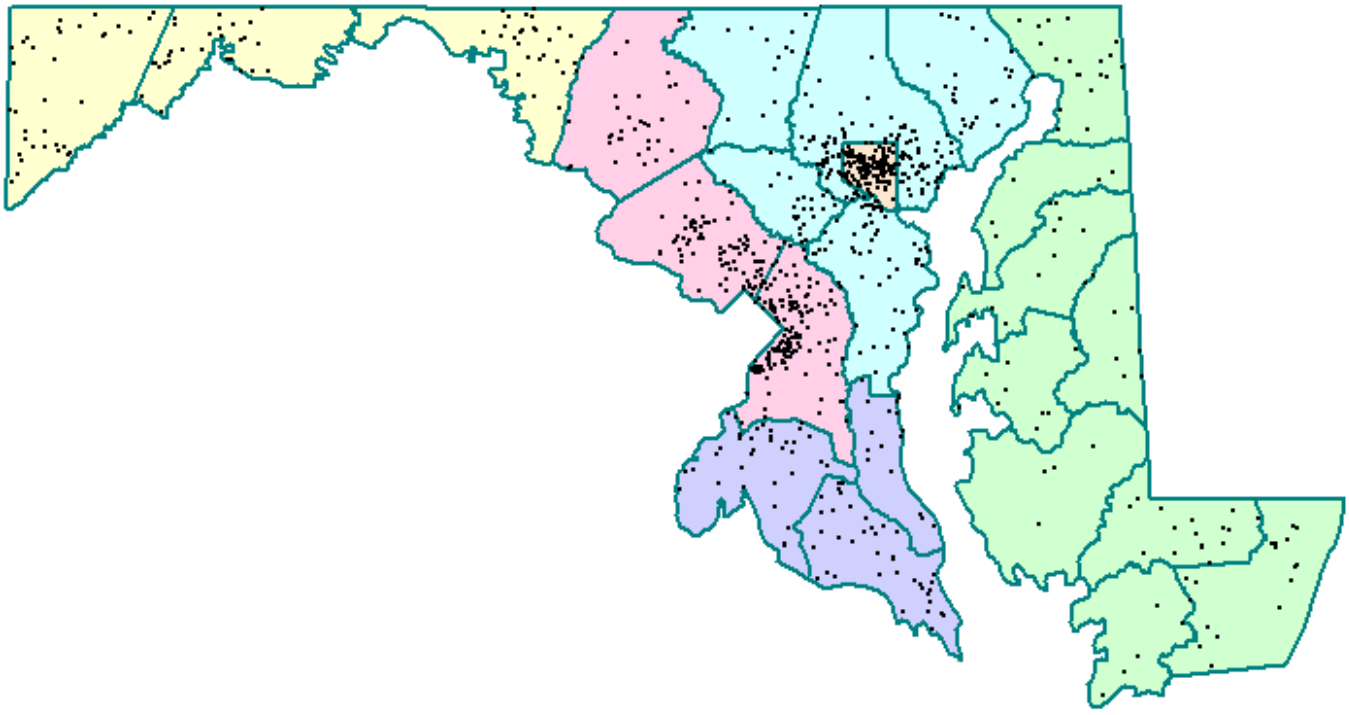
Maryland Children's Health Program (MCHP)

Disenrollee Survey



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Center for Health Program
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Health and Mental Hygiene

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Introduction

The State Children's Health Insurance Program (SCHIP) (Title XXI of the Social Security Act) was created as a part of the Balanced Budget Act of 1997. SCHIP was intended to allow states greater flexibility with regard to providing insurance coverage for low-income children while providing a higher federal match rate than with Medicaid.

