonable national data on SCHIP eligibility or enrollment or to make valid comparisons among states.

The difference between what families see as their income and what states count as income for the purpose of eligibility determination, combined with the narrow band between Medicaid and SCHIP eligibility, have resulted in many families who are inquiring about SCHIP finding out that they are actually eligible for Medicaid. The federal law that established SCHIP requires that those applying for SCHIP be screened to determine whether they are eligible for Medicaid. If they are Medicaid eligible, they will be referred to that program for potential enrollment. In her presentation, Kristen Testa described SCHIP as an important motivator for getting individuals enrolled in Medicaid. Pamela Paul-Shaheen cited the example of a family's calling the 800 number for the Michigan SCHIP thinking that they were eligible, but finding out that instead they were eligible for the Medicaid program. To deal with this problem, the Michigan program located the offices handling Medicaid and SCHIP next to each other so that applications coming to one office that qualified for the insurance provided by the other were simply handed over. This solution resulted in a substantial increase in enrollments by much more quickly identifying proper eligibility.

Furthermore, using national surveys is problematic because states vary in what they consider countable income and assets. Lisa Dubay's simulation of the eligibility rules in the various states required many different formulations of a large number of variables, including age of child, family

size, work status of parents, how income is counted, whose income is counted, types of income (pension income, Social Security income, wage income, etc.), child care expenses, employment status, reasons for not working, and a host of other factors. The factors included and the way they are defined vary considerably among states. For example, Steve Norton reported that in New Hampshire the guidelines for specification of income to determine eligibility are much less detailed than those described by Dubay.

Another problem in determining eligibility is the volatility in family income among low-income families. Therefore, as Linda Bilheimer indicated, to understand eligibility data, access to Medicaid and frequent changes in family income must be taken into account. She presented data from a period prior to the SCHIP legislation that indicated tremendous movement among Medicaid, employer-sponsored insurance, other insurance, and being without insurance. In some cases, the insurance status for a given child changed several times during a year. Vicki Grant pointed out that one applicant may have several denials of insurance before acceptance. Since the transitions into and out of a particular insurance category tend to balance out during the year, the use of longitudinal data is necessary to properly interpret the data.

Furthermore, in nationally representative data, even surveys with large household samples like the Current Population Survey, sample sizes at the state level are too small to provide reliable estimates, particularly for the smaller states, and they are certainly too small to provide estimates at the regional or county level. One result has been that when states do attempt to make estimates based on national data, the standard errors can be so large as to make point estimates meaningless.

STATE SURVEYS

Many states, frustrated by not being able to use national survey data as a basis for their estimates, have developed their own surveys. Thus, at least 27 states were conducting their own household surveys, each of them using their own questions. Cynthia Shirk pointed out that the fact that so many states are conducting their own surveys using their own methodologies makes it very difficult to compare the resulting data among states and to relate outcomes to program characteristics.

Norton expressed the need to move away from nationally based surveys in favor of state-based surveys to be able to better meet the state's

needs. In New Hampshire, the legislature wanted data on eligibility at the county level in order to understand in which areas problems needed to be addressed. In Connecticut, as Mary Alice Lee showed, data by town revealed a decrease in enrollment in Hartford. A subsequent survey in Hartford of those leaving the program indicated that the major reason was transfer to employer-based insurance. These experiences emphasize the importance of analyzing the distribution within the state of the uninsured population and movements in and out of SCHIP in order to better understand the reasons for changes.

In its discussion of the issues presented at the workshop bearing on the problems in estimating the numbers of children eligible for SCHIP, the panel drew the following conclusions:

- **Better ways are needed to estimate eligibility and insurance coverage status from state and national survey data.**
- **More work is needed to determine what data elements needed for estimating eligibility are included in each of the national surveys, how they are defined, and how differences in their content and definitions can be reconciled.**
- **States should explore ways to supplement national sample efforts in such surveys as the Behavioral Risk Factor Sample Survey (BRFSS), the State and Local Area Integrated Telephone Survey (SLAITS), and other national surveys in order to expand the size of their state samples.**
- **Measurement of SCHIP eligibility can be understood only while simultaneously measuring eligibility for Medicaid. It is necessary to measure both in SCHIP eligibility surveys.**

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Counting Enrollment

The percentage of eligible children who are enrolled in SCHIP is an important measure of the success of the program in reducing the number of uninsured children. However, determining this percentage is problematic—both because the number of eligible children is difficult to estimate and because of the difficulty in estimating the number of SCHIP enrollees. This chapter discusses the estimates of the numbers of children enrolled in SCHIP and how they are obtained, reasons for nonenrollment of those who are eligible, and methods that have been employed to improve the rate of enrollment.

ESTIMATING ENROLLMENT

SCHIP enrollment can be determined either from administrative records or from sample surveys. Although administrative records may be seen as ideal for this estimation, in fact differences in the number of children "ever enrolled" versus the number enrolled at a point in time can lead to widely divergent enrollment estimates. The official federal estimate provided by the Centers for Medicare and Medicaid Services (CMS) estimates that nationally 3.3 million children were enrolled in SCHIP at some time during FY 2000, ending September 30, 2000 (U.S. Department of Health and Human Services, 2001). However, this number overstates the number of children enrolled at any point in time, due to the high rates of mobility in SCHIP eligibility and enrollment. Data obtained directly from the states

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by Kaiser Family Foundation show that only 2.3 million children were enrolled in June 2000 (Smith and Rousseau, 2001).

Bilheimer reported on data from Oregon and Kansas that illustrate the high levels of volatility in insurance status for the SCHIP-eligible population. The Oregon data indicate that half of the SCHIP enrollees came directly from Medicaid and almost half of the SCHIP disenrollees went back to Medicaid. Kansas reported that three-quarters of their first-time SCHIP enrollees had been in Medicaid at some point prior to their enrollment in SCHIP and that more than one-third of their SCHIP disenrollees went directly into Medicaid. Bilheimer argued that because of the many transitions, the point-in-time number is much more meaningful than the ever-enrolled number.

Administrative data may not provide a completely accurate picture of SCHIP enrollment due to inadequacies in some state's administrative data systems. Lack of a consistent identifier for a child over time may make it difficult to distinguish whether the same child is enrolling and reenrolling, or whether two distinct children are enrolled. Creating identifiers that track all of the children in a family is also important. This was complicated, however, by the fact that, prior to June 25, 2001, states were prohibited from asking SCHIP enrollees for their Social Security numbers. Some states that have chosen to implement SCHIP by expanding Medicaid have incorporated the reports on their SCHIP enrollees into their preexisting Medicaid data systems. As Bilheimer pointed out, the latter were primarily designed to track enrollment and pay medical bills and are often ill suited for use as a management tool. Although SCHIP provides the opportunity to put in place data systems better suited for management purposes, these systems still need to interface with the Medicaid data systems, given the high rate of transition between the two programs.

Given the difficulties in relating administrative data to an appropriate estimate of the number of eligible children, some sample surveys estimate both the number eligible for participation in SCHIP and the number enrolled. For example, Dubay reported that the National Survey of America's Families oversamples low-income populations, thus permitting national estimates as well as more disaggregated estimates of enrollment in 13 states. Among the 13 states, the estimates of percentage of eligible children enrolled in Medicaid in 1999 ranged from 58.4 percent in Texas to 92.7 percent in Massachusetts. Enrollment in SCHIP ranged from a low of 34.7 percent of eligible children in Florida to 88.1 percent in Massachusetts.

Surveys are also subject to error, including reporting error. Some respondents reply that they are enrolled in SCHIP when they are not, while others reply that they are not enrolled when they are. Gestur Davidson reported that a 1999 survey in Minnesota showed that a large number of those known to be on Medicaid responded that they were on SCHIP, whereas most of those known to be on SCHIP replied that they were covered by SCHIP. The resulting survey estimates of the number enrolled in SCHIP exceeded the numbers reported in Minnesota's administrative data. David Hanig reported similar mismatches in the state of Washington, where the survey estimates of Medicaid enrollees greatly exceeded the number of Medicaid enrollees recorded in administrative data. This problem was most pronounced in counties with a large proportion of Hispanic migrant workers, suggesting either a problem with the time period covered or with respondents' understanding of the survey question.

REASONS FOR NONENROLLMENT OF ELIGIBLE CHILDREN

While national surveys can be used to estimate numbers of enrollees, few of them pinpoint reasons that eligible children are not enrolled in SCHIP. State-specific surveys can be very helpful in determining if state policies (such as the length of the application or documentation requirements) are impeding enrollment and can also help identify geographic regions where enrollment efforts should be enhanced.

Based on the results of state-specific surveys, the Michigan SCHIP instituted several changes in its application process that substantially decreased the number of incomplete applications. These changes included: reordering the questions on the application form and simplifying the language; reducing the documentation requirements, which had required, for example, a copy of the child's Social Security card; allowing self-declaration of income rather than requiring that the applicant submit pay stubs; and discontinuing the practice of income verification except on a sample basis. Other states have made similar changes with positive results on enrollment rates.

Given the sample sizes and confidentiality constraints in national surveys, state-specific surveys are also required to understand divergent enrollment trends in different areas of a state. Paul-Shaheen emphasized the importance of state surveys to identify where within the state to direct limited resources for increasing enrollment in the program. Norton reported that in New Hampshire a large state survey revealed that specific

rural areas had considerably higher rates of uninsured children. These areas were then targeted for enhanced outreach efforts.

