



Health Policy Research

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Impact of hawk-i, Iowa's S-SCHIP program

Public Policy Center, The University of Iowa

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Health Policy Brief

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University of Iowa, Public Policy Center

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Background of the *hawk-i* program

15,710
children
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enrolled in
hawk-i in
November
2003

The *hawk-i* program is part of Iowa's State Child Health Insurance Program (also known as SCHIP or Title XXI), which is designed to provide health insurance coverage for uninsured children up to 200% of the federal poverty level (FPL).

The Iowa legislature authorized the creation of a two-part 'combination' SCHIP program. The first part is a Medicaid expansion (M-SCHIP) for children with family incomes up to 133% of FPL. The second component is *hawk-i*, the separate state child health insurance program (S-SCHIP). *hawk-i* provides health insurance for children with family incomes from 134% to 200% of FPL. In *hawk-i*, the State of Iowa contracts with private health plans to provide covered services to enrolled children in the program. Families with

incomes from 134% to 150% of FPL have no premiums or copayments, while those from 151% to 200% of FPL pay a premium of \$10/child/month up to a maximum of \$20/family/month. The first recipients were enrolled in *hawk-i* in January 1999. As of November 1, 2003, there were 13,821 children enrolled in the Medicaid expansion program and 15,710 children enrolled in *hawk-i*.

Two health plans are participating in select counties: John Deere Health Plan and Iowa Health Solutions. The remainder of the state is served by an indemnity plan offered by Wellmark.

This policy brief draws information from ongoing studies evaluating the *hawk-i* program for the Iowa Department of Human Services by the University of Iowa Public Policy Center.

Access to medical care improved

Children were
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year.

Children's access to medical care was significantly improved after they were in the *hawk-i* program for a year. For example, children were much less likely to be stopped or delayed from receiving medical care after one year in the *hawk-i* program. 17% were stopped from getting medical care in the year prior to joining *hawk-i* compared to 4% during their first year in the program. Another improvement was in the percentage of children who always received the care they needed for an illness or injury. This rose from 65% in the year prior to joining *hawk-i* to 82% after a year in the program.

This improvement in access to medical care occurred without an apparent increase in the percentage of children who were thought to need medical care after receiving *hawk-i* insurance. 66% of all enrolled children were reported to need medical care both for the year before joining the program and for the year while in *hawk-i*.

Similar patterns were found for specialty care. There was no difference in the percentage of children reported to be in need of specialty care after one year however the percentage who were stopped from receiving specialty care declined from 18% of those in need to 10% while the percent delayed dropped from 27% of those needing specialty care to 13%.

*Children were reported to be more likely to have always received needed preventive care after being in **hawk-i** for a year, however only 1/3 of children received a preventive care visit during the year.*

Preventive care improved but could be better

The percentage of children who were reported to 'always' receive the preventive health care (e.g., physical exams and vaccinations) they needed increased from 65% to 82% after being in **hawk-i** for a year.

The percentage of children and adolescents who received a preventive examination however was lower than desired. From the insurance claims data,

only about one-third of children ages 3-6 who had been in **hawk-i** for at least 11 months had received a preventive visit. According to the American Academy of Pediatrics, every child ages 4-6 should receive a preventive visit at least once each year. The rates of use did vary for children in the different health plans and by age of the child. 4-year-old children were most likely to have had a preventive visit during the year.

Unmet need for dental care was reduced from 22% to 8% after one year in **hawk-i**.

Access to dental care also improved

Access to dental care improved after one year in **hawk-i**, without a corresponding increase in the percentage of children reported to need dental care. Unmet need for dental care declined from 22% to 8% after one year in **hawk-i** with a similar decline in the percent delayed from receiving dental care.

About half of the children ages 4-18 had a dental visit during fiscal year 2001 (figure. 1). The percentage with a visit was higher in most age categories than for children enrolled in Medicaid.

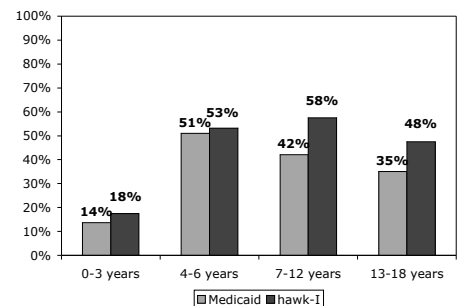


Figure 1. Percentage with a dental visit during FY 2001 for children in **hawk-i** and Medicaid

Unmet need was reduced for vision and behavioral and emotional care as well as for prescription drugs.

Access improved for other services

Access to care for **hawk-i** enrolled children was improved for three other service areas: vision care, behavioral and emotional services and prescription drugs.

