

Issue Brief

Children's Health: The Connections between the Economy, Coverage, and Healthy Kids

Maine, like the most of the other forty-nine states, is caught in a conundrum. For the past decade state policymakers have worked in a bipartisan manner to extend health insurance coverage to young Mainers, but the economic recession that commenced in late 2007 is creating new pressure on both private and public health insurance coverage. This policy brief brings into relief the basic connections between the national economy, private and public insurance coverage for children, and the benefits of covering children and the issues that emerge when children's health insurance coverage becomes sporadic as often happens during times of economic distress.

Maine's Children and Health Policy

Maine has sustained and expanded its commitment to health care during the last decade, but this commitment does not come cheaply and it is under pressure as both private insurance and public resources contract. Despite a relatively modest median family income, Maine's child poverty rate is six percentage points lower than the national average of 23%. Despite this relatively good economic profile, a slightly larger proportion of children in Maine, 31%, are enrolled in Maine's Medicaid program, MaineCare, which is the federal-state program serving low income children and adults, compared to a national average of 28%.

Because of the coverage provided by MaineCare and through employer based coverage, only 6% of Maine children lack health insurance coverage. Nationally, 11% of children are without insurance coverage. This coverage helps families access preventive, dental, and screening health services in a timely manner

that improves public health and saves public and private resources over time.

The Last Ten Years: Bipartisan Commitment to Covering Kids

The 1997 Balanced Budget Agreement between President Clinton and Congressional Republicans created the State Children's Health Insurance Program (SCHIP), which represented the largest federal initiative to extend health insurance coverage since Medicaid's passage in 1965. SCHIP became the foundation for a prolonged and successful bipartisan effort to reduce the number of uninsured children, particularly children whose families had incomes below 200% of the federal poverty line (the 2008 federal poverty line is \$21,200 for a family of four). Over the next ten years, the percentage of children from families with incomes below 200% of the federal poverty line who lacked health insurance declined from 23% in 1997 to 14% by 2005. Nearly one-third of children from low and moderate income families became covered (Dubay, Guyer, et al. 2007). Figure 1 shows the progress that states made for low and moderate income families in comparison to upper-middle and higher income families, for whom uninsurance rates have remained nearly constant at 5% (Vistnes and Schone, 2008).

A closer look at the data about health policy and insurance coverage reveals that much of the progress in providing health coverage to children derived nearly equally from the State Children's Health Insurance Program and increased enrollment in Medicaid. During its first four years of enrollment, SCHIP enrollment grew briskly to 4.6 million children out of approximately ten to eleven million eligible

Fast Facts

- Because of its support for MaineCare and other outreach efforts, only 6% of Maine children lack health insurance coverage compared to a national average of 11%.
- Seventeen percent of children without insurance coverage delay seeking treatment compared to only 3% of children on Medicaid or SCHIP.
- A 1% increase in the unemployment rate leads to a 1 million person increase in Medicaid enrollment, 1.1 million people losing their health insurance, and \$3.4 billion in increased Medicaid and SCHIP spending.
- Studies in California and Kansas have demonstrated that children enrolled in SCHIP miss fewer days of school, are more attentive, and are significantly more likely to keep up with school assignments than children who lack coverage.

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children. Enrollment growth then tapered off, and enrollment reached six million by 2003.

Parallel to SCHIP growth, Medicaid has experienced substantial enrollment increases during the 2000s. Ten years ago, Medicaid enrolled 20.7 million children. That enrollment has grown steadily throughout the last decade. By 2008, 28.3 million children were enrolled in Medicaid. The most recent monthly data from 2007 indicate that 121,000 Maine children were enrolled in Medicaid, and children comprise approximately 40% of MaineCare enrollees. Approximately 13,000 Maine children are in MaineCare via SCHIP funding.

The largest challenge currently facing state legislators and governors stems from the increasing cost of public insurance coverage coupled with the increasing demand for enrollment as the economy contracts. Based upon a 2008 study by the non-partisan Kaiser Commission on Medicaid and the Uninsured, every one percent increase in the national unemployment rate increases enrollment in Medicaid and SCHIP by approximately one million children, the number of uninsured Americans rises by approximately 1.1 million people, and state costs for Medicaid and SCHIP spending rise by \$1.4 billion. Figure 2 presents these figures.

Children's Coverage and Children's Health Services

As enrollment grows in both Medicaid and SCHIP nationally, and in MaineCare locally, legislators are likely to focus on the efficacy and cost-effectiveness of sustaining or expanding enrollment. Recent studies have indicated that overall children enrolled in public health insurance programs are nearly as likely as privately insured children and much more likely than uninsured children to receive adequate medical care in a timely manner and they perform better in school (Sommers, Dubay, et al, 2007).

