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COVERING ALL KIDS

Expanding Children's Health Insurance Coverage is a Wise Investment in Oklahoma's Future

By Cindy Decker, Ph.D.

KEY FINDINGS:

•Children with health insurance are more likely to receive early, preventive health care, less likely to visit emergency rooms or be hospitalized, less likely to be absent from school, and more likely to perform better academically.

•In Oklahoma, currently about 130,000 children, or 15 per cent, have no health insurance, the 6th highest rate in the nation.

•Expanding eligibility for publicly-supported health insurance to children in families with incomes between 185% and 300% of poverty would provide cost-efficient support for working families.

EXECUTIVE SUMMARY

Expanding access to health insurance for Oklahoma's children would have significant, far-reaching impacts that benefit all Oklahomans. Children with health insurance are more likely to receive early, preventive health care, less likely to visit emergency rooms or be hospitalized, less likely to be absent from school, and more likely to perform better academically. Expanding health insurance coverage also lowers the expense of uncompensated care for health care providers, which in turn reduces health insurance costs for all consumers. For all these reasons, many policymakers and health advocates are promoting the expansion of children's health coverage as a wise and effective policy priority.

In Oklahoma, currently about 130,000 children, or 15 percent, have no health insurance. Oklahoma has the nation's sixth highest percentage of uninsured children. Lack of health insurance disproportionately affects low- and moderate-income children living in working families. Although families with income less than 185 percent of the official federal poverty level ($37,000 for a family of four) are eligible for care through Medicaid, families earning just a little more, between $37,000 and $60,000 (300 percent of the federal poverty level) are less likely to have access to insurance. Many are not offered employer-sponsored coverage, or are unable to afford their share of its cost when it is available.

The Oklahoma State Legislature is considering the "All Kids Act", which would extend eligibility for state-administered health care, or provide a subsidy toward the cost of privately sponsored health insurance, to children with family income between 185 percent and 300 percent of the federal poverty level. The bill passed the Senate in early March 2007 and is waiting to be considered by the House. Expanding health insurance coverage for children through public assistance is a cost-effective approach for Oklahoma since the federal government contributes up to $3.48 for every $1 state dollar spent on health care costs for eligible children. In addition, health expenditures per child are lower for public programs than for children insured through private insurance.

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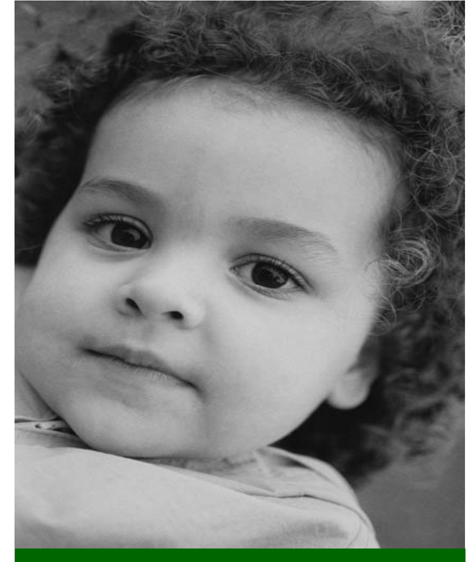
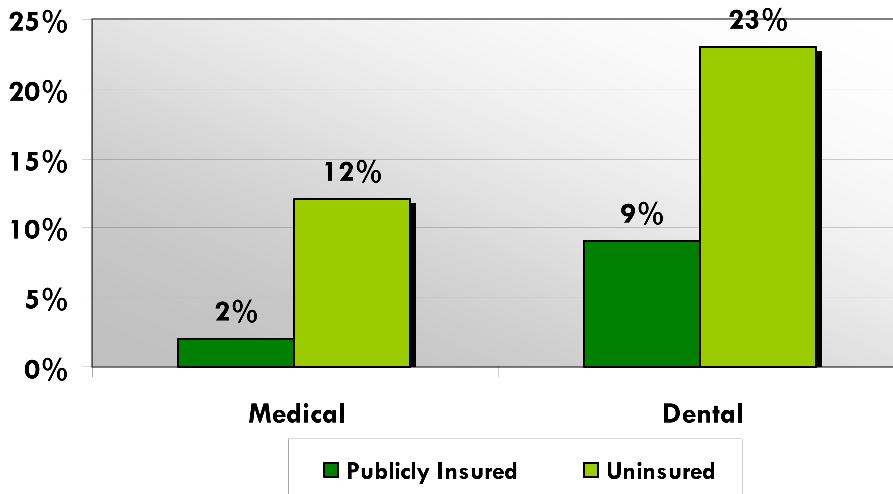
I. Oklahoma's Health Insurance Crisis