Implemented in July 1998, Maryland's SCHIP, the Maryland Children's Health Program (MCHP), uses federal and state funds to provide health care coverage to low-income children up to age 19 and pregnant women of any age who meet the income guidelines (up to 200 percent FPL). MCHP enrollees obtain care from a variety of managed care organizations (MCOs) through the Maryland HealthChoice Program. In July 2001, Maryland implemented an MCHP expansion (MCHP Premium) that increased income eligibility levels (201 to 300 percent FPL) and introduced enrollee cost-sharing through premiums for the newly eligible expansion population. During that time of program expansion, Maryland's Department of Health and Mental Hygiene (Department) determined that the state would benefit from a thorough examination of why potentially eligible enrollees left MCHP. According to a review of program enrollment data, an excess of 40,000 individuals left MCHP during fiscal years 2000 and 2001. Although the state attempts to gather data for all disenrollees in an effort to track reasons for disenrollment, a review of state data revealed that nearly 75 percent of disenrollees had left for reasons that could not be classified as relating to a loss of eligibility. These disenrollees failed to renew their coverage, cancelled their coverage without a given reason, or failed to provide information required for continuing coverage.

Given that adequate disenrollment data was lacking for such a large portion of the disenrollee population, the state questioned whether eligible individuals might have been losing coverage under the program. If these disenrollees were still eligible, then potentially thousands of eligible individuals were needlessly living without health

coverage. An additional question was whether these individuals had known that they were still eligible but departed the program as a result of general dissatisfaction.

In an effort to determine why these individuals disenrolled from the program, the Department commissioned a survey, to be designed and analyzed by the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County. The Center, in association with the Schaefer Center for Public Policy at the University of Baltimore, conducted a telephone survey with a random sample of program disenrollees from FY 2000 and 2001. The specifics of the survey and population selection will be discussed further in the Methodology section.

In late 2001, the National Academy for State Health Policy (NASHP) released a study detailing a telephone survey of 3,780 SCHIP parents in seven states: Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah. Those states had joined together with NASHP to study issues of retention and disenrollment from SCHIP – with an eye toward exploring how to keep eligible children enrolled. The study results answer a number of questions, such as why families are leaving SCHIP, to what degree children are leaving the program despite the fact that they might still be eligible, how parents feel about the program, and what the barriers are to families sustaining their enrollment in SCHIP. Where appropriate, results from the NASHP study will be presented relative to the Maryland MCHP survey. Although many questions and response options were worded differently, the surveys are, in large part, comparable.[1]

Section I: Methodology

This section provides a brief overview of the technological and methodological specifications of the MCHP Disenrollee Survey. More detailed information is contained in Appendix Two.

[1] NASHP excluded from much of the survey all of the families that had left their state's SCHIP for reasons that would have made them ineligible.

The survey population was culled from a database of MCHP disenrollees from FY 2000 and 2001. The database contained 23,015 records of disenrolled children. The database was then refined so that only one child per household could be selected for the purpose of surveying the adult listed as primarily responsible for the child's health care. SPSS (Statistical Package for the Social Sciences) was used to generate random numbers, which created a database containing only one randomly selected record per household. This produced 15,710 unique records. From this, records were randomly selected for calling. Ultimately, some 5,297 records were used to obtain 925 fully completed interviews (Table I).

Table I: Targeted N and Completions by Region

Region in Maryland	Targeted N	Completed Surveys
1. Baltimore City	155	156
2. Baltimore Suburbs	220	220
3. Eastern Shore	95	95
4. Southern Maryland	92	92
5.Washington Suburbs	270	269
6. Western Maryland	92	92

Stratified sampling was used to ensure that survey results were distributed across Maryland in proportion to the number of disenrollees in each region. In two cases - Western Maryland and Southern Maryland - disenrollees were over-sampled in order to obtain sufficient interviews for analysis. Statewide results were then weighted in order to control for the over-sampling.

Telephone interviews were conducted between April 24 and June 24, 2002. The statewide findings contained in this report have a sampling error of ∀3.2 percent and a confidence interval of 95 percent.[2]

[2] A larger sampling error applies to sub-populations. By region, the sampling errors at a 95 percent confidence interval are: Baltimore City ∀7.7, Baltimore Suburban ∀6.5, Eastern Shore ∀9.8, Southern Maryland ∀9.8, Washington Suburban ∀5.9, and Western Maryland ∀9.8.

Section II: Overview

The findings from this survey suggest that the majority of disenrollees were not eligible for continued MCHP coverage, and most continued to have health insurance after leaving the program.

The following (and additional) findings are discussed in greater detail in Section III of this report.