METHODS TO IMPROVE ENROLLMENT RATES

Children who are eligible for SCHIP may already be enrolled in a number of social programs targeted to low-income children. This overlap across programs makes it possible to target SCHIP to children who may not yet be enrolled but who have a high probability of being eligible.

In her analysis of data from the 1999 National Survey of America's Families, Genevieve Kenney found that almost three-quarters of the uninsured children participated in the National School Lunch Program, the Special Supplemental Nutritional Program for Women, Infants, and Children (WIC), or the Food Stamp Program. The survey revealed that about 45 percent of the parents of the uninsured children had heard of the SCHIP and Medicaid programs, but they did not know that they did not have to be on welfare to participate. Families that participate in federal food programs represent a significant target for outreach efforts for both Medicaid and SCHIP because of the overlap in eligibility and the fact that the application process for the food programs is much simpler than that for Medicaid or SCHIP.

The state of Washington has successfully linked the medical insurance application system with the school lunch system to increase outreach for SCHIP. The SCHIP program made an arrangement with the schools to add a check box on the school lunch application form indicating whether the applicant wanted medical coverage. While this is a promising approach, it has some complications. Almost all of the participants in the school lunch program are eligible for Medicaid or SCHIP, and a large percentage are already participating in one of those programs. As a result, for those forms on which the box had been checked, it was necessary to check names against Medicaid and SCHIP enrollment records so that application forms would not be sent to those who were already in one of these programs. The initial results showed an enrollment yield of less than 5 percent.

New Jersey also developed a program to coordinate applications for SCHIP with the state's school lunch program. Heidi Smith reported that since the school lunch application was a Department of Education form, getting a health insurance question on the form had to be coordinated with that department. The New Jersey Family Care agency wrote a letter, signed by the Commissioner of Education, to the school superintendents about

the health insurance program asking the schools to cooperate. Family Care then sent a letter to the school principals asking them to send copies of all the forms that had a check mark in the health insurance box to Family Care for potential enrollment. The response was initially problematic, because many of the principals did not forward copies of the forms. The help of the school nurses was enlisted, and they were successful in seeing that most of the forms were forwarded to the Family Care agency. The number enrolled through this process was relatively low, but improvements were instituted for the following year with the expectation of better results.

The overlap between Medicaid and SCHIP eligibility must also be considered when seeking ways to enhance SCHIP enrollment. Dubay concludes that reducing the uninsurance rate among low-income children must involve targeting Medicaid-eligible children, as well as those eligible for SCHIP, because 60 percent of uninsured children are eligible for Medicaid, while only 25 percent are eligible for SCHIP.

State-specific surveys identified cumbersome application procedures as an impediment to enrollment for many SCHIP-eligible children. Michigan found that many of those who requested application forms did not return them because the forms were too confusing. This was remedied by a substantial revision of the form.

A promising strategy that some states are using to increase enrollment in SCHIP is presumptive eligibility without requiring documentation of income or assets. To control the proportion of those who are actually ineligible from enrolling, some states audit the incomes of a sample of enrollees and make it known to enrollees in advance that they may be included in the audit sample. This policy is used as a possible deterrent to misrepresentation. Evidence from some of the states seems to indicate that a vast majority of the enrollees sampled have met the eligibility criteria. Michigan, for example, found that 94 percent entered their incomes correctly and that some of those who did not had reported income that was too low for SCHIP but not too low for Medicaid. An alternative method of checking on error rates is to "plant" persons of known eligibility status into the applicant pool and to determine whether they are approved for enrollment or not.

Based on the workshop discussion the panel concluded that enrollment could be improved by a number of means:

• **Continuing to share state experiences to identify the most effective ways to get hard-to-enroll eligible children enrolled with mini-**

mum error rate. As budgets tighten, cost effectiveness becomes even more important.

• Implementing presumptive eligibility on the basis of self-reporting of income, with income auditing, using sample-based auditing as a way to measure and limit error rates in enrollment.

• Continuing to apply lessons learned in SCHIP outreach to improve Medicaid outreach.

• States should consider using the school lunch program and the Special Supplemental Nutrition Program for Women, Infants, and Children to target SCHIP-eligible children.

4

Disenrollment

Many states are experiencing high rates of disenrollment from their SCHIP programs, yet it is not clear if these rates reflect dissatisfaction with the program by participants, changes in income limits that cause participants to lose SCHIP eligibility, participants moving to private insurance, or deficiencies in the administration of the program. Improved data on the insurance status of disenrollees and reasons for disenrollment would allow policy makers to better understand which of these factors results in disenrollment.

A number of states reported low levels of retention in the SCHIP program. Data for these studies are primarily administrative. Ian Hill, in his Urban Institute survey of five states, found the approval rate at redetermination to range from a low of 26 percent in Michigan to a high of 65 percent in New York. He found that the SCHIP retention rate was less than 50 percent in four of the five states. However, these data provide little information about whether or how a child was insured after leaving SCHIP or the reasons for disenrollment. Hill's data do show that referral rates to Medicaid ranged from 9 percent in Colorado to 32 percent in Michigan. (The length of time from initial coverage by SCHIP until renewal—or reapplication for continued coverage—varies among states from a few months to one year.)

Enrollment, retention, and disenrollment from the SCHIP program represent a dynamic process, since the target population can be classified as being in one of four statuses at any given time: uninsured, Medicaid en-

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rolled, enrolled in a separate state SCHIP program, or privately insured. Currently, little information is available about the insurance status of children leaving the SCHIP program, who may leave for many reasons, including that they are no longer eligible because of income or age. They may be enrolling in Medicaid because their family income has fallen, or they may be covered by private insurance because their family income has risen. Alternatively, they may become uninsured either because they are no longer eligible for SCHIP or Medicaid and have no private insurance option, or because they were unable to complete the paperwork needed for renewal.

It is important to distinguish among these reasons for disenrollment, because policy makers would interpret coverage under private insurance as a success, but failure to renew due to paperwork burden as a failure. Hill listed some of the factors that hinder the redetermination process. Among them are the reliance on a mail-based system, rather than on personal contact, that many times left the recipient confused; the requirement to resubmit documentation that had already been submitted on initial enrollment; lack of coordination with Medicaid when income dropped, leaving the family eligible for Medicaid rather than for SCHIP; and automatic disenrollment in some state programs when there was no response to the renewal notice.

In Hill's five-state survey, the major reason for discontinuation at the time of redetermination was failure of the family to respond to renewal notices. This reason accounted for as much as 41 percent of all discontinuances in North Carolina. In Michigan, in contrast, renewal forms are sent out 50 days before they are due. Denise Holmes found that only 6.3 percent (77 families out of 1,219) failed to return their forms and most of these families had obtained private insurance. A major reason for the high rate of return was that candidates for renewal received application forms that were already filled out from previous information so that the applicant merely had to indicate any changes that had occurred and sign the form.

Several strategies were mentioned by participants in the workshop for increasing retention in SCHIP. They included:

- Sending out notices well in advance (Hill mentioned 60-90 days).
- Simplifying the language on the form—for example, using the word "renewal" rather than "redetermination" or "reenrollment."
- Sending forms that are already completed and requesting only changes and a signature.

- Using "passive reenrollment"—that is, if no response is received, the child is automatically reenrolled.

The opportunity to transfer learning about SCHIP retention from one state to another is lost through the lack of consistent definitions of insurance categories and reasons for lack of reenrollment across states. Lack of consistent definitions impedes understanding of how differences in these rates relate to state policies, such as passive reenrollment. We have indicated above how the simplified reenrollment process has played a role in increasing reenrollment in Michigan. Another factor that Michigan found to be instrumental in increasing the rate of reenrollment was allowing self-declaration of income rather than requiring the submission of pay stubs or copies of income tax statements.

The SCHIP population is continually changing, both in terms of residence and income, and because eligibility for Medicaid coverage depends on the age of the child. Thus, there is much movement among the insurance statuses. Marilyn Ellwood cautioned that, while assessing retention in SCHIP is important, the problems of retention in Medicaid should not be ignored. She points out that there are seven times as many children on Medicaid than are covered by SCHIP. The churning of applicants among insurance statuses is not tracked by most states, and longitudinal record systems do not appear to be prevalent. Holmes reported that Michigan has begun selecting monthly samples of new enrollees and then following them over time to be able to track changes in their insurance status and changes in factors that affect insurance eligibility, such as increases or decreases in income.

Administrative data often provide little information about the reasons for disenrollment from the program. Some states have merged their Medicaid and SCHIP files to gain more information about the movement between the two programs. Ellwood reported that, beginning in 1999, all states were required to submit to the Centers for Medicare and Medicaid Services monthly information on all of their Medicaid-eligible children, including those on the traditional Medicaid program as well as the children eligible for the Medicaid expansion through the Children's Health Insurance Program. This information is included in CMS's Medical Statistical Information System (MSIS). CMS also offered the states that had separate SCHIP programs the option of including their SCHIP data in the MSIS. As of 2001, only nine of the seventeen states with separate SCHIP programs had submitted their data. For the states whose data are included in

the MSIS, analysis of the data in the system can provide a picture of movements in and out of SCHIP and transfers between SCHIP and Medicaid. Several of the speakers at the workshop commented that, while some data indicate a net flow out of SCHIP, no consistent data exist that indicate reasons for such movement.