Nearly 20 percent of Oklahomans do not have health insurance, putting Oklahoma at the forefront of a national issue. Many of the uninsured are low-wage workers whose incomes disqualify them for public programs such as Medicaid, and who lack access to affordable employer-sponsored private health insurance.

Between 2000 and 2006, the cost for annual family health insurance premiums in Oklahoma rose by 65 percent for employers and by 58 percent for employees. Meanwhile, median earnings grew by only 13 percent.[1] The enormous premium increases are leading to hard decisions for employees and employers alike. Employers who are trying to manage costs have several choices: cover a smaller share of the premiums, increase eligibility requirements, hire contract or part-time workers who are not eligible for benefits, reduce benefits, or drop coverage. Employees, in turn, are choosing to reduce benefits to save on premiums or to drop coverage and face the financial risk of being uninsured. One indication of the heightened risk is that the number of bankruptcies due to medical reasons is 23 times this number in 1981, with about half of all personal bankruptcy filings attributable to either illness or medical bills.[2]

The share of employees covered by employer-sponsored insurance dropped from 82 percent in 2001 to 77 percent in 2005. This decrease has not been offset by a corresponding increase in Medicaid and non-employer based private plans. Almost half of the drop is the result of employers, particularly smaller firms, choosing not to continue health insurance, while one-fourth of the drop is attributed to employees choosing not to continue receiving benefits.[3]





Source: *"Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP" by Leighton Ku, Mark Lin, and Mathew Broaddus, Center on Budget and Policy Priorities, January 2007.*

II. States Take Action

Faced with the growing ranks of the uninsured and an absence of federal action to address the problem, a number of states have stepped forward with innovative proposals. Four states – Connecticut, Illinois, Pennsylvania, and Tennessee – have adopted universal access to coverage for children. All four states make comprehensive health insurance available to all children under 19, although they do not require that children obtain it. None of the programs has pre-existing condition exclusions or an income eligibility requirement, but they do assess monthly premiums and co-pays that increase with income. An additional three states have passed legislation aimed at providing access to insurance for all citizens in their state. Many more states are considering universal health care bills or have commissioned studies to look at the possibilities for such a system.[4] In addition to these efforts, states have had a variety of programs to expand eligibility, and states have

made a number of efforts to increase enrollment, often focusing on outreach and simplifying enrollment.[5]

In early March 2007, the Oklahoma Senate passed SB 424, the "All Kids Act", with bipartisan support. This bill would make a state-administered health care benefit, or a subsidy toward the cost of privately sponsored health insurance, available to children whose family incomes are between 185 percent and 300 percent of the federal poverty level. (For a family of four, that would mean annual income between $37,000 and $60,000.) Unlike Medicaid, which charges no premiums and has only token cost-sharing, the families of children enrolled in the state-administered health benefit program would contribute to the cost of care on a sliding-scale based on family income. This bill is waiting to be considered by the House.

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III. Benefits of Insuring More Children

While children make up only one segment of the overall uninsured population, many policymakers and health advocates have promoted the expansion of children's health coverage as a wise and effective policy priority. The benefits of insuring more children include the following:

Improve Children's Health Care Access and Health: Many studies have shown that children who are insured have better access to health care and are more likely to have seen a physician when compared to children without health insurance.[6] Insured children have fewer unmet needs for medical and dental care and for prescription drugs, and are less likely to have health problems when compared to uninsured children.[7] As shown in Figure 1 (see p. 2), national data show that children insured through a public insurance program are one-sixth as likely to have unmet medical needs and less than one-half as likely to have unmet dental needs. Other research indicates that improved child health may lead to better health when these children are adults.[8] Additionally, health coverage for children reduces the large financial risk that an uninsured child places on families.

