New York's SCHIP Program Improves Health Care Access, Continuity, and Quality

ISSUE BRIEF

Since 1997, States have used the State Children's Health Insurance Program (SCHIP) to provide health insurance coverage to low-income children who are ineligible for Medicaid but lack private health insurance. SCHIP provided health care coverage to over 5.3 million children nationwide in fiscal year 2002, 15 percent of whom were enrolled in New York. Policymakers are interested in understanding the impact of SCHIP on the health care children receive.

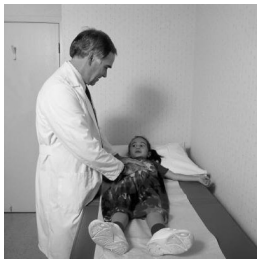
This Issue Brief summarizes findings from a Child Health Insurance Research Initiative (CHIRI™) project that examined the impact of the New York SCHIP program on access, quality and utilization of health care services for SCHIP enrollees.

Overall highlights include:

- The proportion of enrollees with a regular source of care reached nearly universal levels as a result of SCHIP (an increase from 86% to 97%).
- A greater proportion of children received preventive health care visits (an increase from 74% to 82%).
- Unmet health care needs among enrollees decreased by more than one-third (from 31% to 19%) after SCHIP enrollment.
- The proportion of enrollees who used their regular source of care for all health care visits nearly doubled (from 40% to 77%).
- Families of SCHIP enrollees gave higher ratings of satisfaction with health care after SCHIP enrollment compared with before.

Highlights for particularly vulnerable children include:

- Racial disparities in access, unmet need, and continuity of care were eliminated.
- The long-term uninsured and lowest-income children, who were most disenfranchised before SCHIP enrollment, demonstrated the most dramatic gains after enrollment.
- Parents of children with asthma or special health care needs were more satisfied and better able to afford care and medications for their child's condition.



"Enrollees were more likely to obtain their health care from a regular source during enrollment in SCHIP."

WHAT WAS LEARNED

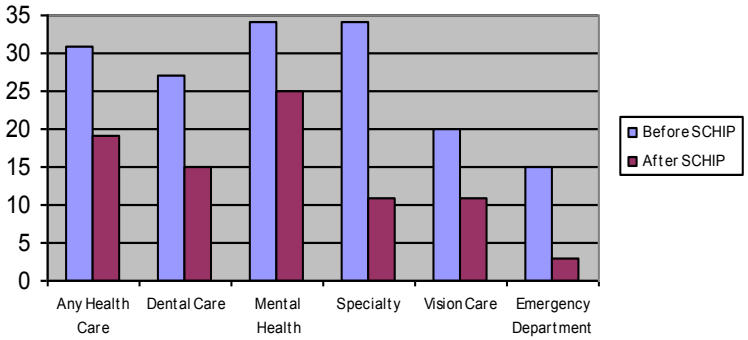
Researchers interviewed families of SCHIP enrollees about their child's health care experiences one year before and one year after enrollment in the New York SCHIP program – Child Health Plus. The study included a special focus on racial disparities, children with asthma, and children with special health care needs (CSHCN).

SCHIP Improved New Enrollees' Access to Care

Most SCHIP enrollees (97%) had a regular source of care after SCHIP enrollment. Fewer families of SCHIP enrollees reported problems in accessing a health care provider by phone or in getting an appointment after enrollment compared with before enrollment. More children used preventive care services as a result of SCHIP (an increase from 74% to 82%). There were no significant changes in utilization of emergency rooms or in mental health, specialty, acute, or dental care.

The proportion of enrollees who had any unmet health care need decreased from 31% before to 19% after SCHIP enrollment for all three racial/ethnic groups studied; to levels commonly found for other types of health insurance. Despite reductions, unmet needs remained high for mental health care (24% of children still reporting an unmet need after SCHIP enrollment), dental care (15%), specialty care (11%), and vision care (11%) (see Figure 1).

Figure 1: Unmet Needs by Service Before and After SCHIP Enrollment

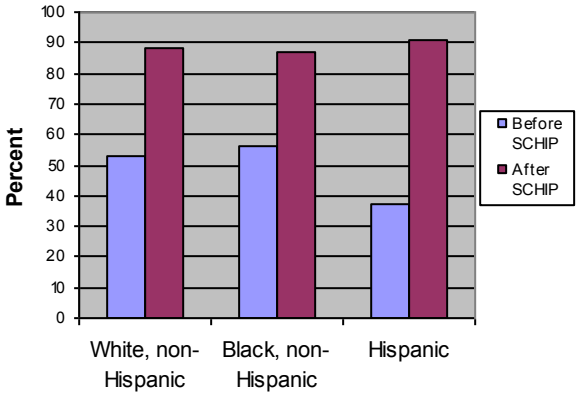


SCHIP Families Reported Improved Continuity and Quality of Health Care

More SCHIP enrollees utilized their regular source of care for health care services instead of going to other or multiple sources of care. The proportion of enrollees who used their regular source of care for all or most of their health care visits nearly doubled (from 47% to 89%). Here, too, racial disparities that were present before SCHIP were eliminated during SCHIP, with large improvements among Hispanic children (See Figure 2).

