The Consequences of States’ Policies for SCHIP Disenrollment

Andrew W. Dick, Ph.D.¹
R. Andrew Allison, Ph.D.²
Susan G. Haber, Sc.D.³
Cindy Brach, M.P.P.⁴
Elizabeth Shenkman, Ph.D.⁵

August 2, 2001

This version of the paper has been edited for the Healthy Kids Corporation Board of Directors by Elizabeth Shenkman, PhD, Institute for Child Health Policy

¹Department of Community and Preventive Medicine, University of Rochester School of Medicine and Dentistry; ²Kansas Health Institute; ³Center for Health Economics Research; ⁴Center for Organization and Delivery Studies, Agency for Healthcare Research and Quality; ⁵Institute for Child Health Policy, University of Florida.

This work was supported by four cooperative agreements issued by the Agency for Healthcare Research and Quality (AHRQ) that included co-funding from the David and Lucile Packard Foundation, and the Health Resources and Services Administration (AHRQ Nos. HS10465, HS10536, HS10450, and HS10463). Additional support was provided for the Kansas project by the Kansas Health Foundation, the United Methodist Health Ministry Fund, and the Prime Health Foundation.

Reprints may be requested from the AHRQ Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547, ahrqpubs@ahrq.gov.
INTRODUCTION

Congress’ primary aim when it passed the State Children’s Health Insurance Program (SCHIP) in 1997 was to increase the number of children who had health insurance [, 1997 #64]. SCHIP extends health care coverage to low-income children who are not eligible for Medicaid. Like Medicaid SCHIP is a both a Federal and State program, but SCHIP affords states more discretion in the design and implementation of their programs. Among the decisions states have had to make is whether to run a separate free-standing SCHIP program, an expansion of their Medicaid programs, or a combination of the two approaches [Rosenbaum, 1998 #65].

Having made the initial decisions regarding their SCHIP program structure and policies, states’ next major challenge was to enroll children into the program. To do so, they launched multi-prong campaigns using advertising and creative outreach methods to get the word out to families potentially eligible for SCHIP [National Conference of State Legislators, 1999 #37][Mickey, 1999 #23][Perry, 2000 #5][Schwalberg, 1999 #25][U.S. General Accounting Office, 2000 #13]. In addition, the Federal government, national organizations, foundations, and even corporations have been active in increasing public awareness of SCHIP [Edmunds, 2000 #24]. Efforts have also been made to streamline the enrollment process by simplifying applications and eliminating requirements [Rosenbach, 2001 #33][National Conference of State Legislators, 1999 #37][Mickey, 1999 #23][Schwalberg, 1999 #25][Ross, 2000 #1]. As a result of these concerted efforts, 2 million children participated in SCHIP sometime during Federal Fiscal Year (FFY) 1999 and 3.3 million during FFY 2000 [Health Care Financing Administration, 2000 #36].

Attention is now shifting to retention of those children already enrolled in SCHIP [Rosenbach, 2001 #33][Klein, 2001 #45][Kannel, 2001 #14][Bachrach, 2000 #40]. Aggregate numbers show that disenrollment in SCHIP is substantial. While 1.96 million different children were enrolled in SCHIP at some time during FFY 1999, only 1.61 million different children were enrolled during
the 4th quarter of FFY 1999, indicating a high turnover rate [Rosenbach, 2001 #33]. Thus, a minimum of 18 percent of children enrolled at some time during FFY 1999 had a disenrollment. In some cases, states’ successes in enrolling children into SCHIP have been substantially eroded by disenrollments [Bachrach, 2000 #40][Allison, 2001 #48]. As findings from the 1999 National Survey of America’ Families (NSAF) demonstrate, the number of uninsured children could be reduced, perhaps by 10 percent, if children who enrolled in SCHIP or Medicaid remained enrolled [Kenney, 2001 #27].