Improve Attendance and Educational Performance: Expanding health insurance for children would improve

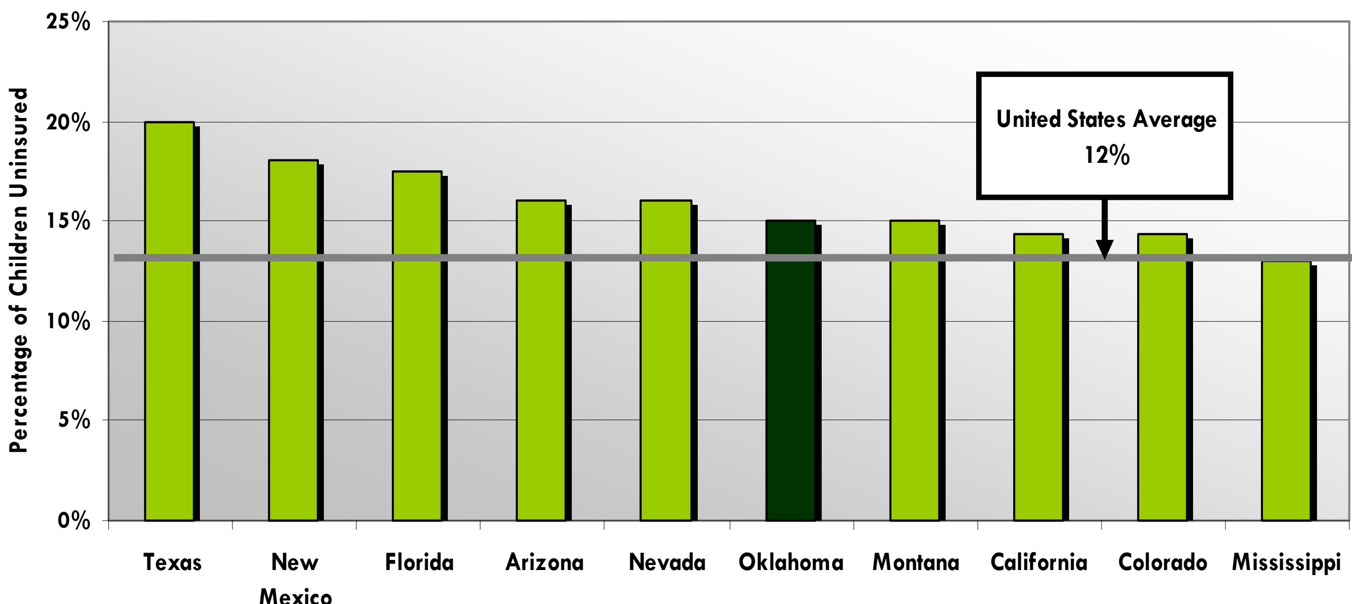
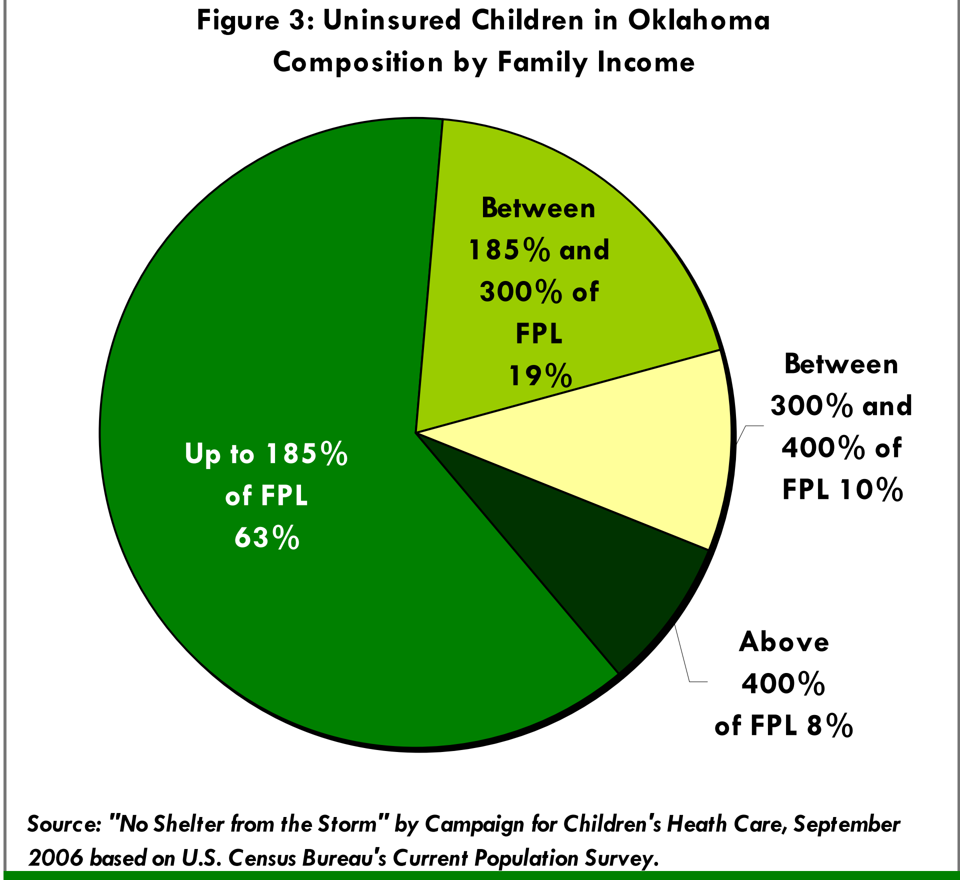