Unmet need for vision care declined from 32% to 9% of those needing this service. Unmet need for behavioral and emotional care was reduced from 39% to 16%, while prescription drug unmet need declined from 15% to 10% of children needing these services.

Impact of child having *hawk-i* insurance positively affected family environment

Because a child had health insurance coverage through *hawk-i*, there were positive implications for the family environment.

For example, stress was reduced in 96% of the families of children because of the child's enrollment in *hawk-i*. 75% said the stress was reduced "a lot". Parents' worry about their ability to pay for their child's health care was reduced greatly from 54% worrying a "great deal" to 20%.

The activities of significantly fewer children were limited because of concerns about health care costs from 23% before enrolling to 12% after one year in *hawk-i*.

More parents had health insurance coverage after one year of the *hawk-i* program, although 41% were still uninsured.

The hawk-i program reduced stress and worry within the family about children's health care costs significantly.

Other considerations

The findings of these studies about the *hawk-i* program raise questions for consideration by policymakers:

1. Concerns about the transition to the *hawk-i* health plans were identified:
 - a. 20% of children had to get a new personal doctor or nurse
 - b. 27% of these had trouble finding a personal doctor or nurse they were happy with.
 - c. Almost 40% did not know their health plans had a help line they could call for assistance.
2. Preventive health visits were much lower than recommended by the American Academy of Pediatrics. Reasons for the low rates are under investigation by the Iowa Department of Human Services.
3. Dental rates are lower than national averages for children (73% according to the 2001 National Health Interview Survey). Further studies are investigating additional aspects of access to dental care and factors related to the receipt of dental services.
4. States have the option of covering parents in their SCHIP programs. Given that 41% of *hawk-i* enrollees had parents who were uninsured, this could be a mechanism to provide coverage to a relatively low risk group of uninsured adults.

Hawk-i could be a mechanism for covering the 41% of enrollee's parents who were uninsured.

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reports are available
for download or can
be ordered from our
Website:

<http://ppc.uiowa.edu>

Study methodologies

This policy brief draws information from ongoing studies conducted at the University of Iowa Public Policy Center for the Iowa Department of Human Services.

Two different approaches are being used to evaluate the impact of the **hawk-i** program: 1) An enrollee survey evaluating access to care, health status and the family environment, and 2) insurance claims data and enrollment files used to study outcomes from the **hawk-i** health plans.

The enrollee survey is conducted concerning one child from each enrolled household at the time they enroll (about experiences in the year before they joined). The results of this baseline survey are compared to a survey

conducted after the child has been in **hawk-i** for a year. Results in this brief were for 1,698 children initially enrolled between July 1, 2001 and June 30, 2002 for whom we received both a baseline and follow-up survey.

The administrative claims data and enrollment files are being used to evaluate outcomes of care for the program. Thus far, these outcomes studies have evaluated preventive health visit rates, dental visit rates, use of behavioral and emotional health care services and rates of receiving the Measles, Mumps and Rubella immunization. A more detailed study of children with Attention Deficit Hyperactivity Disorder (ADHD) was also completed. Data presented in this brief were for fiscal year 2001.

Related PPC reports

1. Damiano PC, Willard JC. **hawk-i: Impact on Access and Health Status**. Third Evaluation Report to the Board of Directors of the Healthy and Well Kids in Iowa Program. January 2004.
2. Momany ET, Damiano PC. **Outcomes of Care for Children in the hawk-i program**. Final report to the Iowa Department of Human Services, January 2004.
3. Momany ET, Damiano PC. **Attention Deficit Hyperactivity Disorder and Children in hawk-i**. Final report to the Iowa Department of Human Services, January 2004.
4. Damiano PC, Willard JC. Comments about the **hawk-i** program. Report to the Board of Directors of the Healthy and Well Kids in Iowa Program. March 2004.

About these policy briefs

The University of Iowa's Public Policy Center's **Policy Briefs** are designed to succinctly provide our research findings in a manner that is more accessible to policymakers and others. The nature of the Briefs does not allow for extensive explanation of the methods we used in our research however. More information about the specific methodologies used in any particular study can be obtained by contacting researchers at the Center and or by downloading reports with more detailed methods sections. We hope you find these policy briefs helpful to your discourse of some of the most challenging societal issues.

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The University of Iowa's Public Policy Center was formed in 1987 to facilitate interdisciplinary academic research on public policy issues. A freestanding unit in the Office of the Vice President for Research, the Center's mission is to: carry out public policy-related research; facilitate collaboration among researchers from a variety of fields and disciplines; conduct research on topics that will affect future development and promote positive social change within the state and region; and disseminate research findings both to scholarly and lay audiences.