The phenomenon of disenrollment from public children’s insurance programs is not new. Children are frequently enrolled in Medicaid for only a short period of time [Carasquillo, 1998 #42][Czajka, 1999 #11][Ellwood, 1999 #8]. For example, in 1991 only 38 percent of new Medicaid enrollees remained on Medicaid a year later [Carasquillo, 1998 #42]. Medicaid disenrollees also frequently return to the program after a brief gap in coverage. For example, in FFY 1993 and 1994 one of every five enrollments into the Medicaid program were by children who had been previously enrolled in Medicaid that year but had subsequently disenrolled [Czajka, 1999 #11].

In order to provide some stability of coverage, 31 states have instituted a policy of continuous eligibility in SCHIP (26 states for 12 months and 4 states for 6 months [National Conference of State Legislatures, 2000 #15]). This was designed to reduce the number of short enrollments by disregarding income variations during the defined period of continuous eligibility. As enrollees come up for re-certification at the end of the continuous eligibility period, however, states are findings that a large proportion of children are not re-enrolling [Holmes, 2001 #38][Hill, 2001 #39][Kalkines Arky Zall & Bernstein, 2000 #40][Bachrach, 2000 #40]. Furthermore, there have been indications that children are disenrolled from the program before their period of continuous eligibility expires [Allison, 2001 #41][Cooper, 2001 #44].
Although there is growing concern about SCHIP disenrollments, few data exist about the extent of disenrollment and re-enrollments, the variations across states, and the degree to which state policies may affect enrollment patterns of covered individuals.

**STUDY QUESTIONS**

Our goal is to determine whether SCHIP disenrollment patterns differ across states and whether these differences can be attributed to variations in state SCHIP policies. We begin by describing two basic features of SCHIP enrollment:

1. how long children enrolled in SCHIP are likely to remain enrolled, and
2. whether children who disenroll from SCHIP are likely to re-enroll at a later time.

We next ask whether particular state policies affect those patterns. Specifically, we address five questions regarding the impact of different state policies:

1. What is the impact of presumptive eligibility?
2. What is the extent of disenrollment during periods of continuous eligibility?
3. To what extent is disenrollment associated with re-certification, what affect does re-certification at 6 versus 12 months have on retention, and what impact does passive re-enrollment have?
4. How do these policies interact with one another?

We consider SCHIP disenrollment in four states that enacted separate free-standing SCHIP programs -- Florida, Kansas, New York, and Oregon. These states represent different regions of the country, as well as varying demographic and population density profiles. They also represent a sizable proportion of the SCHIP caseload. In fiscal year 2000, 32 percent of all children enrolled in SCHIP resided in these four states [Health Care Financing Administration, 2000 #36].

**SCHIP POLICIES IN THE FOUR STATES**

Table 1 shows how the four states in our study used their discretion in setting SCHIP policies. Each state begins SCHIP eligibility where Medicaid eligibility leaves off, and families remain eligible until their income reaches a maximum level, which varies by state. All four states use
age-based eligibility rules, whereby younger children are Medicaid eligible at higher incomes than older children. As a result, children on Medicaid can become SCHIP eligible by virtue of aging, without any change in income. However, the converse is not true – SCHIP-eligible children will transfer to Medicaid only if they experience a decrease in income or a change in family structure, not because they have aged. The range of incomes that qualify a child for SCHIP is fairly small. Eligibility bands are even narrower than they appear because the lower end of the band, where Medicaid coverage stops, is usually calculated using net income after income disregards, while the top end of the band of SCHIP eligibility is generally calculated on the basis of gross income [Ku, 1999 #56].

TABLE 1 ABOUT HERE
Presumptive eligibility, another state option, provides applicants with immediate coverage while eligibility determinations are made. New York is one of 6 states that has enacted presumptive eligibility [National Conference of State Legislatures, 2000 #15].

Three out of our four study states elected to implement premiums, an option that is limited to states that enact separate SCHIP programs. Only Florida, however, instituted premiums for all families participating in SCHIP, while Kansas and New York instituted premiums only for higher income families. Nationally, 21 states elected to institute premiums, while 12 did not. [National Conference of State Legislatures, 2000 #53].

