



Children's Health Fund

**The Recession and Child Health Access:
Why 21 Million Uninsured Kids and
Young Americans Can't Wait for
Health Care Reform**

Children's Health Fund
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EXECUTIVE SUMMARY

Health reform that will establish and maintain stability and security in insurance coverage is necessary to insure children who currently lack coverage and to provide children who have insurance with continuous access to health care. New estimates of the number of uninsured children and youth vary. According to perhaps the most reliable federal survey, about **11.9 million 0-18 year-olds lack coverage; and if we add young people to the age of 24, there are as many as 21 million children and youth who are currently uninsured.** Expanding coverage to all children, and extending that to older adolescents and young adults, is essential to successful health care reform.

The recession that began in December 2007 laid bare the lack of stability and security of our employer-provided health insurance system. As jobs were lost, so too was health insurance. By May 2009, far too many children were missing health appointments for needed care. Lower income families (income less than \$50,000) were most affected: nearly one-fourth had lost income and 15% of children had missed a check-up – that’s 4.5 million children going without the preventive health services all children need. It is generally recognized that 14,000 people a day have been losing health insurance during this recession; this number must include at least 2,000 children. As is most often the case, children in low-income families are most affected, and 15% of children in families with incomes below \$50,000 are missing regular health care appointments.¹

Many children were protected from long-term loss of insurance because of the availability (if income eligible) of a public insurance safety net (Medicaid and State Child Health Insurance Program, CHIP). But assuming they enrolled in these insurance programs, many affected children experienced a gap in coverage and loss of continuity with their doctor or nurse. This disruption alone compromised the quality of their health care. The cost of this increase in public insurance enrollment was borne by states that often responded by cutting services.

Children are the least expensive age group to care for, costing about 20% as much per year as adults. Providing quality preventive care can reduce long-term health care costs, a fact that is missed in Congressional Budget Office fiscal projections, which limit the window for savings to

10 years. **Keeping children healthy pays a lifetime of dividends, as can be quantified with reference to chronic conditions associated with obesity, and to the most common childhood chronic condition, asthma. We know that expanding health coverage improves access to care and health outcomes; it is time to apply what we know to implementing effective health policy that ensures all children have access to timely, continuous and comprehensive health care.**

Covering all children and eliminating the financial barriers that keep them from receiving the care they need when they need it is an essential first step to guaranteeing access to health care for all children. However, we also know that as important as it is to reform health insurance, ensuring health access for all children will require additional steps. Other obstacles to care, such as workforce shortages and transportation barriers, affect low-income children and must be addressed.

To improve the security and stability of health insurance coverage, expand coverage to the uninsured, and ensure access to quality health care for all children, CHF recommends the following as guiding principles for national health reform:

- Health care reform must provide universal coverage for all kids
- Health care reform must promote the medical home model of care for children to ensure that all of their health care needs are addressed, from primary preventive care to specialty care.
- Health care reform must include safeguards to protect children who currently rely on CHIP for health insurance coverage. If there is no comparable cost-sharing and benefits in plans offered through the proposed health insurance exchange mechanism, CHIP should remain an option for low-income working families after 2013.
- Health care reform must ensure that poor and low-income families can truly afford insurance by establishing premium assistance for the purchase of health insurance on the exchange and protecting children from bare bones coverage plans.

THE RECESSION AND CHILD HEALTH ACCESS

When the U.S. economy was recognized as being in a recession in December 2008, according to the National Bureau of Economic Research, it had already been in recession for nearly a year – longer than the average length of any U.S. post-World War II recession. Key indicators were the decline of the stock market, retraction of the credit market, which affected home and automobile purchases, and reduced consumer spending.² Subsequent discussions of the recession have centered on these and similar economic indicators. Very little attention has been given to the impact of the recession on children and families.

This inadequate focus on children and families is also a feature of current discussions about how best to reform the health care system. While it has been clear that loss of jobs has too often meant loss of health insurance coverage, discussions about health reform have focused on Medicare, the public health insurance option for people 65 and older. Flying under the radar are Medicaid and the State Children’s Health Insurance Program (CHIP), safety net programs that provide coverage for millions of children. These programs are successful and vitally important in times of economic hardship.