Figure 2: Percent of Children Uninsured, 2004-2005
Ten States with Highest Percentages

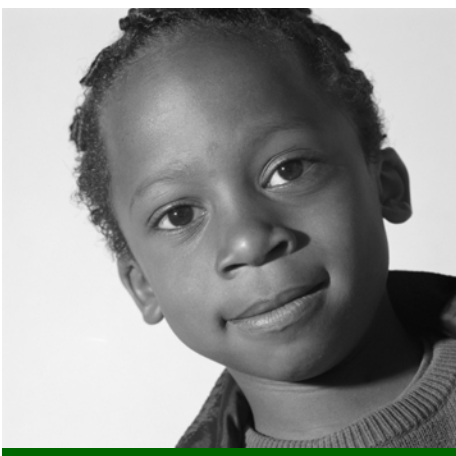
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

children's development and educational performance, because children in good health are less likely to miss school and are more able to concentrate on their studies. Since the opening of the on-site Bedlam school clinics in Tulsa, for example, student attendance has reportedly increased 30 percent, student mobility has decreased 30 percent, and test scores have dramatically increased. (See text box on p. 6.)[9] A study in Kansas found that children were absent less frequently after they obtained health insurance. In California, parents reported that their children's school performance improved after obtaining coverage for a year.[10] When children are in school and healthy, teachers spend less time reviewing material already covered. Expanding health insurance coverage would therefore have educational benefits for all students.

Decrease Costs for Health Providers: Insuring more children would not only improve children's health but would also help health providers. Uninsured families are unable to pay for roughly two-thirds of the total cost of the health care services they receive.[11] Consequently, the lack of coverage for children places costs on health providers. Health providers are reimbursed for some of these costs, but hospitals, doctors, and clinics are still left providing a large amount of care that is not paid for by the uninsured, the government, or any other public or private insurance source. Therefore, increasing the number of children who are insured would decrease the costs to health providers.



Source: "No Shelter from the Storm" by Campaign for Children's Heath Care, September 2006 based on U.S. Census Bureau's Current Population Survey.



Decrease private health insurance premiums: Because the uninsured are not able to pay the entire cost of the health care services they receive, many providers attempt to recover their unpaid care costs by negotiating higher rates for health care services paid for by private insurance. As a result, premiums for private health insurance increase. *Indeed, Families USA estimates that premiums for both individuals and families in Oklahoma are 15 percent higher due to the cost of health care for the uninsured.*[12] While this estimate is of the impact from all uninsured and not just children, it still suggests how the lack of coverage for children has adverse impacts on the insured.

IV. Uninsured Children in Oklahoma

Roughly 130,000 children in Oklahoma, or 15 percent of the population under age 18, lack health insurance at some point during the year.[13] This percentage is higher than the national average and, as shown in Figure 2 (see p. 3), places Oklahoma as the state with the sixth highest rate of uninsured children. Oklahoma clearly has a health insurance gap.