Other policies that might affect retention are the procedures states use to recertify enrollees. Kansas, New York, and Oregon all require that additional paperwork be returned to the state, including verification of income. Florida, however, has adopted a system of passive re-enrollment, whereby the state sends a letter to enrollees, asking them to update any inaccurate information. Children remain enrolled in SCHIP, however, even if their families fail to return the form.
DATA AND METHODS

We used state administrative records as our main data source. From these records, we constructed monthly enrollment histories for every child enrolled at any time from January 1998, through the most recent data available in each state (June 2001 for Kansas and Florida, March 2001 for New York, and January 2001 for Oregon).

Our analysis considers “new” enrollment episodes that began in January 1999, or later, and all subsequent enrollment episodes for each child. We chose January 1999 as our start date because it was the earliest date for which the analyses could be performed in all four states. We define a “new” enrollment to be one that was preceded by at least 12 months during which there was no SCHIP enrollment. We included 1998 enrollment experiences in the enrollment histories, but only for the purpose of identifying “new” spells as of January 1999.

From the enrollment histories, we generated SCHIP enrollment spells, or episodes of continuous SCHIP enrollment, for each child. Thus, our analytical data set includes information on the universe of spells that start on or after January 1999. For each we know whether it is a “new” spell, its length (number of continuous months of enrollment), the calendar month during which the spell began, the premium level paid at the beginning of the spell, the characteristics of prior spells, and whether the spell is censored.

We admit censoring from two sources. First, spells are censored if they continue through the last month in our data because we do not know whether the children would have remained enrolled beyond that month. Spells such as this are said to be right censored. Second, when children pass the eligibility age limit (19 years old in all four states), they are disenrolled or age-censored. While these are real exits, we do not know how long the spells would have lasted had the children
not aged out of the program. We investigate the importance of this kind of exit by censoring these spells in some of our analyses.

We characterize SCHIP enrollment and disenrollment experiences in the three states with three sets of statistics. First, we consider the enrollment experiences in “new” spells. We calculated Kaplan-Meier (empirical) hazard functions and the corresponding non-parametric survivor functions for these spells, both incorporating censoring [Kaplan, 1958 #60] [Kalbfleisch, 1980 #61]. More detail on the technical aspects of the calculations are available from the authors.

We generated a second set of statistics because we are interested not only in how long a child stays on SCHIP during his or her initial spell, but also the length of time a child stays disenrolled from SCHIP. The length of disenrollment spells could signal that certain explanations for disenrollment are more likely than others. For example, disenrollments that occur because of administrative mistakes or because of families’ difficulties with re-certification processes are likely to be short. To investigate this, we characterized disenrollment spell durations by calculating Kaplan-Meier hazard functions and the corresponding non-parametric survivor functions for these spells. Disenrollments that occur at the time of re-certification may be very different in nature from those that occur at other times.

Children may have many short enrollment and disenrollment spells, and as a result, the Kaplan-Meier hazard functions for “new” spells and for disenrollment spells may understate the long-term attachment to SCHIP coverage. To investigate this, we estimated a third set of statistics, the probability that a child will be enrolled in each month during the 2 years following initial enrollment, regardless of disenrollment experiences in the interim.
Our estimates are based on very large numbers of observations (N = 177,615 in Florida, 40,572 in Kansas, 792,111 in New York, and 44,243 in Oregon). Because our models are nonparametric, our results contain neither sampling nor estimation error. Thus, we do not report standard errors or p-values.

RESULTS

“New” SCHIP Enrollment Spells

Figure 1 presents the Kaplan-Meier hazard function for “new” spells, by state. Several differences across the states are immediately apparent. First, relative to the other states, New York has a much higher hazard (or exit) rate during months 2 and 3, which correspond to the months in which presumptive eligibility is resolved. Second, each of the states has a relatively low underlying exit rate during the remaining months of continuous eligibility. Oregon, with a program more closely linked to Medicaid, and Florida have higher rates than either New York or Kansas. Third, the three states that do not have passive re-enrollment at the end of continuous eligibility all have large spikes in the hazard functions at the points of re-certification. The hazard rates in Kansas and New York account for approximately 50 percent reductions in total enrollment at every re-certification point. Oregon shows an even higher hazard at the first re-certification and then a 10 to 15 percentage point reduction in the hazards for successive re-certifications. Conversely, Florida shows no evidence of an increased disenrollment rate any period.