By 2005, the Centers for Disease Control estimated that only 3% of children enrolled in Medicaid did not have a usual and reliable source of health care such as a family physician or locally-based clinic. In contrast, 28% of uninsured children had no usual source of health care (Lu, Lin, and Broaddus, 2007). The relatively low proportion of Medicaid and SCHIP children with a regular health care provider represents significant progress toward involving physicians and community providers in these programs. Over the last fifteen years the proportion of children on Medicaid without a regular health care provider has fallen from nine to 3%.

In terms of using physician services, 92% of children on Medicaid and SCHIP had one or more visits with a doctor or health professional (such as a physical therapist or physician's assistant), compared to only 74% of uninsured children. With respect to preventive care, three-quarters of Medicaid and SCHIP children had one or more well-baby or well-child visits during 2005. Less than half of uninsured children have well-child visits with a physician. Overall, children who are enrolled in Medicaid and SCHIP on a year-round basis are twice as likely

as children with sporadic or intermittent insurance coverage to have a preventive or well-child health visit, and continually enrolled children are five times as likely as uninsured children to have preventive care (2005 National Health Interview Survey). Whereas 17% of uninsured children's parents reported delaying their children's medical care due to cost, only 3% of Medicaid and SCHIP children's parents reported having to do so.

In terms of cost effectiveness, efforts by policymakers to engage regular health services have generated some success. Although publicly insured children remain more likely than privately insured children to use emergency room services, rates of emergency room use by publicly insured children have fallen over the last decade. Thirteen percent of Medicaid & SCHIP enrolled children experienced two or more emergency room visits in 1997, but only 10% of this same group had two or more emergency room visits in 2005 (2005 National Health Interview Survey).

During the early 2000s, policymakers began to attend to and many states offered expanded dental care for children. Studies had demonstrated that lack of appropriate dental care had both short and long term costs. Although use of dental services by publicly insured children is less than their use of medical services, public coverage facilitates appropriate dental care. The CDC estimates that 9% of publicly insured children, compared to 23% of uninsured children and 4% of privately insured children, had unmet dental needs during 2005, the latest year for which reliable data are available (CDC, 2006). Similar to physician well-child care, children who have been continuously enrolled in Medicaid or SCHIP are more than twice as likely as intermittently covered children and more than five times as likely as uninsured children to have visited a dentist within the past year.

Creating Healthy Children

In evaluating children's health and its relationship to enrollment in Medicaid and SCHIP a note of caution is in order. Table 1 shows children's health status by type of insurance coverage. As the table indicates, five percent of children on Medicaid or SCHIP report fair or poor health compared to three percent of uninsured children and one percent of privately insured children. In contrast, 70% of publicly insured children report excellent or very good health compared to 77% of uninsured children and 88% of privately insured children. At first glance, these data may indicate that public coverage is not producing better health outcomes, but some of the differences in program enrollment are driven by health status itself. Parents whose children have chronic or threatening conditions are more likely to apply for and enroll in public programs that will provide them access to needed health services.

An over-time or longitudinal perspective better informs our understanding of the roles of Medicaid and SCHIP. Among children who have enrolled in these programs within the last twelve months, 24% report improved health status, and this proportion differs significantly from the 18% of uninsured and 18% of privately insured children who report improved health status over a twelve month period. With respect to cost

effectiveness, a survey of SCHIP children in New York state estimated that eleven percent of children were hospitalized for asthma in the year prior to their enrollment in SCHIP. After one year in SCHIP, only three percent of children were hospitalized for asthma (Szilyagi, et al., 2006).

Perhaps the best news for policymakers can be found in evaluations of the effects of Medicaid and SCHIP enrollment on school performance. Studies in California and Kansas have demonstrated that children enrolled in SCHIP performed better and missed fewer days of school due to illness after having been enrolled in SCHIP for one year. In the California study, SCHIP students improved their ratings for paying attention in class by more than two-thirds, and the proportion of SCHIP student who could keep up with school activities improved from thirty-six percent to sixty-one percent over the course of one year.