In May 2009, Children’s Health Fund worked with CBS News to produce a survey exploring the impact of the recession on America’s children with a focus on health access.* The results provide a snapshot of the recession’s impact on children and families interacting with the health care system as of mid-May 2009.³

It was immediately clear that the impact of the recession was most severe on children and families with lower annual incomes (under \$50,000, approximately the median 2007 household income).^{4 5} This strongly implies that economically vulnerable children and families are feeling the recession’s impact most intensely.

* The poll was conducted by telephone between May 6 and 12, 2009 with a random sample of 1,874 adults. Parents of children under 18 years of age living at home were oversampled (N=972). Phone numbers were dialed from random digit dialing samples of both standard land lines and cell phones. The results were weighted in proportion to the total composition of the adult population in the U.S. Census. The margin of error is +/- 2% for the entire survey and +/- 3% for parents.

This is not surprising because before the recession, the majority of children living in low-income (poor or near poor[†]) families had at least one working parent.⁶ Job loss was one of the recession indicators that disproportionately affected lower income households:

- Nearly one household in four (24%) with an annual income under \$50,000 had an adult family member who was temporarily unemployed, and another 18% had a family member no longer in the job market. Only 56% of these families reported full-time current employment, compared to the 78% of families with annual income above \$50,000.
- One-third, 34%, of families with income under \$50,000 reported a recent loss of employment (within the preceding six months) compared to 19% of higher income families.
- 59% of parents who reported experiencing financial problems since the recession began had annual incomes below \$50,000, compared to 41% of parents with higher incomes.[‡]

The specific impact of these financial problems on lower income families is especially troubling. During the six months preceding the survey (December 2008 - May 2009):

- Nearly two-thirds, 64%, found it harder to pay for groceries.
- 62% found it harder to pay utility bills.
- 44% found it harder to pay medical bills.
- 40% found it harder to pay for housing.[§]
- A higher proportion of families in which at least one wage earner had lost employment within the preceding six months had difficulty meeting these core expenses than did other families.^{**}

[†] Near poor was defined as twice (200%) the 2005 federal poverty level, or \$39,600 for a family of four

[‡] These differences based on family income are all statistically significant ($p < 0.01$).

[§] These differences among families with annual income of \$50,000 and up are statistically significant ($p < 0.01$).

^{**} Difference is statistically significant ($p < 0.01$)

THE RECESSION, HEALTH INSURANCE & CHILD HEALTH ACCESS

Prior to the recession, an estimated 8.6 million children (11.1% of U.S. children) were uninsured. The vast majority of them, 88.2%, lived in a family where at least one parent worked.⁷ In this snapshot of the impact of the recession, the situation for children in lower income families had worsened.

Among families with an income under \$50,000 per year, 18.2% were uninsured compared to 3.7% for incomes \$50,000 or higher.^{††} Of the uninsured lower income children, 57.8% had lost their insurance coverage during the preceding six months, and 12.6% of parents (with income below \$50,000) reported that they had applied for public health insurance (Medicaid or CHIP) for their child for the first time within the preceding six months.

The combination of lost health insurance and increasing financial pressures strongly suggests that access to child health care would suffer, and this was confirmed in the data. For children in families with annual income under \$50,000:

- 17% had skipped a dental appointment for their child
- 15% had skipped a child check-up in the preceding six months
- 13.5% had skipped an appointment for their child with a medical specialist
- 9% had declined to purchase or reduced their use of medications for their child^{‡‡}
- A higher proportion of families in which at least one wage earner had lost employment within the preceding six months had made these drastic changes with respect to health care for their child than did other families.^{§§}

^{††} Difference is statistically significant ($p < 0.01$).

^{‡‡} Differences with respect to families an annual income of \$50,000 and above are significant, $p < 0.01$

^{§§} Difference is significant, $p < 0.05$.