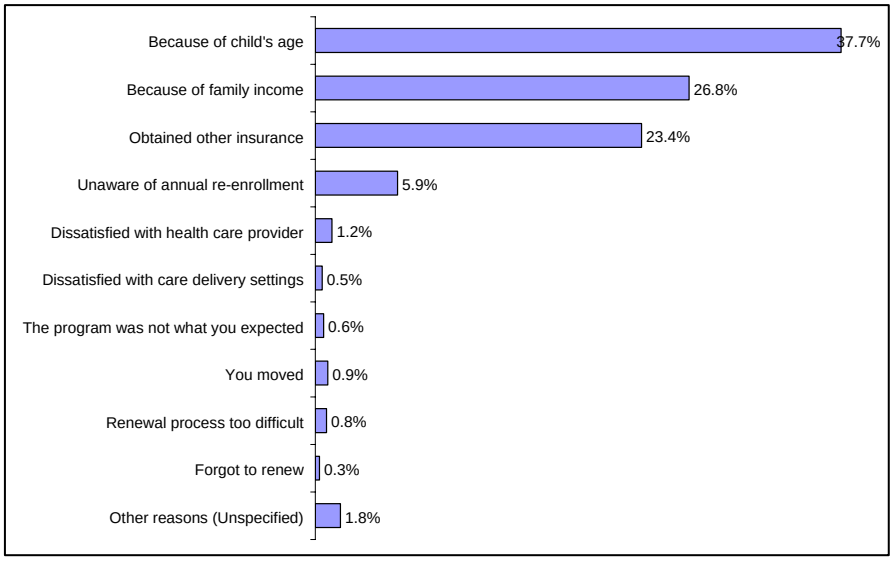
- Nearly 90 percent of the disenrollees left the program for reasons that would have made them ineligible for program participation.
- Of the remaining ten percent, more than half indicated that their child left the program because they were not aware that they had to re-enroll each year.
- Nearly three-quarters of the disenrollees had since obtained other insurance, and over 95 percent of them indicated that their new insurance was either private or employer-sponsored.
- Parents/guardians were very pleased with the care that their child received through MCHP. Nearly 90 percent rated the quality of care as Good to Excellent and an equal amount said that they were Satisfied to Very Satisfied with their child's physician while in MCHP.
- With regard to care quality, nearly three-quarters (71.9 percent) stated that their child now receives about the same care as when they were enrolled in MCHP.
- Over 95 percent of respondents stated that they would recommend MCHP to friends or family.

Section III: Detailed Findings

Most Children Left MCHP for Legitimate Reasons

Data collected by the state at the time of disenrollment, indicating that nearly 75 percent of disenrollees had left for reasons that could not be classified as relating to a loss of eligibility, clearly over-estimated the number of potentially eligible children who had left the program. As previously discussed, the survey population was culled from a state database of MCHP disenrollees. The accuracy of that database depends on whether the parents/guardians of disenrollees provide the state with reasons for disenrolling. If a parent/guardian were to obtain private coverage and simply allow MCHP coverage to expire, the state would have no way of knowing why the child left the program. This survey was exclusive to those disenrollees for whom the state lacked a clear cause for disenrollment. This group accounted for three-quarters of all disenrollees for fiscal years 2000 and 2001. In theory, these disenrollees may have still been eligible for program participation and were needlessly going without health insurance coverage. When the parents/guardians of these disenrollees were contacted, however, it became clear that the vast majority were not eligible for continued coverage under the program. Nearly 90 percent of the disenrollees had left the program due to a change in their situation that would have made them ineligible for MCHP. More specifically, over one-third (37.7 percent) indicated that their child had disenrolled because they would have been too old to continue participating,[3]

Figure 1: Reason for exiting MCHP



[3] A review of the birth dates associated with these disenrollees revealed that a significant number did not appear to be too old to retain eligibility. Roughly one-third were below the age of fifteen.

more that one-quarter (26.8 percent) stated that the child disenrolled because family income had risen above the eligibility limit, and over one-fifth (23.4 percent) indicated that their child had left the program because they had obtained private insurance coverage.