Families of SCHIP enrollees rated the quality of interactions with their child's primary care provider more highly after SCHIP enrollment as compared with before enrollment. One year after SCHIP enrollment, there was a significant increase in the percentage of families who indicated that their provider regularly or always: listens carefully to them; explains things in understandable terms; respects what they have to say; and spends enough time with them. Racial disparities in satisfaction persisted, however, with lower reported satisfaction among parents of Hispanic children relative to their black or white counterparts.

Figure 2. Most/All Visits to Regular Source of Care by Race Before and After SCHIP Enrollment



Parent's overall ratings of their child's health remained largely unchanged — most children were reportedly healthy before SCHIP and remained that way. A small percentage of parents reported that their child's health improved, whereas less than 1% reported that the child's health was worse. Consistent with other studies, fewer parents worried about their child's health after enrollment as compared with before. Indeed, other studies confirm that having health insurance can reduce family stress and ease family burdens.

The Most Vulnerable Children Experienced Important Gains from SCHIP

In addition to the overall improvements noted above, health insurance programs face added challenges in meeting the needs of particularly vulnerable children. SCHIP demonstrated success in meeting some of the specialized needs of children with asthma or other special health care needs.

(AFTER ENROLLING IN SCHIP)

Children with asthma experienced:

- Fewer asthma-related attacks (decreasing from 9.5 to 3.8 per year)
- Fewer medical visits for asthma (from 3.0 to 1.5)
- Fewer difficulties getting to their usual doctor's office for asthma care (from 13% to 1% having problems)

Children with special health care needs (CSHCN) experienced:

- Fewer unmet healthcare needs for specialty care (from 40% to 19%)
- Improved continuity with their usual doctor's office (53% to 81%)
- Higher parent rating of healthcare

CONCLUSION

During SCHIP enrollment, families had better access to care and were more likely to use a regular source of care. Other studies have found that such continuity with a single source of care is associated with higher quality care and with greater parent satisfaction.

The proportion of families reporting unmet medical needs dropped overall, yet remained at nearly 20% even after SCHIP, with notable need for mental health, dental and vision care. Although more efficient care delivery and reduced fragmentation of care across multiple sites may contribute to reduced unmet need, the remaining unmet need highlights that families face continued non-financial barriers to care and that efforts beyond the provision of health insurance may be needed.

"More children received preventive care, but unmet needs for mental health, dental, and vision care remained equivalent to those found with other types of insurance."

POLICY IMPLICATIONS

These findings highlight several benefits of SCHIP and suggest strategies that other states can use to improve health care access and quality for low-income children.

- Investments in public health insurance programs for low-income children produce significant improvements in health care access and quality, especially for the most the most vulnerable.
- Low-income children are likely to enroll in SCHIP with significant unmet health care needs. SCHIP benefit packages and delivery systems should be designed to accommodate a variety of health care needs among enrollees to help ensure that the needs of enrollees are adequately met.
- Specialty services, particularly dental, mental health and vision care may warrant focused programmatic efforts and strategies to reduce barriers to care.

STUDY METHODOLOGY

This CHIRI Issue Brief is based on a pre/post-study of children enrolled in the New York SCHIP program – Child Health Plus – between 2001 and 2002. Families of first-time SCHIP enrollees were interviewed soon after enrollment and again 13 months after enrollment. Baseline interviews reflect the child's health care experiences one year prior to SCHIP enrollment; follow-up interviews reflect health care experiences during the first year of SCHIP enrollment. One child was randomly selected as the "study" child from each family. Researchers used a comparison group to establish that SCHIP, instead of other influences, was responsible for the changes between the two time periods.

Telephone interviews were conducted in 2001 with the adult in the household most knowledgeable about the child's health insurance and medical care.

Children whose parents completed both surveys (87% of baseline respondents also completed the follow-up for a total of 2,290 families) were included in the analyses. Participation in the study was limited to non-Hispanic white, non-Hispanic black, and Hispanic SCHIP enrollees.

Measures of health care access, utilization and quality were tabulated separately for the year before enrollment and the year after enrollment in SCHIP. Statistical significance was tested using both bivariate and multivariate statistical analyses to assess the change in outcome measures from the year before SCHIP to the one-year period after enrollment in SCHIP. Multivariate analyses to assess SCHIP's impact controlled for demographic and socioeconomic measures.

SOURCES

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ABOUT CHIRI™

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

This Issue Brief is based on the work from the CHIRI™ project, "New York's SCHIP: What Works for Vulnerable Children" (Principal Investigator: Peter Szilagyi).

CHIRI™ FUNDERS

The Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use and access.

The David and Lucile Packard Foundation is a private family foundation that provides grants in a number of program areas, including children, families and communities, population, and conservation and science.

The Health Resources and Services Administration, also part of the U.S. Department of Health and Human Services, directs national health programs that provide access to quality health care to underserved and vulnerable populations. HRSA also promotes appropriate health professions workforce supply, training and education.

Credits: This CHIRI™ Issue Brief was written by Karen VanLandeghem, Jennie Bonney, Cindy Brach, Lisa Kretz, Peter Szilagyi and Laura Shone.

For a full literature review of SCHIP nationally, see:

Shone LP, Szilagyi PG, 2005. The State Children's Health Insurance Program. *Current Opinion in Pediatrics* 17 (December,):764-772.