The table below summarizes the application of these figures to the number of children in families with an annual income under \$50,000.^{***} The data suggest that **recession- related health access problems will affect 3 to 5 million children in low- and middle-income families.**

Health Access Problems for Children in Families with Annual Income Under \$50,000	Percent of children	Number of children
Loss of Health Insurance ^{†††}	10.5%	3.15 million
First application for Medicaid or CHIP	12.6%	3.78 million
Skipped dental appointment	17%	5.1 million
Skipped well child check-up	15%	4.5 million
Skipped medical specialist appointment	13.5%	4.05 million
Declined to purchase/reduced use of medications	9%	2.7 million

While we have emphasized the impact of the recession on lower income families, job loss and with it loss of employer-provided health coverage have affected workers at all income levels. The September 2009 report from the Economic Policy Institute notes that in the professional and business service sector, “only” 22,000 jobs were lost in August, down from a pre-economic stimulus average of 110,000 per month.⁸ Related trends include a decline in the percentage of Americans with employer-provided health coverage and an increase in the number of uninsured.⁹

^{***} The U.S. Census Bureau does not specifically tabulate the income distribution of families (or households) with children (<http://pubdb3.census.gov/macro/032008/hhinc/toc.htm>). It is necessary to extrapolate from income data for all families (or households), using the percentage of children living in families with income below 200% of the federal poverty level (FPL) as a reference point. The annual income consistent with 200% FPL varies with family size, further complicating the calculation. We reached a conservative estimate of 41% of children (~30 million) as a lowest plausible estimate for children in families with less than \$50,000 annual income. (200% FPL in 2009 is \$44,100 for a family of four.) The National Center for Children in Poverty, Columbia University Mailman School of Public Health (<http://www.nccp.org/>), estimated the figure at 46% or ~34 million children living in families with an annual income under \$50,000. (Personal communication, 6/9/09.) Using U.S. Census Bureau data, the number of children in the U.S. used for these calculations was 73.6 million.

^{†††} We applied the percentage of children who had lost insurance during the preceding six months to the percentage of uninsured children to determine the percentage of newly uninsured for children with an annual family income below \$50,000.

The Kaiser Family Foundation Health Tracking Poll¹⁰ asks access to health care for any family member, not just children. Its results show even higher percentages of people missing health care. In February 2009, 35% of families reported at least one family member missed or delayed a doctor's visit; this percentage was nearly unchanged—37%—in June 2009. The percentage of those who either declined to purchase or reduced their use of prescription medications also remained stable over time—15% in February and 19% in June, as did the percentage of those who missed a dental visit (34% in February and 35% in June 2009). These data suggest that recession, the high cost of health care, and possibly the loss of insurance or value of benefits, is leading adults to cut back on health care utilization to an even greater extent than children's care is being cut back.

The above could be explained by the difference in safety net options available to children versus adults. The insurance safety net available for children—public insurance (Medicaid or CHIP depending on financial eligibility)—often replaces employer-provided private coverage. The adult safety net is a time-limited financial offset to support “COBRA” benefits,⁺⁺⁺ meant to help recipients purchase continued health coverage. For the newly unemployed, the COBRA offset is often insufficient, and the cost of maintaining coverage unaffordable. Also related is the increase in public insurance enrollment at a time when states, due to the recession, are losing tax revenue and face strained budgets, forcing some to cut services.^{11 12}

This loss of health insurance is to be expected as unemployment rises. Nearly 60% of Americans receive their health insurance coverage as a benefit associated with employment. Loss of employment too often equals loss of health insurance for the worker laid off and his or her family. During this recession, as many as 10,000 people a day have lost their jobs, and by May 2009, an estimated 2.4 million newly unemployed workers had lost their health insurance. This number does not fully reflect the extent of newly uninsured people because it does not capture spouses and children covered in the insurance plan.¹³

⁺⁺⁺ Consolidated Omnibus Budget Reconciliation Act

UNINSURED CHILDREN WITH NO FINANCIAL ACCESS TO CARE

It is by now well recognized that estimates of the percentage and number of uninsured children in the U.S. vary, and none may be considered definitive. Available estimates are complicated by the different methodologies and different definitions of “uninsured” in the various federal surveys that are used.¹⁴ A general problem with most of the data, including the one most frequently cited (U.S. Census Bureau), is that to be counted as “uninsured” a person would have to have been continuously without health insurance for 12 consecutive months. If we include children with gaps in coverage (uninsured for any period during the year), the number and percentage of uninsured children increases significantly.¹⁵ The impact of discontinuous coverage for children is similar to that of being uninsured: limited access to preventive care, inadequate management of chronic conditions like asthma, and delays in receiving or missing care when ill.¹⁶

Focusing only on 12 month continuous lack of health insurance reduces the number of children whose health access—and health status—have been compromised by this critical financial factor. Another reason why data typically underestimate the percent and number of uninsured children is that typically only children 17 years and younger are counted.¹⁷ This excludes youth aged 18-24, for whom the uninsured rate is consistently higher than for children.