Over 80 percent of all uninsured children are in families with income at or below 300 percent of the federal poverty level, while 8 percent are in families with income

above 400 percent of this level, as shown in Figure 3.[14] Even though uninsured children tend to live in poorer families, they also tend to live in families with a worker. Nearly 90 percent of Oklahoma's uninsured children are estimated to have at least one family member that works full- or part-time.[15] Nationwide, nearly 70 percent of uninsured children live in households in which the family head works *full-time* all year.[16]

To decrease the number of uninsured children, a state program should increase the access to coverage for children in families who are not currently eligible for Medicaid, yet find employer-sponsored coverage either unavailable or unaffordable. Families with incomes between 185 percent and 300 percent of the federal poverty level, which translates to roughly $37,000 to $60,000 for a family of four, may find it disproportionately more difficult to provide health insurance coverage for their children than families with incomes below or above this amount. Children from families in this income range are not currently eligible for Medicaid, and they are less likely to be offered health insurance by their employer than workers with families earning 300 percent or more of the federal poverty level – a difference that has been widening over time. The families also are less likely to be able to afford health insurance if it is offered. Nationwide, only 69.6 percent of working adults with children and income between 200 percent and 400 percent of the federal poverty level were offered employer-sponsored insurance in 2005, down from 73.4 percent in 1997. By contrast, for

working adults with children and incomes *above* 400 percent of the federal poverty level, 78.1 percent were offered employer-sponsored coverage in 2005, down slightly from 79.6 percent in 1997.[17]

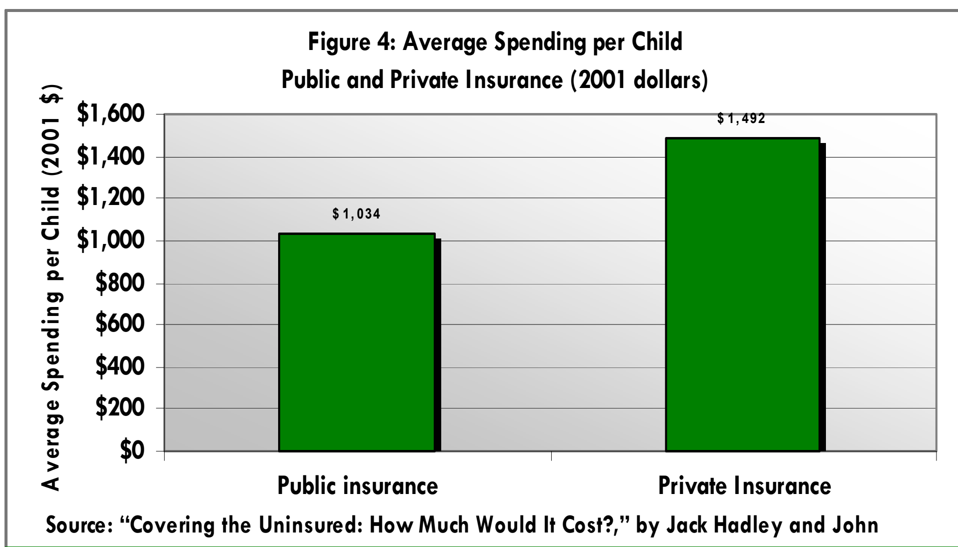
A state program should also continue and increase efforts to enroll children who are already eligible for Medicaid, given that a large portion of uninsured children are, in fact, eligible. Oklahoma has increased its outreach and simplified enrollment in recent years, which have increased the enrollment of children by 84 percent from 2000 to 2006.[18] Still, more could be done.

V. Offering Benefits through a State-Administered Program is a Cost-Effective Approach

Medicaid serves as America's main safety net health insurer, providing health care for millions of Americans who lack affordable access to employer-sponsored insurance, such as very low-income seniors, adults, children, and people with disabilities. In Oklahoma, children with family income up to 185 percent of the federal poverty level are eligible for Medicaid. Children with family income between 135 percent and 185 percent of the federal poverty level became eligible in 1997 with Congressional passage of the State Children's Health Insurance Program (SCHIP) and are considered Medicaid enrollees under SCHIP. Oklahoma has the option of increasing the eligibility limit for children enrolled under SCHIP.