The need for qualitative data (also discussed in Chapter 5) was mentioned by several speakers as a means for states to learn why children do not reenroll, so that they can alter their procedures to improve reenroll. Hilary Bellamy described plans for a series of 52 focus groups in 9 states to obtain information that will be helpful at both the state and national levels in improving enrollment and retention in both SCHIP and Medicaid. Of these, 15 of the groups will involve families whose children had recently disenrolled from SCHIP and were not enrolled in any health insurance program at the time of the focus group meeting. Discussions will center on reasons why SCHIP participants have not reenrolled in the program.

Although Medicaid and SCHIP participation are often seen as distinct in state data systems, they are often conflated in household responses to surveys. Population-based surveys, such as the National Survey of America's Families and the State and Local Area Integrated Telephone Survey, rely principally on household reports. Because household respondents are often poor reporters of type of coverage, other sources of data are needed. Ideally, a combination of data from surveys and administrative records would be useful as a way of obtaining more accurate information.

Several states are trying to unravel the reasons for SCHIP disenrollment by conducting sample surveys of disenrollees. However, it is difficult to draw conclusions about how program characteristics, such as whether it is integrated with Medicaid or a stand-alone program or whether the state has passive reenrollment, relate to retention in SCHIP because there is little uniformity in the categories that states use to classify reasons for disenrollment.

On issues related to disenrollment raised by workshop participants, the panel concluded:

• Longitudinal studies measuring gross flows across the four insurance categories—Medicaid, SCHIP, private coverage, and no coverage—would be helpful to state and national planners. Cross-sectional surveys can provide, at best, limited information on transitions among insurance categories. Short-term retrospective studies may be yet another approach to measuring these transitions.

• **Data from multiple sources, including qualitative data, are needed to fully understand the dynamics of the enrollment/ disenrollment process.**

• **Separating reasons for disenrollment from SCHIP—ineligibility, application burden, disinterest—is important. More uniform categories would facilitate comparisons across the states.**

• **Knowing the subsequent insurance status of children who leave SCHIP and the reasons for their disenrollment would allow policy makers to better understand how state policies, such as integrated Medicaid/SCHIP program and passive reenrollment, affect retention rates in the program.**

5

Cross-Cutting Issues

Collaboration among state SCHIP programs is an important way to expand knowledge about effective ways of, and problems in, administering SCHIP programs. The workshop itself was evidence of this. More generally, a number of issues common to most SCHIP programs would be informed by cross-fertilization among the states. The development of common approaches could benefit many of the state programs.

ANALYTICAL ISSUES

Estimating eligibility, enrollment, disenrollment, and more generally, understanding how children (and families) move among the different insurance categories—SCHIP, Medicaid, private insurance, or no insurance at all—are common goals of the SCHIP programs across the states. Each state has developed its own methods of measurement to deal with these issues, sometimes adopting methods used by one or more other states. Central development and dissemination of analytic methods to accomplish these goals would be useful to the individual SCHIP programs.

Another common issue is the tremendous movement among insurance statuses and the problem of how to measure these changes. As indicated earlier, 27 states conduct their own surveys to attempt to measure the extent of these transitions. Dubay described the Urban Institute's National Survey of America's Families, which provides a national picture and has a

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sample size large enough to provide detailed data for 13 states. It is difficult for many states to adopt this methodology, primarily for budgetary reasons. Norton's experience in New Hampshire is evidence of this; his budget allowed him to use only a stripped-down version of this survey.

The State Health Access Data Assistance Center at the University of Minnesota has been organized to provide assistance to states in dealing with these issues. The center is funded by a grant from the Robert Wood Johnson Foundation to provide technical assistance to states that are interested in collecting relevant data for state health policy. Lynn Blewett described what states want from national surveys. The list includes data that are representative of the individual state; a sample size that is large enough to provide valid and reliable estimates; a survey design that produces policy-relevant information; timely and routine release of data; and access to micro data for further state-specific analyses.

The effect of missing data in surveys can be a critical issue in deriving estimates from surveys. Panel member Paul Newacheck pointed out that questions on income, for example, are known to have large nonresponse rates in some of the major national surveys. He raised the question of how much imputation is going into the microsimulation models that produce estimates on insurance eligibility and what effect this might have on the estimates. If as much as a quarter of the data are imputed, this could have a substantial effect on the validity of the analysis. The discussion that followed provided no direct answer to the question, but some of the presenters stated that when they attempted to compare survey results, they found considerable similarity. This seemed to give them confidence in the use of the data from the surveys, despite high levels of missing data.

DATA STANDARDIZATION ISSUES

Several of the workshop participants pointed out that data definitions are not, in general, standard across states or across databases of related federal programs. The criteria for eligibility for SCHIP vary considerably among the states, not only due to the differing income limits for SCHIP and Medicaid among the states, but also due to how income is defined for determining eligibility. Perhaps the most detailed set of factors for determining income is that used in the National Survey of America's Families. At the other end of the scale, several states use self-declaration of income to determine eligibility with considerable variation in the extent of the guidelines that are given the applicant on what to include as income. Superim-

posed upon this is the fact that the employment status of the low-income population is so volatile that income may change several times during a short period, altering a given individual's eligibility status several times. Ellwood proposed that demographic data as well as reasons for disenrollment be reported in standardized categories to facilitate relating outcomes to underlying factors across the states.

DATA FOR TRACKING

In order to model how children move among the health insurance statuses, it would be helpful to have a consistent family identifier in SCHIP and Medicaid data sets so that the health insurance status of children from the same family can be tracked. Also, matching information from different datasets is a valuable way to identify who is eligible for coverage but not using SCHIP. The Medical Statistical Information System of the Centers for Medicare and Medicaid Services, described above, is a mechanism that can shed light on this issue. It has the advantage of giving children unique identifiers (Social Security numbers for most states) so that tracking them over time as they change statuses and tracking children from the same family are possible. Data are not yet available from this system, but there are preliminary indications of major differences among states in turnover and in transfers between Medicaid and SCHIP as well as the extent of short-term gaps in enrollment. It should be pointed out, however, that computer matching of records is not without its problems. Robert Gellman cautioned that the Computer Matching and Privacy Protection Act of 1988 limits the extent to which computer matching of records is permitted if at least one of the datasets contains federal records. This act lists a set of requirements that must be met to allow matching to proceed. Gellman pointed out that compliance with this act and enforcement of its provisions have been mixed, but that those who plan to conduct a match involving federal records should be aware of the provisions and take them into account.

EVALUATION ISSUES

In December 2000, the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human services issued a contract for a congressionally mandated study to evaluate the impact of the SCHIP (Mathematica Policy Research, 2002). The study was to include

10 states that would have some degree of national representation. Although the study places substantial emphasis on such program aspects as outreach, enrollment efforts, relation to Medicaid and private insurance, etc., it also includes plans to address access to health care and utilization of health services. With respect to those issues, the researchers were asked to pursue the following questions:

- What experiences do SCHIP enrollees have in seeking and obtaining services, and how does this compare with their experiences prior to enrollment?
- What proportion of SCHIP enrollees has a usual source of medical care?
- How does the program and benefit design impact access and utilization of services?
- How satisfied are enrollees with SCHIP and the health services they receive through the program?
- How adequate are states' or contracted provider networks in meeting the need of SCHIP enrollees?

Data that bear on questions of this type would be extremely helpful to each state for monitoring the effectiveness of its SCHIP.

QUALITATIVE INFORMATION

In evaluating SCHIP, it is important to use qualitative as well as quantitative information. As the workshop discussions reflected, very little information has been available to indicate reasons for the failure of eligible children to enroll in SCHIP or the failure of those in the program to reenroll when the time for renewal arrives. Most of the national and state surveys are not designed to provide this information. Qualitative information can be quite useful for this purpose. The focus groups, mentioned above, that Bellamy will be conducting are aimed at obtaining answers from four different groups: families who are eligible for either Medicaid or SCHIP but not enrolled, families who are enrolled, families who are disenrolled, and families who have private insurance. The discussions in each of the groups will be focused on questions aimed at uncovering what the participants know about health insurance coverage for children. This is the kind of information that will be helpful to those administering SCHIP and Medicaid in making their programs more accessible.

On these cross-cutting issues, the panel drew the following conclusions:

- **Federal-state cooperation is essential in developing a national strategy to disseminate "best data practices" across states.**
- **The use of family identifiers on a sample basis for modeling, within the constraints of privacy considerations, is a tactic to be considered to match insurance coverage data from different datasets and to track health insurance coverage for children in the same family.**
- **An appropriate federal or private national agency should undertake the following:**

   —**Develop a central repository for analytic expertise on methods for conducting sample audits.**
   —**Disseminate analytical models for handling missing data and survey nonresponses in statistical modeling.**
   —**Develop and share among the states protocols for obtaining qualitative information to assess reasons for lack of enrollment and for disenrollment.**

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Workshop Highlights

One of the basic goals of SCHIP is to reduce the number of children from low-income families who are without health insurance. That number has remained at almost 12 million nationwide. This may be due, in part, to the fact that SCHIP is a young program that did not begin until FY 1998, and the last 2 of the 50 states and the District of Columbia were accepted into the program during FY 2000. Although states were allowed three years to spend SCHIP funds appropriated for a given fiscal year, as of late in FY 2000, $1.9 billion of the $4 billion appropriated for FY 1998 remained unspent. This situation was due primarily to the fact that the states began their programs after the SCHIP legislation went into effect on October 1, 1997. The workshop focused on the issues of eligibility, the rate at which children who were eligible were actually enrolled in the program, and the extent to which those who were enrolled were retained in the program when time for renewal of insurance coverage arrived.