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Figure 1

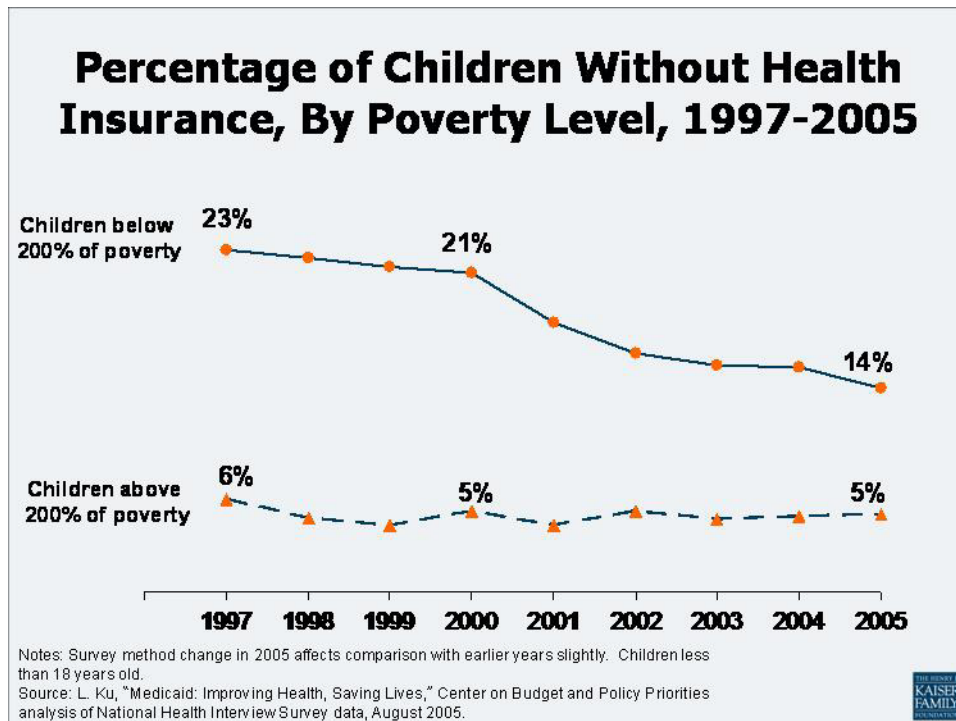


Figure 2

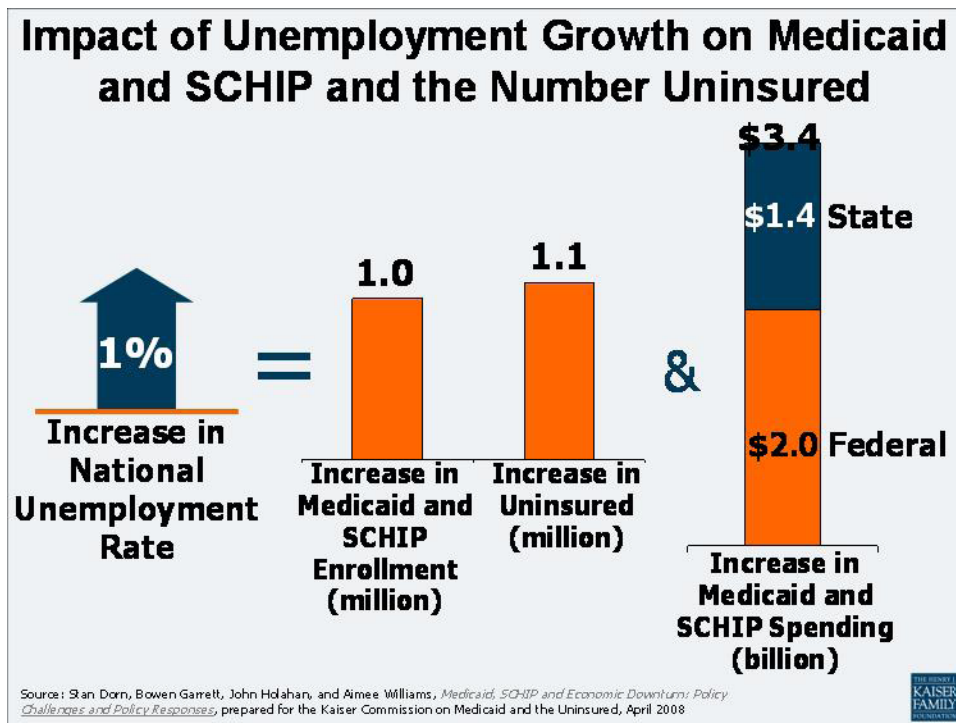


Table 1: Health Status of Children, by Insurance Type

Health Status	Medicaid/SCHIP	Uninsured	Privately Insured
Excellent	41%	47%	61%
Very Good	29%	30%	27%
Good	25%	21%	11%
Fair/Poor	5%	3%	1%

Source: CDC, 2006, Analysis of 2005 National Health Interview Survey.