Research Brief

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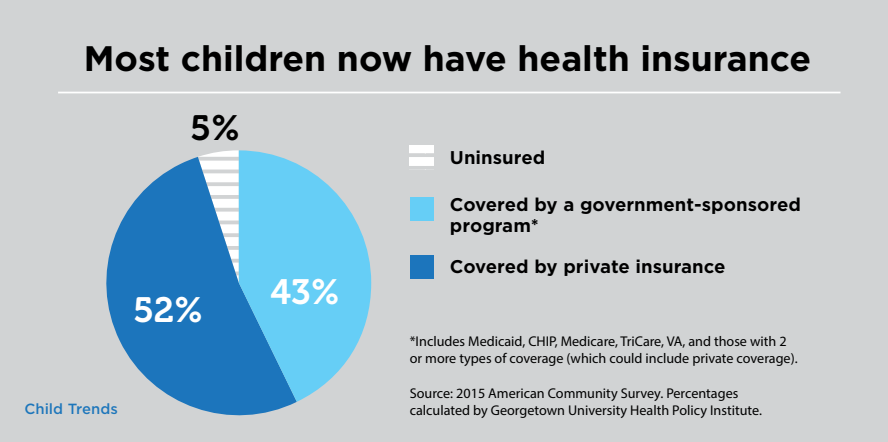
Health Insurance Coverage Improves Child Well-Being

David Murphey, PhD



When children have health insurance, they are more likely than uninsured children to be healthy and to get medical care. They are also more likely to have improved outcomes related to education and economic security that benefit society as a whole.

One remarkable social achievement in recent decades has been the expansion of health insurance coverage for U.S. children. The coverage rate for this group was 95 percent in 2015,[1] an all-time high. Coverage for Latino children (whose rates have historically lagged behind those of white or black children) reached a record high as well—93 percent in 2015.[2]

While the majority of U.S. children (52 percent, as of 2015) are covered by private insurance plans, 43 percent—primarily those in low-income families—are covered by government-sponsored programs, the largest of which are Medicaid and the Children's Health Insurance Program (CHIP).[3] (For state-level breakdowns, see the map on page 2, and the appendix) Medicaid care for children is a relative bargain: per-child costs are about three quarters of what they are for non-disabled adults.[4] In fact, children comprise about 40 percent of the Medicaid population, but account for less than one fifth of all Medicaid expenditures.[5]

Children with health insurance are more likely than those who are not covered to receive early care for health problems, and they are at lower risk for hospitalization.[6] However, insurance coverage by itself does not guarantee that children will receive appropriate and timely care. Based on their knowledge and attitudes, families make decisions about when and from where to seek formal care for their children. Multiple barriers may inhibit access to care, including time constraints, out-of-pocket costs, possible lost wages, transportation availability, the supply of providers who accept a child's insurance plan, and actual or perceived prejudice (on the basis of race/ethnicity or income, for example).[7]

There is growing evidence that when children (particularly those eligible for public health care insurance[a]) have coverage, they are not only more likely to get care[b] but also more likely to have improved outcomes—in health, of course, and in other important areas of life as well.

a More than one third of U.S. children up to age 19 are covered by Medicaid (Georgetown University Health Policy Institute, Center for Children and Families. [2017]. Medicaid's role for children). Public insurance coverage is more often studied than is private coverage, because of difficulty accessing data from private plans.

b A wealth of evidence finds that Medicaid-insured children receive care that, in many respects, is as good (or better) than care received by children with private insurance. (Wagnerman, K. [2017]. Medicaid provides needed access to care for children and families. Georgetown University Health Policy Institute.)

Child Trends
7315 Wisconsin Avenue
Suite 1200 W
Bethesda, MD 20814
Phone 240-223-9200

childtrends.org

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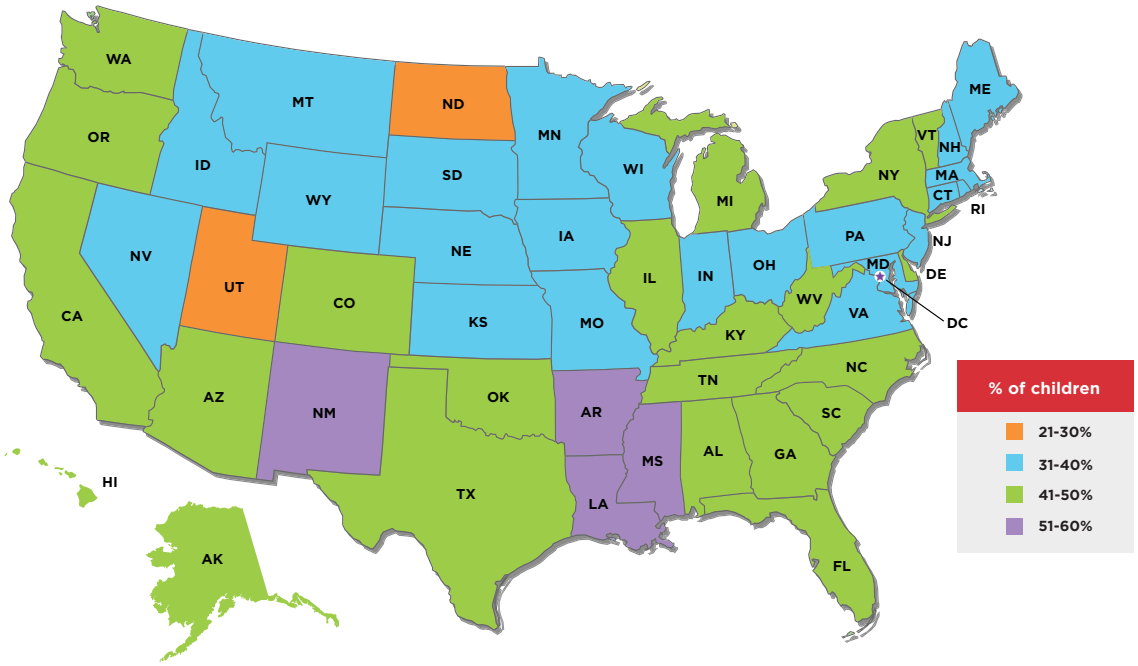
Nearly half of children nationwide rely on government-sponsored health insurance, but that varies dramatically by state:



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Public insurance includes Medicaid, the Children's Health Insurance Program, and smaller government-sponsored programs.
Source: 2015 American Community Survey. Percentages calculated by Georgetown University Health Policy Institute.