The Center for Medicaid and Medicare Services uses the March supplement of the Current Population Survey to estimate the number of children in low-income families that are eligible for SCHIP. These estimates are then used in a formula to determine the allocation of SCHIP funds among the states. Since the size of the Current Population Survey sample for most states is too small to permit valid analysis of eligibility data within a state, as many as 27 states have conducted their own surveys to obtain estimates that are useful for directing outreach efforts to specific geographic areas

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within the state. Such surveys have also been found to be useful for obtaining more detailed data on the low-income population.

Since each state has developed its own procedures for implementing SCHIP, it is very difficult to combine state-by-state data on eligibility, enrollment, or disenrollment to obtain national estimates or to make valid comparisons among states. Thus, there is no standard against which those administering a state program can assess their results. Some of the participants indicated that they found comfort in the fact that, even with different methodologies, comparisons of data among states seemed to reveal similar results. One of the most helpful aspects of the workshop is that it created an increased awareness of these problems and led to a sharing of information among state representatives on program aspects that seemed to be successful.

An issue that was raised time and again during the workshop was the lack of information on the reasons why those eligible for SCHIP were not enrolling and why those due for renewal in the program were not renewing. Such information is crucial for reducing the rolls of the uninsured. Some of the participants stated that they have begun to conduct sample surveys among those who have dropped out of the program at renewal time to determine the reasons for these disenrollments. This has enabled them to find ways of reinsuring these children and of preventing such disenrollments in the future.

There was considerable discussion in the workshop of the value of using federal programs, such as the National School Lunch Program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program, and the Food Stamp Program as vehicles for increasing enrollment in SCHIP. The majority of the children in those programs are also eligible for SCHIP, and the application forms are much simpler than those for SCHIP. At least two of the states have used this approach successfully, but they had to work through the problem of creating an additional burden for a system that was set up for another purpose.

Because of the narrow window for income eligibility, there is tremendous movement back and forth between coverage by SCHIP and coverage by Medicaid. Many workshop participants cautioned that one cannot understand the issues of enrollment and disenrollment in SCHIP, without taking Medicaid into account. Even though the income gap between these two programs varies considerably among states, all of the states face the problem of how to deal with the continual churning between these programs.

Cynthia Shirk of the Centers for Medicare and Medicaid Services spoke of its plans to convene a group to consider whether it would be possible to develop a set of core national performance measures for SCHIP that would be easily administered. Such an effort is clearly needed, not only to provide national data, but also to provide the state programs a set of benchmarks against which they can compare their own data. Evidence was presented that seemed to indicate that the numbers of enrollments were increasing and that the numbers of disenrollments were decreasing. However, there has been little change in the rate of enrollment as of a point in time. The workshop discussions helped to put into perspective some of the measures that are needed to improve this situation.

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Appendix
A
Workshop on the State Children's Health Insurance Program

AGENDA
June 19-20, 2001

Background: Legislation authorizing SCHIP was passed by the Congress with strong bipartisan support. State policy makers also welcomed with great enthusiasm this program for expanding health insurance to children. Nonetheless, many states have not been able to enroll sufficient numbers of children to take full advantage of federal funds allocated to their state within the time period allotted. This workshop will present tools for "enrollment success," which we define as enrolling and retaining a substantial share of the eligible, uninsured children into the SCHIP program, while avoiding enrollment of ineligible children. Given the financial resources that are currently available to expand health insurance to children, it is particularly timely to discuss methods that would help states productively target their enrollment efforts, improve the retention of children in the program, and assess their success in reducing the numbers of uninsured children.

Although it will be important to understand the quality of health care services offered to children enrolled in SCHIP and the effect on their health, a necessary first step is to understand enrollment and retention in the program. Thus, this workshop will focus on the tools that states need to improve outreach, increase retention, and examine the relationships between SCHIP and other state programs.

The meeting will commence at noon on Tuesday, June 19, 2001. The preliminary schedule is as follows:

12:00 – 1:00   ***Buffet Lunch***

1:00 – 1:30   ***Welcome and Introductions***

Arleen Leibowitz, Ph.D., Workshop Chair; Professor and Chair, Department of Policy Studies, University of California, Los Angeles

Andrew White, Ph.D., Director, Committee on National Statistics

Caroline Taplin, MSPH, and **Julia Paradise**, MSPH, Senior Policy Analysts, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (DHHS)

1:30 – 2:45   ***Session I: Background and Program Parameters***

Chair: **Robert Valdez**, M.P.H., Ph.D., Dean, School of Public Health, MCP Hahnemann University, Philadelphia, and RAND Health Sciences Program, Santa Monica, CA

Presenters:

Linda Bilheimer, Ph.D., Senior Program Officer, Robert Wood Johnson Foundation
Title: *Data Needs for Tracking Children's Health Insurance Coverage*

Vicki Grant, M.S.W., Ph.D., Research Director, Southern Institute on Children and Families, Deputy Director "Covering Kids" and "Supporting Families after Welfare Reform" (both are national projects funded by the Robert Wood Johnson Foundation [RWJF])
Title: *Managing by Eligibility Outcomes Data*

Discussants:

Pamela Paul-Shaheen, Dr.P.H, Director, Center for Advancing Community Health, Okemos, Michigan
Title: *Covering Michigan's Kids: Using Information to Inform Policy and Practice*

Mary Alice Lee, Ph.D., Assistant Director, Connecticut Children's
Health Council
Title: *Connecticut's HUSKY Program: Using Data to Improve Enrollment
and Retention*

2:45 – 3:00   ***Break***

3:00 – 5:30   ***Session II: Enrollment***

Chair: **Lynn Blewett**, Ph.D., Assistant Professor, Division of Health
Services Research and Policy, School of Public Health, University of
Minnesota

Presenters:

Lisa Dubay, Ph.D., Principal Research Associate, The Urban Institute,
Washington, DC
Title: *Assessing CHIP Impacts Using Household Survey Data: Promises and
Pitfalls*

Thomas Selden, Ph.D., U.S. Agency for Healthcare Research and
Quality
Title: New and Improved Eligibility Simulation Methodology Using
MEPS National Survey Data

Discussants:

Stephen Norton, M.A., Director of Office of Knowledge and Decision
Support, State of New Hampshire – Department of Health and Human
Services

Gestur Davidson, Ph.D., Health Economist, Minnesota Department of
Health and Human Services, Office of Reports and Forecasts

Wednesday, June 20, 2001

8:30   *Continental Breakfast*

9:00 – 10:30   *Session III: Retention*

Chair: **Ian Hill**, M.P.A., M.S.W., Senior Research Associate, Health Policy Center, The Urban Institute

Presenters:

Ian Hill, M.P.A., M.S.W., Senior Research Associate, Health Policy Center, The Urban Institute
Title: *There's a Hole in the Bucket . . . Understanding SCHIP Retention*

Hilary Bellamy, M.P.H., Senior Policy Associate, Health Systems Research, Inc., Washington, DC
Title: *Exploring Disenrollment from Medicaid and SCHIP through Focus Group Research*

Denise Holmes, Michigan Department of Community Health
Title: *Using Data to Focus Outreach, and Improve Enrollment and Retention in Michigan's SCHIP Program*

Discussant:

Marilyn Ellwood, M.S.W., Senior Fellow, Mathematica Policy Research, Inc., Cambridge, MA

10:30 – 11:00   *Break*

11:00 – 12:30   *Session IV: Links to Other Programs*

Chair: **Deborah Chollet**, Ph.D., Senior Fellow, Mathematica Policy Research, Inc., Washington, DC

Presenters:

Genevieve Kenney, Ph.D., Principal Research Associate, The Urban
Institute
Title: *Using Other Government Programs to Reach Uninsured Children*

David Hanig, M.S.W., Program Manager, Washington Department of
Social and Health Services
Title: *Nutrition & Health: Matching Data from Two Systems*

Robert Gellman, J.D., Privacy and Information Policy Consultant
Title: *Will Computer Matching Law Affect SCHIP?*

Discussant:

Heidi J. Smith, R.N., M.S.N., Executive Director, New Jersey
FamilyCare

12:30 – 1:30   ***Lunch***

1:30 – 3:00   ***Session V: Implications for Federal and State Data
Collection***

Chair: **Caroline Taplin**, MSPH, Senior Policy Analyst, Office of the
Assistant Secretary for Planning and Evaluation, DHHS

Panelists:

Lynn Blewett, Ph.D.**,** Assistant Professor, Division of Health Services
Research and Policy, School of Public Health, University of Minnesota

Kristen Testa, M.H.S., Health Program Director Children's Partnership,
Sacramento, CA

Cynthia Shirk, M.Ed., Acting Director, Division of State Children's Health
Insurance, Family and Children's Health Programs Group, Center for Med-
icaid and State Operations, CMS

Appendix
B

Workshop Presentations

SESSION I: BACKGROUND AND PROGRAM PARAMETERS

Vicki Grant, Southern Institute on Children and Families
Title: Managing by Eligibility Outcomes Data

Funded by the Robert Wood Johnson Foundation, the Covering Kids National Program Office provides direction and technical assistance to 51 statewide lead organizations and over 170 local pilot programs. These programs received grants to conduct outreach to find and enroll low-income, uninsured children, to simplify the eligibility process, and to coordinate coverage programs. Based on lessons learned during the first year, the foundation created the Supporting Families after Welfare Reform program to provide technical assistance and funding to states experiencing declines or stagnation in Medicaid and SCHIP caseloads for children and adults. A primary focus is to assist states in understanding the causes for stagnation or decline and to provide resources to address the causes.