Of the relatively small number (10 percent) of disenrollees who had left the program but were likely still eligible, most (59 percent) said that they were unaware of the need re-enroll each year, even though the state sends annual renewal applications to enrollees. Other reasons such as forgetting to renew, renewal difficulties, or program dissatisfaction registered in the neighborhood of 1 percent or less.

These findings were similar to those obtained via the NASHP survey that found that over two-thirds (69 percent) of the disenrollees contacted had left their respective programs for reasons directly related to eligibility. The primary reasons cited were a change in family income or the obtaining of private health insurance. Another third (31 percent) indicated that their child's disenrollment was tied to other administrative issues such as renewal issues or premium payment. At the time of the Maryland survey, there were no premiums imposed on the MCHP participants contacted.

Program Retention and Coverage Lapses are not a Pervasive Problem

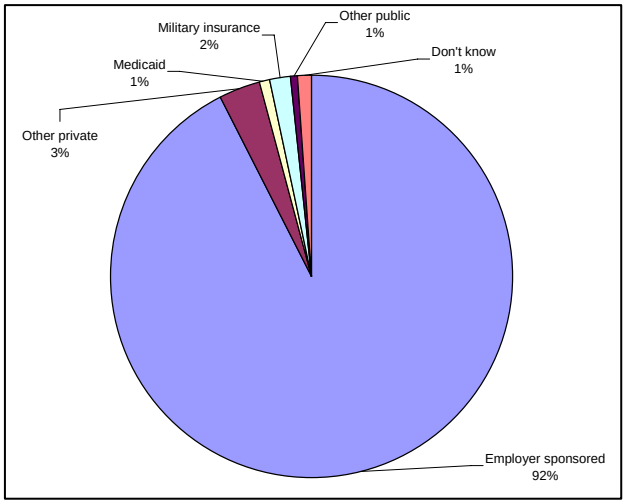
The results from both the Maryland MCHP Survey and the NASHP survey indicate that program retention and lapses in coverage by eligible families is not as great a problem as the state's administrative data may have suggested. Across the seven states surveyed by NASHP (including Maryland), it is clear that most individuals who exit SCHIP do so for reasons that would have precluded them from continued participation. In all likelihood, state data does not reflect this fact as a result of parents/guardians not reporting to states why their child exited the program. The NASHP study presented a useful analogy for understanding why this happens: when canceling magazine subscriptions, most people simply do not renew their subscriptions. They do not take the time to contact the magazine and explain why they are not renewing.

Disenrollees are Obtaining Insurance

Three-quarters (74 percent) of the disenrollees surveyed have since obtained new insurance coverage. Of those policies, nearly all (95.9 percent) are employer-sponsored or other privately obtained policies.

Of the 25 percent who had not since obtained insurance for their child, most (57.4 percent) cited cost, but one in five (19.3 percent) indicated that they were no longer responsible for the child's health insurance. Reasons for this included the child being too old, the child obtaining his/her own policy, or the child being covered via another family member. As such, the true rate of non-coverage would actually be lower than 25 percent.

Figure 2: What insurance did you select?



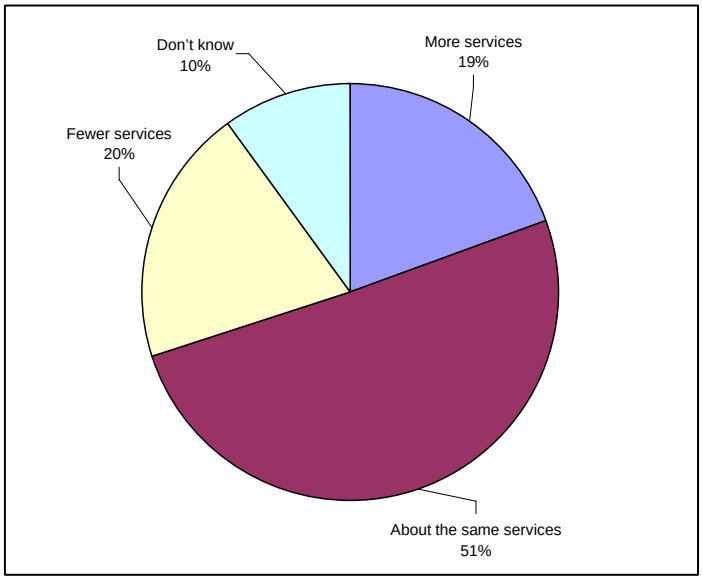
The NASHP survey found that most (62 percent) families whose SCHP coverage had lapsed were now uninsured, but NASHP used differing methodologies and excluded from their calculation all of the families that had left their state's SCHIP for reasons that would have made them ineligible. This would include those who had obtained new insurance. As a result, one would expect the uninsured rate among the NASHP survey population to be considerably higher.