Figure 2 presents the Kaplan-Meier survivor functions for “new” SCHIP enrollment spells, conditional on enrollment until month 4. We present these conditional or normalized survivor functions to eliminate the effect of presumptive eligibility in New York, thereby allowing for a
“fair” comparison across states. The conditional survivor functions for Kansas and New York are strikingly similar. Both show an attrition of about 20 percent prior to re-certification, followed by large drops at re-certification, and the pattern is repeated through the two re-certification cycles. Oregon is also similar, but its re-certification cycle is every 6 months. Conversely, Florida shows only a slightly higher attrition rate than New York or Kansas prior to re-certification, but no large drop in enrollment at any re-certification point.

**Disenrollment Spells**

Figure 3 contains Kaplan-Meier hazard functions for disenrollment spells (i.e. re-enrollment rates) that begin with disenrollment at the time of re-certification (12 months in New York and Kansas, and 6, 12, 18 or 24 months Oregon). Because we are focusing on disenrollments related to re-certification and because Florida shows no evidence of increased disenrollments at re-certification, we exclude Florida from Figure 3. The figure shows that, in Kansas 18 percent and in New York 23 percent of these children return to SCHIP in the first 2 months. However, from the hazard functions, we can deduce that about 65 percent do not return within a year. This represents a large number of children because disenrollment at re-certification is common. Oregon and Kansas have substantial spikes in their hazard functions at 6 and 12 months, respectively. This could be the result of cycling through Medicaid, since Oregon and Kansas have continuous eligibility policies in Medicaid that are similar to that of SCHIP. That is, this may show that many children who switch from SCHIP to Medicaid at the SCHIP re-certification point switch back to SCHIP at the Medicaid re-certification point.

If disenrollments that occur at re-certification are systematically different from those that occur at other times, we would expect to see differences in hazard (re-enrollment) rates for disenrollment.

---

1 The value of the New York’s unconditional survivor function in month 4 is 0.67. Thus, 33 percent of the “new” enrollees in New York disenrolled during the presumptive eligibility period.
spells that began at re-certification and at other times. One possibility is that disenrollments that occur during periods of continuous eligibility are more likely to be permanent disenrollments (e.g. changes to private insurance), while disenrollments that occur at re-certification are more likely to be short term (e.g. errors by parents in submitting forms, or disenrollments because premium payments are in arrears). We find, however, that the hazard rates, conditional on the length of the prior SCHIP enrollment spell, differ, but not dramatically.

Not surprisingly, there is virtually no difference in the characteristics of disenrollment spells that start at re-certification and at any other time in Florida. A child who has been disenrolled in Florida for non-payment of premiums is required by law to wait 60 days before re-enrolling. After the waiting period, however, re-enrollments are not uncommon.

**Long-Term Attachment to SCHIP**

Figure 4 presents our estimates, by state, of $P(t)$, the probability that a child will be enrolled in each month following a “new” enrollment, regardless of disenrollment experiences prior to the month. The curves are not dissimilar from the Kaplan-Meier survivor function estimates during the first year, but for Kansas, New York, and Oregon they are considerably higher during the second year. This is because of the many short disenrollment spells associated with re-certification. In New York, $P(23) = 0.43$, indicating a 0.43 probability that a child will be enrolled 23 months after the initial enrollment. If we discount the presumptive eligibility period, however, that number increases to 0.53. Florida shows a smooth decline in $P(t)$, and levels that easily exceed the other states immediately after their re-certification points. In Florida’s $P(23) = 0.58$, and in Kansas’ $P(23) = 0.39$. Both Kansas and New York show flat or increasing $P(t)$ curves during the 2nd year, indicating that children from the original cohort are returning to SCHIP at least as often as they are disenrolling during the 2nd year. The big disenrollment spikes
(Kansas, New York, and Oregon) at re-certification are still evident, but in Kansas and New York they are somewhat blunted because of the many short disenrollment spells (re-enrollments within 2 months). SCHIP retention, as shown by $P(t)$, is considerably lower in Oregon than in the other states, both because of the more frequent re-certification and the reduced likelihood of re-enrollment.