The presentation focused on reasons why applicants are denied Medicaid and SCHIP coverage and why some participants leave the program. Children should be denied Medicaid and SCHIP or leave the program primarily for economic reasons or because the child is too old for the program. However, there are many other procedural reasons why eligible children are not receiving Medicaid or SCHIP benefits. Some typical procedural reasons applicants are denied Medicaid and SCHIP coverage are

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failure to provide verification, failure to show for an interview appointment, and being uncooperative. A couple of reasons that participants leave the program are that they withdraw or they fail to comply with procedures. Examples of the latter are failure to provide verification, failure to show for interview appointment, failure to return a report, being uncooperative, and failure to apply for other benefits.

Linda Bilheimer, Robert Wood Johnson Foundation
Title: Data Needs for Tracking Children's Health Insurance Coverage

Low-income families, especially those with income between 100 and 200 percent of the poverty level, have volatile health insurance coverage. Despite expansions of public coverage for children through Medicaid and the State Children's Health Insurance Program, evidence from the states suggests that turnover and churning persist among children who enroll in public programs. In this presentation, Linda Bilheimer discussed the types of data needed to understand these phenomena better and the data that are currently available from national surveys and state administrative data systems. Longitudinal surveys, such as the Survey of Income and Program Participation (SIPP), are the best tools for tracking coverage changes. The SIPP data are not sufficiently timely to guide current policy decisions, however, nor can they produce state-specific analyses. Nonetheless, they provide important insights into the volatility of insurance status. For example, an analysis by Mathematica Policy Research of the 1992 panel shows that if all children who were uninsured at a point in time became insured, within one year half of that number of children would be uninsured (Czajka and Olsen, 2000). Other national surveys provide snapshots of who participates, who does not, and the reasons why. The presentation suggested a comparison of point-in-time data on enrollees to ever-enrolled data to indicate the degree of stability in SCHIP. Administrative data from the states can throw light on the outcomes of enrollment and eligibility redetermination processes. But many states have difficulty producing data on enrollment outcomes, definitions vary widely among the states, and linking procedural policies to outcomes is difficult. Medicaid eligibility systems were not designed to be management tools. Also, major investments in eligibility data systems are unlikely to be priorities.

A few reasons why children leave SCHIP were also discussed. Some children rotate between Medicaid and SCHIP. Some states can track this behavior, others cannot. It is very difficult for states to track people who

drop out of public coverage entirely. The National Survey of America's Families suggests a significant percentage of people who drop out of public coverage become uninsured. Surveys of disenrollees would be helpful with this problem.

Pamela Paul-Shaheen, Center for Advancing Community Health
Title: Covering Michigan's Kids: Using Information to Inform Policy and Practice

As the lead agency for the Robert Wood Johnson Foundation-funded Covering Michigan's Kids initiative, the Center for Advancing Community Health works with its state and community partners to optimize the implementation of the state's SCHIP Program: MIChild. The program is a health coverage program that covers children up to age 19 in families with incomes between 150 and 200 percent of the federal poverty level. The program provides subsidized, low-cost medical and dental coverage for uninsured children across the state. Parents pay a monthly premium of $5.00 per family. Coverage is for a 12-month period. Since the initiation of the Covering Kids effort, those engaged in covering Michigan kids have worked diligently to enroll children and provide them access to needed health care services. The Covering Michigan's Kids initiative has developed a comprehensive evaluation strategy that has used qualitative and quantitative data to monitor enrollment and retention trends, identify barriers, and recommend policy changes to promote the goal of covering eligible children. The presentation described the structure of the effort, discussed the areas in which qualitative and quantitative information has been utilized, and discussed the challenges and lessons learned.

The presentation noted some barriers to SCHIP assessment. Some Maximus data, which evaluates MIChild, is not broken down by county. Acquiring Healthy Kids data, which evaluate Medicaid, is cumbersome and there is no electronic version of data available in Michigan. Also, the Healthy Kids data are for enrollment only; there is no attempt to track the transfer of enrollees to other programs. Another problem is that choosing comparison counties or sites requires analysis of many factors and will serve only as an estimate of comparison, never an exact match. One barrier to qualitative SCHIP data is that it is expensive and time-consuming to collect.

SCHIP data analysis influences SCHIP policy. Data analysis has verified that a simplified mail-in application is successful in enrollment efforts.

Co-pays, such as the MIChild $5 per month per family charge, increase the likelihood of utilization and the reduction of stigma associated with public programs. Analysis of enrollment data has shown a dramatic increase in application processing and enrollment since the advent of the self-declaration of income on the application. Analysis of application processing and call volume data has shown increases in application submissions and call volumes associated with statewide campaigns of MIChild and Healthy Kids. As a result, Michigan has refined its efforts toward media blitzes and coordinates efforts among different departments.

Mary Alice Lee, Children's Health Council
Title: Connecticut's HUSKY Program: Using Data to Improve Enrollment and Retention

As lead agency for the Robert Wood Johnson Foundation-funded Covering Kids initiative, the Children's Health Council tracks enrollment in Connecticut's children's health insurance program, Healthcare for UninSured Kids and Youth (HUSKY). HUSKY Part A is a Medicaid managed care program that covers children under 19 in families with income under 185 percent of the federal poverty level. HUSKY Part B is a separate SCHIP plan that provides subsidized, low-cost coverage for uninsured children in families with income between 185 percent and 300 percent of the federal poverty level; higher-income families with uninsured children can buy in at state-negotiated group rates. Key features of HUSKY include a single point of entry; a single simplified application and renewal form; application or renewal by mail; 12 months of continuous eligibility, regardless of changes in family income; and presumptive eligibility (for HUSKY Part A). Despite intensive outreach and simplification of enrollment, net enrollment increases since July 1998 have been lower than expected.

The Children's Health Council developed a systematic, ongoing approach to evaluation of enrollment trends and identification of enrollment barriers. Using enrollment data and reports from families and outreach partners, the Children's Health Council showed that retention is a major problem in the HUSKY program. In the first two years of the program, 78,000 children were newly enrolled in HUSKY Part A, but the net enrollment increase was just 14,500. In one city, net enrollment actually decreased. Many children whose families reported increased income lost coverage at the end of one-year eligibility periods. Renewal forms for HUSKY

Part A were not always forwarded for HUSKY Part B eligibility determination, so some families had to complete the application again. A survey of Hartford families, conducted by the Children's Health Council, revealed that the main reason children were not reenrolled in HUSKY was that their families received employer-sponsored insurance; in fact, 67 percent of formerly enrolled children (n = 225) were insured at the time of the survey. However, the survey also showed that many parents of enrolled children (n = 478) did not know what determines eligibility for HUSKY, did not know how long coverage would last, and did not know that children must be reenrolled every year.

The Children's Health Council and the Connecticut Department of Social Services have used information about enrollment and retention to improve outreach and to design, implement, and evaluate interventions aimed at increasing retention. For example, a special mailing was sent out to 34,000 families whose children lost coverage but might still be eligible; few responded. Monthly mailings on family-friendly HUSKY stationery have been more effective in informing families about "renewal" when their children near the end of continuous eligibility periods. Parents and caretaker relatives in families with income less than 150 percent of the federal poverty level are now eligible for HUSKY coverage; thousands have enrolled since January 2001. Self-declaration of income replaced the need for submitting proof of income, and the percentage of incomplete applications dropped.

The Children's Health Council also recommends that family coverage be expanded to 185 percent of the federal poverty level, that eligibility determinations for Parts A and B be coordinated, and that HUSKY applications be coordinated with applications for other income-based programs, like the subsidized school lunch program. With enrollment data from HUSKY Part B, the Children's Health Council will be able to track enrollment and retention as children move between HUSKY Parts A and B.

SESSION II: ENROLLMENT

Lisa Dubay, Health Policy Center, The Urban Institute
Title: Assessing SCHIP Impacts Using Household Survey Data: Promises and Pitfalls

The objective of this presentation was to describe how household surveys can be used to assess the impacts of the new State Children's Health

Insurance Program, review methodological issues associated with household survey data, and propose solutions for dealing with these issues. While evaluating SCHIP using household surveys has some challenges, if conducted carefully such analyses will provide important information on the impact of the program that cannot be obtained elsewhere.

In assessing SCHIP's impact, eligible children must be identified using a detailed simulation model. Analyses, like the Current Population Survey, that use either a simple eligibility model or examine only children with incomes targeted by the SCHIP program will not accurately identify SCHIP eligible children. Under these circumstances, estimates of the impact of SCHIP will be biased downward.

Extensive individual and family information is necessary to accurately simulate eligibility. Some examples of necessary information are earned income, Supplemental Security Income, Temporary Assistance for Needy Families income, general assistance income, pension income, Social Security income, other income, child support, assets, family structure, family size, welfare history, child care expenses, and employment status and history. Eligibility rules specific to each program also need to be understood in order to estimate eligibility. Examples of these rules are eligibility thresholds, asset limits and disregards, categorically eligible groups, unemployed parent rules, work disregards, earned income disregards, child care disregards, child support disregards, waiting periods, deeming of stepparent and grandparent income, and definition of family unit. The presentation went on to explain that more detailed simulation models are able to find more and more eligible children.

