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Health Policy Brief
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Background of the hawk-i program

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’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%.
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.

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.

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.

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.
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.

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