**Premiums**

Figure 5 shows the Kaplan-Meier survivor functions for “new” enrollment spells, by premiums, conditional on enrollment until month 4. As above, we present the conditional survivor functions to eliminate the effects of presumptive eligibility (see Figures 1 and 2). These results are limited to New York and Kansas because these are the only two states in our sample that have both premium payers and non-payers.

In New York, during the period of presumptive eligibility (not shown), non-premium payers are much more likely than premium payers to disenroll (35 percent vs 11 percent). The underlying rate of attrition from months 4 to 12 (prior to re-certification) is higher for premium payers than non-premium payers, however, and by month 12, the difference in the normalized curve is 0.12 (for premium payers, $S(12)=0.67$, and for non-premium payers, $S(12)=0.79$).

The result is the opposite in Kansas, where premium payers disenroll at greater rates than non-premium payers. By month 12, the difference in the normalized survivor function is 0.10 (for premium payers, $S(12)=0.77$, and for non-premium payers, $S(12)=0.67$).

Figure 6 shows the Kaplan-Meier hazard functions for disenrollment spells that start at re-certification, by premiums. The figure shows that premium payers are much more likely than

---

2 We normalize $P(t)$ be estimating $P(t|1^{st}$ enrollment lasts at least 3 months).
non-premium payers to return after short disenrollments (by more than 2 to 1 in KS and 5 to 3 in New York for 1 month spells).

**DISCUSSION**

**Patterns of Disenrollment**

SCHIP appears to be used as a long-term insurance solution for many children and as a short-term, transitional program for many other children. A significant proportion of SCHIP enrollees are enrolled 2 years after initial enrollment (perhaps as many as 50 percent of enrollees in Florida and New York, and nearly 40 percent in Kansas), although in Kansas and New York many of these children have more than one episode of enrollment. On the other hand, more than 50 percent of enrollees in Kansas, New York, and Oregon disenroll after relatively short episodes of enrollment (12 months or fewer) and most do not return. Given that the income eligibility requirements for SCHIP are fairly narrow, and that income fluctuations are quite common, it is not surprising that many children would remain on SCHIP for relatively brief periods, and that there would be some movement in and out of the program. This, however, is precisely what continuous eligibility policies were designed to prevent. SCHIP enrollees in Florida were much less likely to experience disruptions in coverage at re-certification, and as a result, they had much more stable enrollment overall. As we will see in the discussion below, state policy choices may be important in determining these patterns of disenrollment.

These disruptions in insurance coverage – even those of brief duration – are of concern for a number of reasons. First, relationships with providers and access to care may be interrupted, reducing continuity with primary care providers and subsequent quality of care [Halfon, 1999

---

3 In the only earlier study of disenrollment in a SCHIP-like program, Lin and Lave [Lin, 1998 #46] found similarly short enrollment spells, with a median spell of 10.6 months. Re-enrollment in this Pennsylvania study looked most similar to Oregon, in that approximately 97 percent of children had only one episode of coverage.
Unmet needs have been shown to persist when coverage is transient [Rosenbach, 2001 #33][Schoen, 2000 #49]. Second, if enrollees stay insured for only brief periods of time, health plans do not have the incentive to invest in preventive care. Furthermore, it is difficult to hold plans accountable for providing appropriate care and health outcomes when children are enrolled only for brief periods [Bachrach, 2000 #40]. Third, plans and providers who rely on public insurance payments lose anticipated revenues during periods of disenrollment [Bachrach, 2000 #40]. Fourth, families are at risk for the cost of services utilized during their period of disenrollment. Families might not even realized that they were uninsured, use services, and then be presented with a bill. Fifth, frequent disenrollments and re-enrollments impose high administrative costs on states and plans [Bachrach, 2000 #40]. If disenrollments result in adverse selection – sicker children remaining on the program while healthier children leave the program – then SCHIP programs could become costlier (on a per capita basis) to operate. And sixth, children losing public insurance are at risk of being uninsured, which has been associated with poorer access to care [Newacheck, 1998 #][Kogan, 1995 #66] lower quality of care [Rodewald, 1995 #67], and some adverse health outcomes [Rodewald, 1995 #67][Weissman, 1992 #69][Braveman, 1989 #70].