In order to assess the impacts of expansion in coverage via SCHIP, it is necessary to examine both the change over time for the eligible population (treatment group) and the change over time for comparison populations. The experience of the comparison population should be used as a counterfactual for what would have happened in the absence of the policy change. Multivariate methods control for differences in the composition of the treatment and comparison groups and changes in the composition of the treatment and/or comparison groups between the pre- and post-policy change period. There is no perfect comparison group. The comparison group should be similar to the treatment group, but it should not be affected by the policy change. Alternative comparison groups should also be used so that the researcher can test the sensitivity of the results to the use of alternative groups.

In addition, analyses must rely on the same survey in the pre- and post-

SCHIP period in order to obtain reliable estimates. Moreover, the survey must attempt to obtain data on separate SCHIP programs and analysts must consider the implications of the likely increasing underreporting of public health insurance coverage. Finally, analysts should be cautious about evaluating SCHIP's success before the program is mature. Only small impacts are expected in 1999. Real assessment will not be possible until 2002 or 2003. Moreover, it is likely that Medicaid drives the uninsurance rate for the low-income population.

Thomas M. Selden, Jessica S. Banthin, and Julie L. Hudson, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
Title: New and Improved Eligibility Simulation Methodology using MEPS National Survey Data

The Medical Expenditure Panel Survey (MEPS) offers a valuable resource for tracking national trends in insurance coverage and program eligibility among children. The presentation provided a general introduction to the MEPS data and a description of the eligibility and enrollment research under way at the Agency for Healthcare Research and Quality. The authors are currently refining the eligibility simulation model and applying that model to successive waves of the MEPS from 1996-2000. This research should offer insights into the impacts on children's health insurance coverage of Medicaid, SCHIP, welfare reform, the (now-fading) economic boom, and more.

The presentation began by noting successes and challenges with SCHIP and Medicaid. First, Medicaid expansions have helped more children recently. Under 1987 rules, 15.9 percent of children were eligible for Medicaid, whereas under 1996 rules, 29.5 percent of children were eligible. Expansions are still continuing. By 1996, uninsurance began to decline among children in families under 200 percent of the federal poverty level. There were 4.7 million eligible uninsured children, but 60 percent of uninsured children still remained ineligible. Since 1996, SCHIP has been able to provide coverage for children from families up to and, in some cases, more than 200 percent of the federal poverty level. Outreach has also improved.

Some research goals are to obtain national estimates of uninsured children, to track at-risk children through welfare reform and program expansions, and to obtain measures of access to care and burden of expenditures.

MEPS includes detailed data on coverage, expenditures, and sociodemographics. MEPS is nationally representative. It oversamples high expenditure and low-income children, and it has representation for a mix of states for eligibility and enrollment analyses. Unfortunately, it is currently impossible to estimate eligibility and enrollment by state. MEPS does have longitudinal potential, however. MEPS has problems studying SCHIP for a few reasons: the program's family definitions are broad in many states, waiting periods also cause problems, and not all uninsured children are eligible for SCHIP.

MEPS has found that progress on uninsurance continues. The trend is minus 1.5 percent per year among children from families less than 200 percent of the federal poverty level. The biggest drop occurred in 1999. There has been no discernible trend above 200 percent of the federal poverty level. Targeted outreach programs are having an effect on enrollment. As of 1999, 20 percent of uninsured children from families under 200 percent of the federal poverty level were still uninsured.

*Stephen Norton, New Hampshire Department of Health and Human Services
Title: State-Specific SCHIP Estimates*

Since SCHIP is a state-based program, it is critical to move away from a national model for evaluating it to a more state-based approach. SCHIP, at the state level, has an evaluation component that provides evaluation much sooner than a national-level evaluation could. The state legislators want to know not only that SCHIP has expanded coverage to a certain number of children; they also want to know if SCHIP has actually improved children's access to care or their health status, which is very difficult to demonstrate and tends to be done anecdotally. The simulation models presented by Dubay and Kenney provided incredibly precise estimates for a small state. The models also provided geographic specificity across the state. New Hampshire has developed its own survey and has worked on comparing it with Dubay's and Kenney's simulation models. Norton spoke specifically about estimating whether a person has been uninsured for the previous 6 months. The New Hampshire survey did not ask that question specifically, so Norton's agency is now developing methods of estimating the number of uninsured children. The survey did ask "How many months were you uninsured for the past 12 months?" The use of the 6-month criterion has made a fairly large impact on eligibility and potential eligibility. New Hampshire's estimation model is the best that could be developed

with the resources available. New Hampshire is beginning to use the survey as an outreach tool. The state has been able to identify variation in insurance rates around it. Significantly higher uninsurance rates occur in rural areas, so the state is working to develop more effective outreach for those areas. State-specific estimates will have a huge impact on the ability to evaluate what is happening in each state.

Gestur Davidson, Minnesota Department of Health and Human Services
Title: Finding the True SCHIP Enrollment Rate

This presentation commented on the paper by Lisa Dubay, *Assessing CHIP Impacts Using Household Survey Data: Promises and Pitfalls*, and reviewed a Minnesota health insurance survey. The study discussed in Dubay's paper does not have a true control group. The researchers must compare changes in insurance rates before and after implementation of SCHIP. The comparison group used consists of children just above the eligibility level in the SCHIP states. The uninsurance rate drops after implementation of SCHIP. How do we know that the uninsurance rate did not drop for some other reason? Did SCHIP really have an effect? Perhaps a study of the experience of higher-income groups during the same time period could shed light on what was happening in groups that are not eligible for SCHIP.

Since 1990, Minnesota has conducted a large statewide health insurance survey every four to five years. In 1999, the survey showed that a large number of those known to be on Medicaid responded that they were on SCHIP, whereas most of those known to be on SCHIP replied that they were covered by SCHIP. This is a problem that must be accounted for when analyzing the survey.

SESSION III: RETENTION

Ian Hill and Amy Westpfahl Lutzky, Health Policy Center, The Urban Institute
Title: There's a Hole in the Bucket. Understanding SCHIP Retention

Research Objective: During early SCHIP implementation, considerable policy attention was directed at state efforts to enroll eligible children; comparatively little attention was focused on how states conducted eligibility redetermination and whether strategies have been implemented to maxi-

mize retention of SCHIP enrollees. This study attempts to build the knowledge base in this area by examining state eligibility redetermination processes under SCHIP and administrative data on retention rates and reasons for denial at redetermination. For comparison purposes, Medicaid redetermination processes and outcomes were also explored.[1]

Study Design: Information and data were collected from a sample of nine states. Information on state redetermination processes were collected via telephone interviews with program officials during spring/summer 2000; standard protocols were used to ensure consistency. Administrative data regarding redetermination approvals, denials, and reasons for denial were collected during summer/fall 2000. Data were requested for two points in time—May 1999 and May 2000—to permit longitudinal comparisons.

Population Studied: Children enrolled in SCHIP/Medicaid.

Principal Findings: Findings suggest that while states have primarily focused their energies on maximizing enrollment under SCHIP, some effort has also been made to streamline redetermination processes and maximize retention—most of the study states have 12-month continuous eligibility for SCHIP, do not require face-to-face interviews at redetermination, only verify income at determination, and use forms that are somewhat simpler than initial program applications. However, several additional strategies that would further simplify the process were adopted by a smaller number of states, including use of joint SCHIP/Medicaid redetermination forms, preprinting redetermination forms with information already on hand, and passively approving continued eligibility when families miss deadlines for submitting redetermination information.

Difficulties obtaining data on redetermination outcomes, especially in Medicaid programs, suggest that state data systems are limited in their ability to report on retention indicators. When available, data were reported inconsistently, making cross-state comparisons difficult. However, data provided by four states showed rates of retention ranging from 35 to 50 percent. Leading reasons for denial at redetermination included failure to

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meet eligibility criteria and failure to comply with procedures. Importantly, the number of children "lost" at redetermination (i.e., families never successfully contacted) appears to be high, ranging from 22 to 40 percent.

Conclusions: States have implemented various strategies to maximize retention under SCHIP by simplifying the redetermination process. However data, when available, suggest high rates of turnover among SCHIP enrollees and large proportions of children being denied ongoing eligibility either for procedural reasons or because they were lost to the system.

Implications for Policy, Delivery, or Practice: While states have taken some initial steps to simplify eligibility redetermination under SCHIP, more effort may be needed to enhance rates of retention. Difficulties obtaining administrative data suggest that state data systems lack capacity to provide needed indicators, resulting in large gaps in what is currently known about the outcomes of the redetermination process.

Hilary Bellamy, Health Systems Research, Inc.
Title: Exploring Disenrollment from Medicaid and SCHIP Through Focus Group Research

The presentation discussed the congressionally mandated Medicaid and SCHIP Focus Group Study sponsored by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. A total of 51 focus groups were to be conducted in 9 states throughout summer 2001. Focus groups were to be conducted with parents of children who were eligible for Medicaid or SCHIP but not enrolled, those who were enrolled, and those who disenrolled from these programs. The study also included focus groups with low-income privately insured families. The complex study design was presented, emphasizing the focus groups convened with parents of children who have disenrolled from Medicaid and SCHIP programs. The number and type of focus groups were related to each state's SCHIP program design. There was a mix of geographic regions and populations. Additional populations of interest, such as adolescents, welfare leavers, recent immigrants, and higher income families, were included in the focus group design. The project's approach to identifying and recruiting disenrolled families for the focus groups was also discussed, as well as the issues of enrollment, retention,

access, and quality of care. The focus groups had not yet been conducted as of the time of the workshop.