Expanding children's health insurance coverage through SCHIP is a cost-effective method for three primary reasons:

- The federal government matches state spending on SCHIP on a $3.48 to $1 basis;
- Average health care expenditures per child for public programs are lower than for private insurance, even though Medicaid and SCHIP tend to offer a more comprehensive benefit structure; and



Source: "Covering the Uninsured: How Much Would It Cost?," by Jack Hadley and John

- SCHIP can be designed in several ways to minimize the temptation to drop private insurance for public insurance. These include allowing for appropriate levels of cost sharing for higher-income recipients.

In Oklahoma in FY 2007, the federal government pays 68.1 percent of the Medicaid health care expenditures of children with family income up to 135 percent of the Federal Poverty Level and pays 77.7 percent of the health care expenditures of children enrolled under SCHIP. This means that for every $1 that Oklahoma expends on health care costs for a child covered under SCHIP, the federal government contributes a $3.48 match. These rates are adjusted each year based on the state's per capita income. The federal government caps the amount of spending on children with family income above 135 percent of the Federal Poverty Level. Oklahoma, however, has not reached this cap.

Public insurance for children has proven less expensive than private insurance. Spending per child is estimated to be $1,043 (in 2001 dollars) for children enrolled in a public program and $1,492 for children with private insurance, as depicted in Figure 4.[19] This is true even though benefits under public programs are at least as comprehensive as the commercial insurance market, if not much more, and tend to have lower cost-sharing requirements.[20]

While traditional Medicaid prohibits charging monthly premiums or co-payments for children, as befits a program serving the lowest-income families, the SCHIP program allows states to require participants to share in the cost of insurance. In most cases, family contributions are capped at five percent of family income. Cost-sharing serves to limit the public cost of the program and also limits the temptation to drop private insurance for public programs. States can also adopt other measures to minimize the ability to drop employer coverage to enroll in a public program, referred to as "crowd out." For example, programs can require that the child applicant has been uninsured for a certain time period such as six months. Many families would not risk having their children uninsured for this length of time in order to qualify for a public program. Research supports this. A recent study published in *Health Affairs* examined SCHIP enrollees across ten states and found that relatively few children enrolled in SCHIP could have retained private coverage.[21] Further, state studies in Florida and Minnesota both found that "crowd out" was not a significant problem.[22]

Tulsa School-Based Health Clinics Improve Attendance and Test Scores and Decrease Mobility

Since 2003, clinics on the site of nine public schools and two Head Start sites have opened in Tulsa, Union, and Sand Springs in order to better serve the students in greatest need of health care access. These free clinics provide basic primary care, including immunizations and well-child checkups, plus services such as family counseling, health literacy, and mental health. At a few clinics, this care is also provided to the family members of the students. Most of the children served are either uninsured or enrolled in Medicaid.

Superintendents, principals, and teachers are reporting that the clinics have created a sense of community at the schools and that student mobility has decreased, attendance and academic achievement have increased, and the relationship between the school and the parent have improved. The statistics support these observations. Standardized test scores are reported to have increased 10 points on average. Attendance rates have increased 30 percent and student mobility has decreased 30 percent.[23]

The school-based clinics are operated by the Bedlam Alliance for Community Health, which is an innovative collaboration between the University of Oklahoma and the community. Services are provided by 250 volunteer health care professionals and students from several colleges of the OU-Tulsa campus, with financial support provided from local philanthropy. The Alliance also operates clinics at one public housing community and three walk-in clinics. In 2007, there are plans to open four additional public school-based clinics, two Head Start clinics, a second public housing clinic, and a mobile clinic.

Endnotes

[1]"Premiums Versus Paychecks: A Growing Burden for Oklahoma's Workers," Families USA, November 2006.

[2]"Illness and Injury as Contributors to Bankruptcy," David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, Health Affairs, February 2, 2005.

[3]"Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001-2005," Lisa Clemens-Cope and Bowen Garrett, Kaiser Commission on Medicaid and the Uninsured, December 2006.

[4]The city of San Francisco passed legislation for universal coverage of adults. The Governor of Oregon proposed insuring all children in March 2006. Hawaii has had near-universal access since 1974 with a law requiring employers to offer coverage for employees working 20 or more hours per week.