**Presumptive Eligibility**

New York’s presumptive eligibility policy has the appearance of substantially increasing its disenrollment rate. About 33 percent of New York’s new enrollees had spells that lasted 3 or fewer months. Using the experience of Kansas to estimate the level of attrition not due to presumptive eligibility, we estimate that 23 percent of new enrollees were found to be ineligible. Caution must therefore be used in comparing disenrollments of a state with presumptive eligibility with another state that would never have counted those children as enrollees.
Our findings indicate that non-premium payers were more likely to be deemed ineligible than premium payers as a result of presumptive eligibility (24 percent vs. 13 percent, respectively, again using Kansas as a control for other attrition). We offer two theories to explain this. First, some of these families may have been found eligible for Medicaid, a more likely outcome for lower income non-premium payers. Second, failure to complete the enrollment process by providing the required supporting documentation would have resulted in disenrollment. This may have been more common among lower income families.

New York’s presumptive eligibility policy comes at some cost – the cost of paying health plans to insure these children for 2 or 3 months. Children benefit, however, because they did not have to defer utilizing services until their eligibility status was resolved. In addition, those who received the benefits of presumptive eligibility who never enrolled gained access to health care services during the brief time they were enrolled.

**Continuous Eligibility**

Continuous eligibility policies were designed to protect children from losing coverage due to slight changes in family income. Our findings indicate that continuous eligibility policies had mixed results, and as we will see below, probably only afford a modest protection for higher income enrollees. Even with continuous eligibility policies in place, respectively 29 percent and 25 percent of Kansas’ and Oregon’s new enrollees disenrolled prior to re-certification (12 months in Kansas and 6 months in Oregon). New York and Florida fared similarly.

The extent of the attrition during the period of continuous eligibility, which stems from policy design and implementation, underscores the fact that continuous eligibility policies are not absolute guarantees of enrollment. The policies were crafted to protect only those children who would become ineligible because of changes in family income. Some of the children who left SCHIP
during the period of continuous eligibility were disenrolled for reasons other than income, such as moves out the household (e.g., to another parent’s house or foster care) or out of the state. States also made decisions to allow events that are related to similar income thresholds to trigger disenrollment from SCHIP during the period of continuous eligibility. For example, in Kansas children who enroll in for Temporary Assistance for Needy Families (TANF) are automatically disenrolled from SCHIP and enrolled in Medicaid. In Oregon, pregnant SCHIP enrollees are transferred to Medicaid and enrollees are required to report when they obtain other health insurance and are subsequently disenrolled.

In addition to these designed exceptions, however, there is another type of disenrollment that occurs during the period of continuous eligibility – those due to preventable administrative actions. These include worker errors, such as entering the incorrect date for re-certification or disenrolling a child based on income information collected for other programs. Conversations with Kansas state officials lead us to believe that a significant number of the disenrollments that occur in Kansas during the period of continuous eligibility are due to preventable administrative actions. Focus groups with SCHIP disenrollees in seven states confirm that preventable administrative actions occur elsewhere [Kannel, 2001 #14].

The effect of these continuous eligibility policy choices and implementation issues at least in Kansas, has been to afforded less protection against income reductions than income increases. A comparison of disenrollments prior to re-certification by income groups (determined by premium levels) in New York and Kansas provide some evidence that higher-income enrollees may have benefited modestly from continuous eligibility. Unlike Kansas, New York does not have a

---

4 The results we present include disenrollments due to aging out. When we censored these exits, however, we found that the effect of aging out is minimal.
continuous eligibility policy, but rather enrollees have a legal obligation to come forward if changes in income that would alter their eligibility status. Higher-income (premium paying) enrollees in New York were more likely to disenroll than lower-income (non-premium paying) enrollees. The opposite was true in Kansas (see Figure 5). While some of this difference may be explained by the policy and practice exceptions that disproportionately affect lower-income enrollees in Kansas, it is likely that some of it is the effect of continuous eligibility increasing retention among Kansas’ enrollees who experienced increases in income.