MCHP Comparable to Privately Obtained Policies

Of those respondents who had obtained new insurance coverage, a majority (50.6 percent) indicated that their new policy covered about the same services as MCHP. One-fifth (19.5 percent) said that their new policy covered more services and another fifth (20.1 percent) believed that the new policy covered fewer services. With regard to care quality, nearly three-quarters (71.9 percent) stated that their child now receives about the same care as when they were enrolled in MCHP. The NASHP survey found similar results. Of those surveyed, nearly three-quarters (73 percent) indicated that their new

policy covered about the same or fewer services than did SCHIP. Approximately one-sixth (14 percent) said that it covered more services.

Figure 3: Compared to MCHP, does your new health insurance cover…?

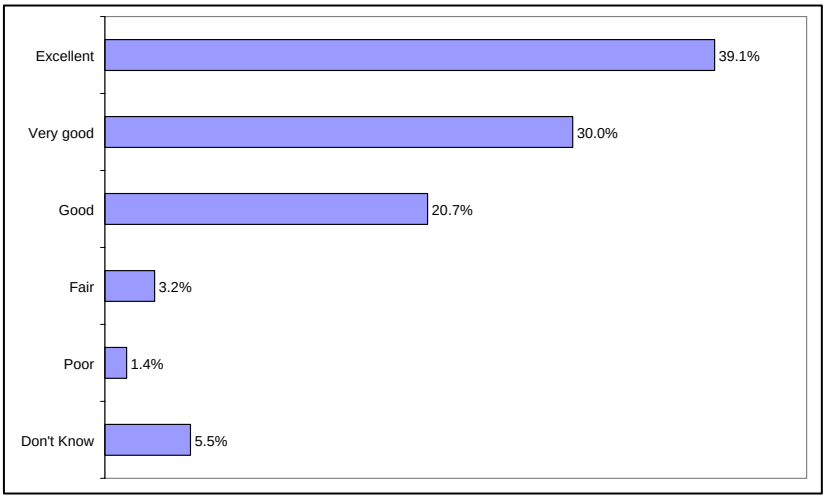


MCHP Lauded by Parents/Guardians of Disenrollees

The vast majority of disenrollee parents/guardians rated the quality of care received through MCHP as Good (20.7 percent), Very Good (30 percent), or Excellent (39.1 percent). Fewer than one in twenty (4.6 percent) rated it as Fair or Poor. Findings from the NASHP survey were quite similar with regard to rating program quality. A clear majority of respondents in the NASHP study rated the quality of care received through their state's SCHIP as Good (25 percent), Very Good (23 percent), or Excellent (40 percent). Although SCHIPs vary across states, there is consistently positive reaction from most participants.

Most MCHP enrollees surveyed (95.7 percent) said that they would recommend MCHP to family or friends, with a few (1.6 percent) responding that they would not. Among the primary reasons cited for recommending the program were affordability (69 percent) and quality (61.5

Figure 4: How would you rate the quality of care that your child received through MCHP?