Denise Holmes, Michigan Department of Community Health, Medical Services Administration
Title: Using Data to Focus Outreach and Improve Enrollment and Retention in Michigan's SCHIP Program

The Michigan Department of Community Health began its SCHIP program, which is called MIChild, in May 1998. Since the program's inception, the department has made extensive use of focus groups, beneficiary surveys, and administrative reports to make improvements in the program. These tools have allowed the department to target limited outreach resources into those methods that most effectively reach families. Survey feedback from beneficiaries who successfully complete the application process as well as from people who request an application but never complete it has resulted in several application and enrollment policy changes. Survey data from beneficiaries who fail to renew coverage when the eligibility period expires have been used to make policy changes that improve retention.

The various tools, the results of analysis of data from these tools, the subsequent policy changes, and the effect of these changes on program enrollment and retention were reviewed in this presentation. Some lessons have been learned about outreach. Media are substantially more effective than other outreach tools. Outreach is a continuous process given the turnover in the target population. MIChild outreach has also been an effective tool to increase Medicaid enrollment. After studying the eligibility process, MIChild made some changes to its application. One of the main reasons that people did not apply was documentation problems. MIChild used to require an applicant to provide a copy of the child's Social Security card and pay stubs from family members. Since MIChild dropped the requirement for a copy of the Social Security card and began to allow self-declaration of income, incomplete applications have fallen dramatically. MIChild has changed aspects of the renewal process as well. The program has achieved higher retention rates by simplifying the renewal process and following up on any failure to return a renewal form. MIChild has also studied reasons for denial. The main reason for denial is that the family has too much income or they have become eligible for Medicaid instead of SCHIP. There has been a steady increase in MIChild enroll-

ment. As the program learns more about enrollees, more people are enrolled and retained in it.

Marilyn Ellwood, Mathematica Policy Research, Inc.
Title: SCHIP Retention and Data Issues

This presentation focused on retention issues. Retention is not a new problem; it has plagued the Medicaid program for years. It is important not to focus entirely on retention in SCHIP. Greater numbers of low-income children are affected by Medicaid retention problems and, since Medicaid-eligible children are even poorer than SCHIP-eligible children, they deserve at least as much attention. Some states claim that they are only enrolling 50 percent of children at point of redetermination. This may be a reasonable outcome and expectation for SCHIP. Some of these children may be enrolling in the Medicaid program or in private insurance; there is no way to determine this using the current data. Standardization of reasons for disenrollment should be developed for the states.

The Medicaid Statistical Information System (MSIS) data system of the U.S. Centers for Medicare and Medicaid Services now offers some potential for analyzing disenrollment patterns across states. Beginning in FY 1999 all states were required to submit to the Centers for Medicare and Medicaid Services complete month-by-month eligibility information for all Medicaid-eligible people, including children enrolled in Medicaid expansion SCHIP programs. In addition, some states submit MSIS information on children in separate SCHIP programs. One of the advantages of MSIS is that children are given unique permanent identifiers, which allow researchers to track children's public insurance status over time. MSIS also provides researchers with a way to compare enrollment and retention across states. State SCHIP officials would like MSIS to gather information about the reasons for disenrollment.

SESSION IV: LINKS TO OTHER PROGRAMS

Genevieve Kenney, The Urban Institute
Title: Using Other Government Programs to Reach Uninsured Children

This presentation examined the potential of certain federal programs (including the National School Lunch Program, the Special Supplemental

Nutritional Program for Women, Infants, and Children (WIC), and the Food Stamp Program) for reaching the families of uninsured children. It used the 1999 National Survey of America's Families to update the information provided in "Most Uninsured Children Are in Families Served by Government Programs" (Kenney et al., 1999). Findings suggest that about 70 percent of all low-income uninsured children live in families that participate in one of these programs. The National School Lunch Program—serving families with almost 60 percent of all low-income uninsured children—appears to be a particularity promising vehicle for identifying uninsured children who are eligible for Medicaid or SCHIP coverage. The presentation considered the potential barriers and gains associated with targeting uninsured children through these programs.

David Hanig, Washington Department of Social and Health Services
Title: Nutrition and Health: Matching Data from Two Systems

In this presentation, David Hanig described Washington State's efforts to coordinate Medicaid enrollment with the school Free and Reduced Price Meals program. He began by reviewing the structure of the Medicaid program in Washington state:

- Medicaid covers children in families between 0 and 200 percent of the federal poverty level since 1994;
- SCHIP covers children from families between 200 and 250 percent of the federal poverty level since 2000;
- The state covers noncitizen children up to 100 percent of the federal poverty level;
- The state sponsors a community outreach and media campaign;
- The state has simplified its SCHIP application down to one page. Simplification includes:
- 12 months of continuous eligibility;
- Self-declaration of income;
- Elimination of the asset test;
- No face-to-face interview; and
- Applicants can apply by phone or on paper.

The state has been using post-TANF funds, which are almost exhausted, to fund its outreach campaigns. In order to avoid caseload decline, the state has developed an online application and is coordinating

enrollment with schools and WIC programs. The state began its coordinated enrollment efforts by including a box on the school lunch application for the parents to check if they wanted an application for medical assistance. The school then forwarded the requests to the appropriate state office. This caused a few problems:

- Schools had to go through all of the applications to find ones requesting medical assistance;
- The Medicaid agency had to manually look up thousands of forms to remove those already on Medicaid;
- Ultimately, the state found that the actual yield from this burdensome process was 3 percent new cases, so the program ended.

Washington is now attempting to electronically match data to identify students on the school lunch program who may also be eligible for medical coverage. Washington's next step will be automation. The state is going to try to develop a scannable school meal application and obtain software to scan hard copy applications and create databases and generate reports.

Robert Gellman
Title: Will Computer Matching Law Affect SCHIP?

The first computer match ever done matched District of Columbia welfare rolls to the federal payroll in order to catch people who might be welfare cheaters. The results were unfortunate. The sponsors did not consider some important factors. For example, some people previously on welfare were working at the time of the match, and the difference in timing produced incorrect results. Some working people were still poor enough to receive welfare legitimately. Because of situations like this, the Computer Matching and Privacy Protection Act of 1988 amended the Privacy Act of 1974 by adding a series of procedural requirements for computer matching. The law regulates computerized comparisons of records for specified purposes as long as any of the records used in the match are subject to the privacy act. The law may apply when federal records are used to identify children eligible for enrollment in the State Children's Health Insurance Program. Beyond the specific requirements of the law, general privacy concerns are relevant whenever personal records are used in ways not anticipated or disclosed when the records were originally collected. There are currently no laws to govern matching in private industry; the law governs

only federal records. State records are also generally not covered, but the same types of privacy concerns arise nevertheless.

Heidi Smith, Office of New Jersey Family Care, Division of Medical Assistance and Health Services
Title: Data Matches in the New Jersey FamilyCare Program

The New Jersey FamilyCare (NJFC) program began without a media campaign, with limited resources, and with limited staff with competing priorities. It has been using existing databases to find families eligible for Medicaid and SCHIP. When NJFC attempted to use food stamp datasets to identify eligible families, it found that the data were too raw to be very useful. It is now working to improve its data systems so that they can use this type of data. The WIC program is another potential source of useful data, but it cannot share its data directly with NJFC. NJFC was able to mail letters out through the WIC office to each WIC family offering them assistance. The response was poor. NJFC has now hired outreach workers to work in each WIC office in the state. Those workers talk to people applying for WIC and provide them with information and applications for Medicaid and SCHIP. NJFC has also begun working with the Free and Reduced Price Lunch Program. The application includes a box for parents to check if they would like an application for public health insurance. This has caused some administrative problems for the schools, but the schools are very interested in helping their students receive health insurance, so New Jersey will continue this outreach.

SESSION V: IMPLICATIONS FOR
FEDERAL AND STATE DATA COLLECTION

Lynn Blewett, School of Public Health, University of Minnesota
Title: Final Comments

There are currently several types of data on the uninsured. Administrative data include information on state enrollment, eligibility, and claims files. Monthly enrollment files of the Health Care Financing Administration are also useful administrative data. Federal survey data are available to the states. There are a few foundation-supported household surveys. The National Survey of America's Families covers 13 states, and community

tracking covers 60 communities. State household surveys and qualitative research are also available. Among national surveys of the uninsured, some include state estimates and others do not. The Current Population Survey, insurance component (Employer Survey Data) of the Medical Expenditure Panel Survey (MEPS) and the Behavioral Risk Factor Surveillance System include state estimates. The Survey of Income and Program Participation and MEPS's household component do not include state estimates. The National Health Interview Survey allows states to do their own estimates.

National surveys should strive to help state programs in several ways. They should offer state benchmarks, trends over time, cross-state comparisons, macro-level analyses, and guide national policy initiatives. States would like national surveys to collect state representative data, take a large enough sample size to allow for valid and reliable state estimates, develop a good survey design to produce policy-relevant information, provide timely and routine release of data, and provide access to microdata or public use tapes for additional state-specific analysis.

In response to a lack of information from national surveys, states have begun to develop their own surveys. In all, 27 states are doing household surveys, and at least 10 states are conducting employer surveys. The Health Resources and Services Administration, U.S. Department of Health and Human Services, has a state planning grant program, which is stimulating even more state survey and data collection activity. The Robert Wood Johnson Foundation is funding a State Health Access Data Assistance Center to support states in their data and survey activities. State surveys will aid policy development by simulating policy options. Program design and development, such as marketing and outreach, premium levels, and willingness to pay, will be studied. State surveys can also provide details on subpopulations of interest, such as specific geographic areas, race and ethnicity, and county or region.