One of the reasons for the relatively weak effect of continuous eligibility policies is that the obligation to report changes of income between re-certifications in states without continuous eligibility is virtually unenforceable. The resulting inequity – those honest enough to report changes in their income are disenrolled while those who do not report changes are retained – could be remedied in these states by instituting continuous eligibility. Reductions in disenrollments, however, would probably be modest compared to reductions generated by the policies discussed below.

**Re-certification and Passive Re-enrollment**

Our findings clearly show that there is a strong and large association between disenrollment and re-certification. At each re-certification in the three states that did not have passive re-enrollment, approximately half of those enrolled at the time dropped out of SCHIP. This happened regardless of whether re-certification took place at 6 months or at 12 months. Re-certification at 6 months, therefore, meant that the effects of this dive in enrollment were compounded – at 24 months only four percent of SCHIP enrollees had been on continuously in Oregon compared to 24 and 19 percent in Kansas and New York, respectively. The effects of these drops at re-certification on

---

5 Disenrollments of this type, which are likely to be followed quickly by re-enrollments, may at least partially explain why disenrollment spells that begin during continuous eligibility are not dissimilar from
long-term attachment to SCHIP are felt more profoundly in Oregon because fewer Oregon
disenrollees rejoin SCHIP later.

Our findings, as well as other studies, provide clues as to why disenrollment spikes at re-
certification. First, earlier results from CHIRI indicate that many SCHIP disenrollees (45 percent
in Oregon and 33 percent in Kansas) move directly into Medicaid, although some of these make
the transition before re-certification [Agency for Healthcare Research and Quality, 2001
#50][Allison, 2001 #71][Haber, 2001 #72]. This indicates that many enrollees experience a
change in income or family composition that is discovered at re-certification and makes them
Medicaid eligible. While increases in income could also drive families above the upper income
threshold for SCHIP eligibility, we have no data on such movement.

Second, the relatively high return rates within 2 months following disenrollment in Kansas and
New York indicate that administrative errors and/or families’ difficulties with complying with re-
certification requirements (possibly including the re-payment of owed premiums) may be
responsible for a portion of disenrollments. If families left SCHIP exclusively because they were
dissatisfied with the program or had obtained other coverage, we would not expect to see such
quick returns.

This is supported by findings from the NSAF and focus groups recently held with SCHIP
disenrollees. The NSAF found that 18 percent of uninsured children had been enrolled in
Medicaid or SCHIP within a year of the survey, and preliminary analyses indicated that the
majority of these children remained eligible but lived in families that experienced disruptions in
other areas of life [Kenney, 2001 #27]. Focus groups have revealed that unanticipated life events
made it difficult for some families to comply with re-certification requirements [Kannel, 2001
#66] disenrollment spells that begin at re-certification.
These focus groups also noted that some families questioned the need for coverage or felt guilty about accepting help. However, families held overwhelmingly positive opinions about SCHIP and there was no support for the conjecture that families left SCHIP because of dissatisfaction.

Florida’s disenrollment pattern is markedly different because it instituted a simplification to its re-certification procedures – passive re-enrollment. A family need take no action in order to re-enroll; unless they provide the state with information that shows that they are no longer eligible or fail to pay their premiums, they remain enrolled. Our results demonstrate a marked impact of passive re-enrollment on SCHIP disenrollment. Unlike Kansas, New York, and Oregon, Florida does not show the precipitous drop off in enrollment at the time of re-certification.

Policy Interactions

Several of the policies that we have identified in the four states have to be considered jointly because of their interactions. For example, in Oregon the decision to re-certify SCHIP enrollees every 6 months has resulted in Oregon’s experiencing much higher cumulative disenrollment than in Kansas and New York, where the basic pattern of disenrollment is similar. However, Florida’s passive re-enrollment policy insulates it from the same impact. Passive re-enrollment has smoothed Florida’s attrition.