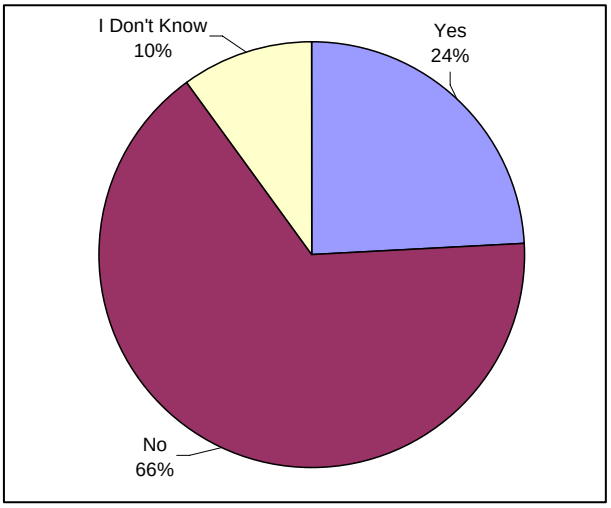


percent). Of the relatively few respondents who said that they would not recommend the program, most (51.9 percent) cited poor quality of services as a primary reason. Again, these findings are similar to those obtained via the NASHP survey. When asked the comparable question of what they liked about their state's SCHIP, respondents cited affordability (54 percent) and quality (22 percent).

Little Evidence of Private Coverage "Crowd-Out"

As federal and state governments seek to increase the proportion of people with health coverage, it is critical to understand the nature and extent of substitution or "crowding-out" of private insurance. If public expansions such as SCHIP are responsible for shifting individuals from private insurance to public programs, the effectiveness of public funds to expand insurance coverage might be limited. In an effort to explore this issue, several questions were included in the MCHP Disenrollee Survey specifically targeted to the question of crowd-out. Those parents/guardians who indicated that they obtained new insurance were asked whether they would consider canceling that coverage in order to re-enroll their child in MCHP. A clear majority (65.8 percent) said "No," but nearly one-quarter (24.3 percent) said "Yes."

Figure 5: Would you consider canceling your child's current insurance so he/she could re-enroll in MCHP?



MCHP rules stipulate that a child must have been without insurance for a period of six-months prior to enrolling in the program. When those responding "Yes" were informed of that requirement and then asked if they would still consider canceling their child's current coverage in order to re-enroll, the proportion of those responding "Yes" fell to less than one in ten (8.6 percent).

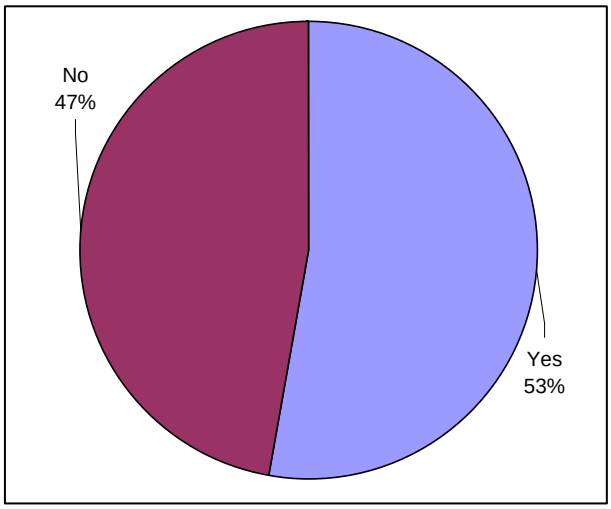
Respondents were also asked whether they would have turned down a pay raise at work, while their child was enrolled in MCHP, if accepting the raise would have meant their income would have been too high for the child to remain eligible. More than two-thirds (69.9 percent) said "No" they would not have turned down a pay raise. Slightly more than one-sixth (16.1 percent) said "Yes" and nearly another sixth (13.5 percent) answered that they "Did Not Know."

These findings suggest that there is a marginal threat of crowd-out, but existing program rules, such as the six-month waiting period, effectively minimize that threat. Additionally, there is little indication that parents/guardians are interested in minimizing their earnings in an effort to retain program eligibility for their children.