In September 2009 the U.S. Census Bureau released data from its Current Population Survey (CPS) showing a decline in the percentage and number of uninsured children from 2007 to 2008, despite an increase in poverty and the well-documented job loss throughout the recession. However, the Congressional Budget Office previously found that estimates of uninsured children from an alternative federal survey, the Medical Expenditure Panel Survey (MEPS),^{§§§} may be more accurate.¹⁸ MEPS data account for part-year (point-in-time) lack in health coverage, not just 12 months of continuous uninsured status, and also provide data for youth over age 17.¹⁹ Contrary to CPS, MEPS data showed an increase in uninsured children in 2007.²⁰

^{§§§} MEPS is a survey of the Agency for Healthcare Quality and Research (AHRQ), U.S. Department of Health and Human Services. See online: http://www.meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp for details.

For the first six months of 2008, MEPS data show 14.5% of children 17 years and younger (10.7 million) are uninsured, compared to 9.9% (7.3 million) in the Census Bureau data for calendar year 2008.²¹ When we include MEPS data for 18 year olds (25.7% or 1.2 million), the number of uninsured children and youth through age 18 is 11.9 million. Add to this the 35.7% of 19-24 year olds (9.2 million) and the enormity of the health insurance crisis affecting our children and youth, even with Medicaid and CHIP available as potential options, is clear. **There are about 21 million children, adolescents and young adults who do not have stable and secure health insurance coverage and therefore lack consistent access to needed health care services.**

INSURING CHILDREN IS INEXPENSIVE AND COST-EFFECTIVE

Public health insurance—Medicaid and CHIP—have long been major insurers of children, covering 29% of U.S. children during 2007.²² Medicaid eligibility is determined in large part by family income being at or near poverty. Medicaid also covers children and adults with disabilities. CHIP is an option for children whose family income exceeds the Medicaid eligibility threshold but is too low for commercial insurance to be affordable. Most publicly insured children are in Medicaid, where the low cost of maintaining their health care is evident.

Typically children make up about half of Medicaid beneficiaries, yet they consume a much smaller fraction of Medicaid dollars. Looking at expenditures for routine pediatric care, only about 16% of Medicaid costs are for children. By comparison, the eligibility category “aged, blind and disabled” comprises about one fourth of those covered by Medicaid and about 70% of Medicaid expenditures.^{23 24 25} When the rate of growth to Medicaid was looked at several years ago, it turned out that only 15% of the overall Medicaid budget increase was attributable to care for children; 57% of the increase was for elderly and disabled adults.²⁶

Medicaid, with its emphasis on early and periodic screening, diagnosis and treatment (EPSDT) services, is a comprehensive benefit package that includes well baby care, immunizations, sick care, management of chronic conditions, and a full range of preventive health services such as hearing, vision, developmental, and oral health screening. While there is some variability

among the states, mental health care is also generally included, as are services that improve access, such as subsidized transportation services. These preventive services are integral to the gold standard of pediatric care, the “medical home” model which also emphasizes comprehensive and continuous care. Timely access to care, economically facilitated with health insurance coverage, is integral to the model.²⁷

The cost of Medicaid care for children is no more than \$1,700 per child per year, while that of others covered by Medicaid exceeds \$10,000 per year. Even though EPSDT standards are not met by all commercial insurance plans, the Medicaid annual cost per child is lower than the average for private plans.²⁸ It is through this emphasis on prevention that we find the greatest return on every dollar invested in health care.