[5]See "Enrolling Eligible Children and Keeping Them Enrolled" by Donna Cohen Ross and Ian Hill, *Future of Children*, 2003.

[6]For an excellent summary of current knowledge on children and their health insurance coverage, see "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP" by Leighton Ku, Mark Lin, and Matthew Broaddus, Center on Budget and Policy Priorities, January 2007.

[7]See "Health insurance and access to primary care for children" by P.W. Newacheck, J.J. Stoddard, D.C. Hughes and M. Pearl, *New England Journal of Medicine*, 1998; "Health care access and use among low-income children" by L. Dubay and G.M. Kenney, Health Affairs, 2001; "The Role of Medicaid in Ensuring Children's Access to Care" by P.W. Newacheck, M. Pearl, D.C. Hughes and N. Halfon, *Journal of the American Medical Association*, 1998; "Effect of child health insurance plan enrollment on the utilization of health care services by children using a public safety net system" by S. Eisert and P. Gabow, *Pediatrics*, 2002.

[8]"The Lasting Impact of Childhood Health and Circumstance," by A. Case, A. Fertig, and C. Paxson, *Journal of Health Economics*, January 2005.

[9]http://tulsa.ou.edu/medicine/bedlam/statistics.htm, "Thinking long-term" by Janet Pearson, Tulsa World, October 16, 2005; "Readers Forum: Health care at schools keeping students in class", Daniel Duffy, Tulsa World, September 17, 2006.

[10]"Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP" by Leighton Ku, Mark Lin, and Matthew Broaddus, Center on Budget and Policy Priorities, January 2007.

[11]See "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?," Kaiser Commission on Medicaid and the Uninsured, Pub # 7084, May 2004. For the nation, the cost of unpaid care was estimated to be $5.4 billion for uninsured children in 2004.

[12]"Paying a Premium: The Increased Cost of Care for the Uninsured," Families USA, June 8, 2005.

[13]Data come from www.statehealthfacts.org. Other estimates are available at U.S. Census Bureau (100,000 in 2005 and 144,000 in 2004) and http://www.childrenshealthcampaign.org/tools/state-fact-sheets/OK-uninsured-kids.pdf (146,000 on average over 2003-05) and in "Supplemental Analysis of the 2004 Oklahoma Health Care Insurance and Access Survey" (119,000 in 2004). Estimates from these sources vary slightly due to data source and methodology. One methodological difference is whether children are defined as under 18 years of age or under 19 years of age.

[14]These percentages are calculated using the percentages published in "No Shelter from the Storm," Campaign for Children's Health Care and the number of Oklahomans at varying income levels as a ratio of poverty available in Table B17002, American Community Survey 2005, U.S. Census Bureau.

[15]"No Shelter from the Storm," Campaign for Children's Health Care.

[16]EBRI Issue Brief, October 2006, Figure 26
.

[17]"Whose Kids are Covered?," prepared by the Robert Woods Johnson Foundation by the State Health Access Data Assistance Center, University of Minnesota, March 2007.

[18]OHCA's State Fiscal Year reports at http://www.ohca.state.ok.us/research.aspx?id=84.

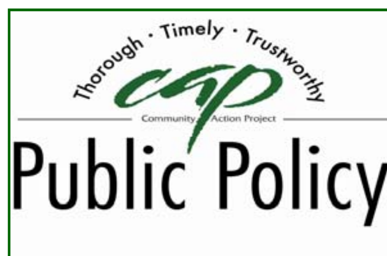
[19]"Covering the Uninsured: How Much Would It Cost?," by Jack Hadley and John Holahan, *Health Affairs*, June 2003.

[20]"State Children's Health Insurance Program (SCHIP) at a Glance," Kaiser Commission on Medicaid and the Uninsured, January 2007.

[21]"Substitution of SCHIP For Private Coverage: Results From a 2002 Evaluation in Ten States," by Anna Sommers, Stephen Zuckerman, Lisa Dubay, and Genevieve Kenney, Health Affairs, volume 26, number 2.

[22]http://www.familiesusa.org/resources/publications/fact-sheets/what-is-crowd-out.html .

[23]http://tulsa.ou.edu/medicine/bedlam/statistics.htm.



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