There is a Willingness to Share Costs

At the time that the respondents to this survey were enrolled in MCHP, the state imposed no premiums on enrollees. Effective July 1, 2001, however, Maryland implemented a program expansion (MCHP Premium) that increased income eligibility levels (201 to 300 percent FPL) and introduced enrollee cost-sharing through premiums for the newly eligible expansion population. Although the participants in this survey never faced premiums during their program tenure, there was an interest in assessing how premiums would impact willingness to enroll in MCHP. Since premiums under the MCHP expansion are only imposed on those earning between 201 and 300 percent FPL, a question was asked only of those who indicated that they had left the program due to an

Figure 6: Would you have been willing to keep your child in the program by paying a premium/fee of between $40 and $50 each month?



increase in family income[4]. Those individuals were asked whether they would have been willing to keep their child in the program by paying a premium/fee of between $40 and $50 (the actual premium range at the time of the survey) each month. Just over half (52.7 percent) of those surveyed said "Yes" and just under half (47.3 percent) said "No." This finding indicates that, at least among those with program experience, there is a willingness by individuals at higher incomes to contribute to the cost of their child's coverage. The findings also suggest that, at the premium levels mentioned, nearly half of the respondents indicated that they would not have been willing to maintain MCHP coverage.

Observations Vary Little by Region

As discussed in the Methodology section, an effort was made to determine whether enrollees in different regions within Maryland had differing perceptions of MCHP. The survey population was stratified by region so that it would represent the true regional distribution of disenrollees and then the smaller regions were over-sampled so as to allow meaningful comparative analysis. The statewide results presented thus far were all weighted in order to account for this over-sampling.

Although there do not appear to be many regional differences among the findings, there are some that merit notation. All statements are made in comparison to regional findings.[5]

- Relative to other regions, more respondents in Baltimore City and on the Eastern Shore said that their child left the program due to age.
- Fewer respondents in Baltimore City said that they lost eligibility due to income.
- Fewer respondents on the Eastern Shore said that they left because they obtained other insurance and compared to other regions, fewer had obtained insurance after leaving the program.
- More respondents on the Eastern Shore and in Western Maryland said that their new insurance covers fewer services than did HealthChoice.

[4] There is no way to know whether these individuals were earning between 201 to 300 percent FPL, but this question was merely intended to assess a general level of willingness to pay premiums.

[5] Most regional differences fall within the margin of sampling error at a 95 percent confidence interval, but are significant at a 90 percent confidence interval.

- Fewer respondents in Western Maryland said that they would consider canceling their current insurance in order to re-enroll in HealthChoice.

Complete regional and statewide results are presented in Appendix One: MCHP Disenrollee Survey Results.

Respondents were also given the opportunity to voice any specific recommendations or suggestions that they may have regarding MCHP. Among the most frequent suggestions made for improving the program were: 1) increasing the eligibility age; 2) raising the income eligibility threshold; and 3) better coordination and explanation of the program.

Section IV: Policy Implications

The findings detailed in this study indicate that MCHP has been a popular and successful program. Disenrollees voiced considerable satisfaction and the vast majority have since graduated to private coverage, which they consider comparable to MCHP. Survey findings also indicate that the program does not have a significant problem with enrollee retention. Survey results, combined with state gathered data, show that a clear majority of individuals who exit the program do so because of situational changes that have made them ineligible for continued participation.

The data suggest that a small number of disenrollees may still be eligible for the program. These individuals account for just under 10 percent of all disenrollees leaving MCHP each year, but the vast majority (72.1 percent) of these potentially eligible disenrollees have yet to find new insurance coverage. This finding stands in stark contrast to the fact that among all disenrollees only one-quarter (25.9 percent) had yet to obtain new insurance. Additionally, the findings indicate that there may be confusion regarding the age requirements for program eligibility. State records indicate that roughly one-third of the children identified as having left program due to age were still within the eligible age range. This finding could result from incorrect state records or from a lack of understanding of program eligibility rules on the part of parents/guardians.

Section V: Conclusion

This study represents just one component in Maryland's ongoing efforts to improve MCHP through a better understanding of the enrollee experience. The findings from this survey suggest that there is a high degree of satisfaction with, and appreciation of, the program among former enrollees. Data also suggest that enrollees are "graduating" from MCHP into private health insurance and that their privately obtained insurance affords them benefits comparable to the state program. The findings do indicate that a very small number of children (roughly 10 percent) disenroll each year that may still be eligible for the program, and most of these disenrollees remain uninsured. In order to address these issues, the state should examine enrollment and education materials to be certain that eligibility and enrollment requirements are clear.