To choose an example, we can focus on obesity. The excess cost of health care for obese adults is attributed to obesity-related conditions that could have potentially been prevented: acquired (type 2) diabetes, heart disease, and hypertension. As obesity has increased, so has the total cost attributable to obesity, in billions of dollars.²⁹ The average annual cost of health care for obese adults is \$732 higher than for non-obese adults, in part because of increased risk of type 2 diabetes—the typical costs of caring for patients at risk of diabetes is nearly double that of patients with no risk of diabetes.^{30 31} Preventing obesity is a public health recommendation of the Centers for Disease Control and Prevention, with a central preventive role ascribed to such simple lifestyle changes as improving nutrition and increasing physical activity.³² Integrating guidance about these points in pediatric primary care and monitoring weight status at check-ups could, together, save billions of dollars in later health care expenditures.

For children, the most common chronic condition to be managed in primary care is asthma. There are multiple studies documenting the savings attributable to reduced emergency department visits and hospitalization for asthma that can be achieved by implementing best-practice asthma guidelines in pediatric primary care. Conversely, children who do not have access to quality asthma management in primary care show more symptoms and higher emergency department use (which is associated with higher health care expenditures).³³ Children’s Health Fund data show that the savings attributable to providing this higher level of

asthma care exceed the cost by nearly eleven to one. The savings per child with asthma exceed \$4,000 per year.³⁴

Expanding health insurance to cover more children is an essential component of achieving these savings. Evidence from a congressionally-mandated evaluation of the CHIP program shows that providing more children with health insurance coverage improves better health care access and receipt of care for acute and chronic conditions such as asthma.³⁵ **Although the time interval between providing care and achieving benefits varies in these examples, it is always a feature of funding prevention that we pay more now to save a lot more later.**

In the case of obesity prevention, the savings are likely to be deferred by decades. Planning to reduce the overall cost of health care in the U.S. must take these long-term savings into account, but this has not been the case in the current debates about health care reform. **Because the Congressional Budget Office does not account for long-term savings in its “scoring” of the cost of health legislation (not looking beyond a 10-year window), the true value of savings attributable to preventive health care is underestimated.**³⁶ While this case has convincingly been made with reference to type 2 diabetes, it applies more generally to pediatric care, where quality health care services in infancy and early childhood, including vaccinations, may pay off with a lifetime of improved health and lower health care costs.

INSURANCE IS NOT ENOUGH

Adequate, affordable health insurance is a necessary component of financial access to health care. There are, however, other barriers to care that affect low-income children. Especially in rural communities, there is a serious shortage of primary care doctors and nurses. The distance to travel to get to a provider is often prohibitive, and transportation emerges as a barrier to child health access.³⁷ In all but nine states, more than 10% of the population lives in an area with too few health professionals. Some states are dramatically more underserved, such as Louisiana, where 34.4% of the population lives in underserved areas, and Mississippi, where 31.9% does.³⁸ Each year as many as 3 million children (4% of U.S. children), regardless of their health insurance status, miss at least one child health care appointment because they do not have transportation.³⁹ Covering all children and eliminating the financial barriers that

keep them from receiving the care they need when they need it is an essential first step to guaranteeing access to health care for all children. However, we also know that as important as it is to reform health insurance, ensuring health access for all children will require additional steps. Other obstacles to care, such as workforce shortages and transportation barriers, affect low-income children and must be addressed.

CHILDREN'S HEALTH FUND RECOMMENDATIONS:

HEALTH REFORM THAT MEETS THE NEEDS OF CHILDREN

CHF supports health care reform that will improve the security and stability of health insurance coverage, expand coverage to the uninsured, and ensure access to quality health care for all children. To ensure that the needs of children are met, CHF recommends the following:

- Health care reform must provide universal coverage for all kids
- Health care reform must promote the medical home model of care for children to ensure that all of their health care needs are addressed, from primary preventive care to specialty care.
- Health care reform must include safeguards to protect children who currently rely on CHIP for health insurance coverage. If there is no comparable cost-sharing and benefits in plans offered through the proposed health insurance exchange mechanism, CHIP should remain an option for low income working families after 2013.
- Health care reform must ensure that poor and low-income families can truly afford insurance by establishing premium assistance for the purchase of health insurance on the exchange and protecting children from bare bones coverage plans.

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