Kristen Testa, Children's Partnership, Sacramento, CA
Title: Challenges of Data Collection for States

Current surveys, such as the Current Population Survey, offer opportunities for meaningful analysis, but states must not rely solely on these national-level datasets. State reporting data in these surveys are not sufficient to base policy decisions upon. State quantitative and qualitative data and monitoring are necessary to identify what is affecting enrollment and disenrollment.

There is a marked lack of data on retention, particularly in Medicaid. In the absence of a tracking system, California is intending to conduct sample case reviews each year parent coverage waiver requests. These types of data should be made public to provide another tool in the absence of data from existing data sources at the state level.

One of the major problems with data collection is that there are two separate programs, SCHIP and Medicaid, with two different systems of reporting. Since SCHIP was an entirely new program, it allowed state workers to build an entirely new system using the knowledge gained from mistakes made in the Medicaid program. Another challenge in California is how to measure the effects of recently enacted policies to see in fact if they have had the intended effect of increasing enrollment. It is also difficult to discern what is affecting what when there are so many policies interacting at the same time. That information is helpful not only for a state to evaluate its own programs but also to identify best practices and effective policies for other states to adopt.

On a positive note, the U.S. Centers for Medicare and Medicaid Services, as part of a statutorily mandated evaluation, has been compiling information available from the states in a manner that allows researchers to make comparisons. Through the federal evaluation, it has also commissioned individual state surveys and focus groups, which can provide some information at the state level as to the effectiveness of their programs.

Cynthia Shirk, Division of State Children's Health Insurance Program, U.S. Department of Health and Human Services
Title: State Data Needs

Remarkable progress has been made in the SCHIP program over the past four years. At the end of fiscal year 2000, 3.3 million children were enrolled in SCHIP; 4.5 million children may be enrolled in the program at the end of fiscal year 2001. The scope of coverage provided is increasing. Currently, 36 states provide coverage to at least 200 percent of the federal poverty level or more. Four years ago, only four states provided coverage that high.

Retention is an important issue for SCHIP. It is important that families not lose coverage unnecessarily. Families are more likely to get comprehensive, coordinated, and preventative services if they remain in the program for the entire time they are eligible. Retention efforts can also help

ensure that states are reaching enrollment goals, obtain more value for managed care dollars, and avoid administrative costs that are associated with families enrolling and disenrolling repeatedly.

States need comparability of data, and systems are needed to support that data. Common definitions are imperative to quality research. The states would welcome some program standardization, but the federal government wants to be sure that the states maintain a certain amount of flexibility in their programs. Both the states and the federal government need technical expertise and funding for adequate data systems to analyze SCHIP data.

Quality of and access to care are two areas of SCHIP that need to be studied. Now that the program is well established, this is even more important.

The federal government's focus has been primarily on enrollment data. It has developed the Statistical Enrollment and Data System (SEDS) specifically for SCHIP. The system provides data on the number of ever-enrolled children on a quarterly and yearly basis. Recently, it has been used to obtain point-in-time data.

SCHIP is currently at a critical point. The economic situation at both the state and federal level is not as good as it was a few years ago. It is more important than ever to show that this program is a good one and helps many people so that progress can continue.

Appendix
C
Brief Descriptions of National Surveys Mentioned at the Workshop

The following descriptions are taken largely from the web sites cited.

Current Population Survey, March Supplement: The Current Population Survey (CPS) is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted since 1940. The CPS is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian noninstitutionalized population. For the annual March income supplement, the CPS asks respondents about income received during the previous calendar year. This serves as the basis for estimating the number of children who may be eligible for Medicaid and SCHIP. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas. CPS data are used by government policy makers and legislators as important indicators of the nation's economic situation and for planning and evaluating many government programs. CPS data are also used by the press, students, academics, and the public. CPS data provide state-level estimates of the low-income population to the SCHIP community.

Additional information can be found at: http://www.bls.census.gov/cps/overmain.htm.

Medical Expenditure Panel Survey: The Agency for Healthcare Research

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and Quality (AHRQ) began fielding the Medical Expenditure Panel Survey (MEPS) on a continuing basis in March 1996. MEPS is conducted in conjunction with the National Center for Health Statistics (NCHS) and through contracts with Westat, a survey research firm headquartered in Washington, DC, and the National Opinion Research Center, which is affiliated with the University of Chicago. MEPS is a vital resource designed to continually provide policy makers, health care administrators, businesses, and others with timely, comprehensive information about health care use and costs in the United States and to improve the accuracy of their economic projections. MEPS collects data on the specific health services that are used, how frequently they are used, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of private health insurance held by and available to the U.S. population. For purposes of the current study, MEPS data have been combined for the period 1996-1999 to obtain a sample of 35,000 children.

MEPS Fact Sheet. February 2001. Agency for Healthcare Research and Quality, Rockville, MD. Additional information can be found at: http://www.meps.ahrq.gov/whatismeps/bulletin.htm.

National Health Interview Survey: The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian noninstitutionalized population of the United States and is one of the major data collection programs of the National Center for Health Statistics (NCHS). The National Health Survey Act of 1956 provided for a continuing survey and special studies to secure accurate and current statistical information on the amount, distribution, and effects of illness and disability in the United States and the services rendered for or because of such conditions. The survey referred to in the act, now called the National Health Interview Survey, was initiated in July 1957. Since 1960, the survey has been conducted by NCHS, which was formed when the National Health Survey and the National Vital Statistics Division were combined. NHIS data are used widely throughout the U.S. Department of Health and Human Services (DHHS) to monitor trends in illness and disability and to track progress toward achieving national health objectives. The data are also used by the public health research community for epidemiological and policy analysis, determining barriers to accessing and using appropriate health care, and evaluating federal health programs. The NHIS data for 2001 revealed that around 11 percent of children under the age of 18 lacked

health insurance. The MEPS, described above, uses the NHIS as the basis for its sample.

Additional information can be found at: http://www.cdc.gov/nchs/about/major/nhis/hisdesc.htm.

National Survey of America's Families: Conducted by the Urban Institute, the National Survey of America's Families provides a comprehensive look at the well-being of adults and children and reveals sometimes striking differences among the 13 states studied in depth. The survey provides quantitative measures of quality of life in America, paying particular attention to low-income families. The survey includes a sample of approximately 1,800 families with children under 18 in each of 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Together, these states comprise more than half the nation's population and represent a broad range of fiscal capacity, child well-being, and approaches to government programs. Data from 1997 and 1999 are now available. The survey collected data on health insurance, access to care, and the health status of children. In 1999, most SCHIP programs were not yet mature, so that survey data provide only limited information on SCHIP coverage.

Additional information can be found at: http://newfederalism.urban.org/nsaf/.

State and Local Area Integrated Telephone Survey: The National Center for Health Statistics developed the State and Local Area Integrated Telephone Survey (SLAITS) initially for the National Immunization Survey. SLAITS was originally designed to include a sample of almost one million households per year to produce estimates of the vaccination coverage of children age 19-35 months. It has since been made available to collect important health care data at the state and local levels to meet various program and policy needs in an ever-changing health care system. The survey is funded through sponsorship of specific questionnaire modules. Sponsors include both government agencies and nonprofit organizations. Just as public and private organizations collaborate in the planning and delivery of health care services, SLAITS facilitates additional collaboration leading to more complete data for informed public health policy decisions. Decision makers require quality health data for program development and policy-making activities. SLAITS research areas range from health insurance coverage and access to care to perceived health status and utilization of

services to measures of child well-being. SLAITS addresses state-specific data needs with customized questions and specific domains of interest. It also targets population subgroups such as persons with specific health conditions or from low-income households. SLAITS is an ongoing survey for child immunization efforts, but it is not conducted at regular intervals for other specific studies. Rather, survey sponsors may implement SLAITS surveys at any time. Typically, it takes at least 3 to 6 months to develop, program, and test a new survey questionnaire before data collection can begin.

Additional information can be found at: http://www.cdc.gov/nchs/slaits.htm.

Survey of Income and Program Participation: Conducted by the U.S. Census Bureau, the Survey of Income and Program Participation (SIPP) collects sources and amounts of income, labor force information, program participation and eligibility data, and general demographic characteristics to measure the effectiveness of existing federal, state, and local programs. The survey also estimates future costs and coverage for government programs, such as food stamps, and provides improved statistics on the distribution of income in the country. The survey design is a continuous series of national panels, with sample size ranging from approximately 14,000 to 36,700 interviewed households. The duration of each panel ranges from $2^{1}/_{2}$ to 4 years. The SIPP content is built around a "core" of labor force, program participation, and income questions designed to measure the economic situation of persons in the United States. These questions expand the data currently available on the distribution of cash and noncash income and are repeated at each interviewing wave. The survey uses a 4-month recall period, with approximately the same number of interviews being conducted in each month of the 4-month period for each wave. Interviews are conducted by personal visit and by decentralized telephone. The survey has been designed also to provide a broader context for analysis by adding questions on a variety of topics not covered in the core section. These questions are labeled "topical modules" and are assigned to particular interviewing waves of the survey. Topics covered by the modules include personal history, child care, wealth, program eligibility, child support, disability, school enrollment, taxes, and annual income. Over the years, SIPP has included data that have indicated considerable volatility in children's health insurance coverage.

Additional information can be found at: http://www.sipp.census.gov/sipp/sippov98.htm.