Passive re-enrollment in Florida, however, might have had adverse financial consequences for the state if it had not been implemented with another policy -- a universal premium requirement. Passive re-enrollment together with capitation puts the state at financial risk for paying health plans unnecessarily, since families would have no incentive to notify the state about unneeded coverage in the absence of premiums. Nonpayment of the premium provides a signal that a family
may have obtained coverage elsewhere, moved out of state, or otherwise no longer wanted the insurance. To accommodate families who still desire insurance but are having trouble making payments, Florida has instituted its 30-day grace period policy.

LIMITATIONS
Our work has several significant limitations, and as a result, we leave many important questions unanswered. First and foremost, we do not know what happens to children when they disenroll from SCHIP: how many switch to Medicaid coverage, private insurance, or become uninsured. Second, some of our states lack individual level data that would allow us to use multivariate methods to control for population differences across the state, address more detailed questions about targeted policies, and investigate racial and ethnic disparities in enrollment trends. Third, we have no information on health status or health care utilization, and consequently, we cannot address questions about adverse selection or the links between utilization and enrollment retention. And fourth, we have considered only four states, and therefore only four sets of policy combinations. Future work of CHIRI, which will include survey and additional administrative data, will address many of these issues.

ACKNOWLEDGMENTS
This study is a product of the Child Health Insurance Research Initiative (CHIRI™), sponsored by the Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA). Additional support was provided for the Kansas project by the Kansas Health Foundation, the United Methodist Health Ministry Fund, and the Prime Health Foundation. Four CHIRI™ projects participated in the study and thanks are due to the Principal Investigators who oversee these projects and various
members of the project teams who made critical contributions: University of Florida - Elizabeth Shenkman, Principal Investigator, Bruce Vogel, Investigator, Nat Boyett, Programmer [AHRQ grant HS10465]; Kansas Health Institute– Robert St. Peter, Principal Investigator, Barbara LaClair, Research Analyst [AHRQ grant HS10536]; University of Rochester, NY – Peter Szilagyi, Principal Investigator [AHRQ grant HS10450]; Center for Health Economics Research (Oregon) – Janet Mitchell, Principal Investigator [AHRQ grant HS10463].
Table 1: SCHIP Policies in Four States

<table>
<thead>
<tr>
<th>Eligibility for SCHIP separate program as a percent of the Federal Poverty Level (FLP)</th>
<th>FL</th>
<th>KS</th>
<th>NY</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-1</td>
<td>None</td>
<td>150%-200%</td>
<td>185%-250%</td>
<td>133%-170%</td>
</tr>
<tr>
<td>Children 1-5</td>
<td>133%-200%</td>
<td>133%-200%</td>
<td>133%-250%</td>
<td>133%-170%</td>
</tr>
<tr>
<td>Children 6-19</td>
<td>100%-200%</td>
<td>100%-200%</td>
<td>100%-250%</td>
<td>100%-170%</td>
</tr>
<tr>
<td>Presumptive Eligibility</td>
<td>No</td>
<td>No</td>
<td>Yes – for 3 months.</td>
<td>No.</td>
</tr>
<tr>
<td>Continuous Eligibility</td>
<td>None, but eligibility not re-certified for 12 months.</td>
<td>12 months.</td>
<td>None, but eligibility not re-certified for 12 months.</td>
<td>6 months.</td>
</tr>
<tr>
<td>Premiums</td>
<td>$15/family/month</td>
<td>151%-175% FPL: $10/family/month 176% to 200% FPL: $15/family/month</td>
<td>160%-222% FPL: $9/child/month to $27/family/month 222%-250% FPL: $15/child/month to $45/family/month</td>
<td>None.</td>
</tr>
<tr>
<td>Passive re-enrollment</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No.</td>
</tr>
</tbody>
</table>


---

6 All children are eligible for New York and Florida’s SCHIP programs, but if their incomes exceed the maximum noted in this table, the families must pay the full cost for the coverage.