THE BENEFITS OF INSURING CHILDREN

The benefits of health insurance to children, highlighted below, were primarily drawn from the findings of "natural experiments"—studies of cohorts of children who became newly eligible for Medicaid under states' expansion programs.[c]

Health outcomes

Health insurance begins benefiting children prenatally and, according to several studies, has positive health effects into adulthood. For instance, in one study, children of mothers who were included in a Medicaid eligibility expansion (which included prenatal as well as post-birth infant care) were followed into adulthood. In early adulthood, they had lower body mass index (BMI) and lower rates of obesity. Those whose coverage began prenatally had fewer preventable hospitalizations and fewer hospitalizations related to endocrine, nutritional, and metabolic diseases, and immune-system disorders.[8] Among black children whose mothers became Medicaid-eligible in pregnancy or during the child's first year, there were lasting improvements in children's oral health.[9]

Medicaid coverage in childhood has been shown to have positive effects on a number of adolescent health outcomes: decreased reports of mental health problems, reduced likelihood of eating disorders, reduced BMI, lower likelihood of risky sexual activity, and less smoking and marijuana and alcohol use.[10] Among black children, Medicaid expansion experienced during their childhood was associated with reduced mortality from preventable causes at ages 15 to 18.[11] Among unmarried, low-income adolescent girls, those who had health insurance coverage were less likely to become teen parents.[12]

c These studies presume that the alternative to children's Medicaid coverage is lack of insurance. These studies provide a conservative estimate of the effects of coverage, because not everyone who is eligible actually takes up coverage. Researchers could not track actual receipt of Medicaid-paid services (or whether children were covered), because people go on and off Medicaid frequently as their circumstances change.

Another study found that Medicaid coverage in early childhood (birth to age 5) was associated with improvements in health from ages 25 to 54. These improved outcomes included lower likelihood of high blood pressure, heart disease/heart attack, adult-onset diabetes, and obesity. Researchers presented evidence for two possible explanations of the connection between Medicaid coverage and the positive outcomes: children used more health care services, and families had reduced medical debt, presumably giving them access to a healthier lifestyle.[13]

Lastly, childhood Medicaid eligibility has been linked with reduced mortality in adulthood,[14] with particularly strong effects for black children.[15]

Educational outcomes

A child's health directly affects his or her ability to learn,[16] and the converse is also true: children who have high-quality learning experiences are more likely to enjoy good health as they grow up.[17] Thus, it is not surprising that research finds many associations between health insurance coverage and academic outcomes.

For example, one study found that children who were born in states that recently expanded Medicaid and CHIP had better reading scores. The researchers linked increases in eligibility with better health status at birth, which in turn was linked with improved academic outcomes.[18]

In another study, an expansion in health insurance for low-income children increased their rate of high school and college completion, probably by contributing to better health in their teen years.[19]

Economic outcomes

Children who are healthier and who have greater educational opportunity are more likely to be economically secure and contribute to their communities (through volunteering and other forms of civic engagement, for example) as adults.[20]

Furthermore, low-income families with children who are covered by Medicaid gain a measure of financial security, and have more to spend on food and housing. In fact, a 2010 analysis determined that Medicaid was the third-largest anti-poverty program, responsible for raising 2 to 3 million people out of poverty.[21] Additional evidence for childhood Medicaid's role in promoting family economic security is provided by studies that find coverage is associated with reduced medical debt and fewer bankruptcies.[22]

According to one recent study, expansions to Medicaid and CHIP were also associated with long-term economic benefits when children reached adulthood. They paid more in taxes and collected less in Earned Income Tax Credit payments. Women (though not men) had higher wages.[23]

In sum, Medicaid for children generates considerable financial returns to society. Several studies have examined its return on investment, including one that found that, for each dollar spent on childhood Medicaid, the government recouped 32 cents in increased income tax payments.[24]

RECOMMENDATIONS

Given the evidence that children's health insurance coverage is associated with multiple benefits that accrue into adulthood, it would be a sound investment to sustain programs that have increased coverage rates, while also addressing remaining barriers and inequities.

1. Maintain and expand government initiatives that have raised rates of coverage among children to record levels.

Initiatives including the Affordable Care Act ("Obamacare," or the ACA), Medicaid expansions, and CHIP, have resulted in unprecedented numbers of children receiving coverage. These gains would be threatened by efforts to repeal their provisions.[25]

2. Address gaps in continuity of coverage.

Government regulators and insurance plans should collaborate in developing policies that ensure children have continuous coverage even as family circumstances change. A similar model has recently been adopted for a family's eligibility for the federal child care subsidy, where states must provide 12-month periods of child care assistance before they reassess eligibility.[26]

When children are not covered at all by health insurance, or when they experience gaps in coverage, they are less likely than those with continuous insurance coverage to have a regular source of health care. They are also more likely than continuously insured children to have their medical care delayed or unmet and to have prescriptions unfilled.[27,28]

Gaps in coverage can be particularly detrimental for children with chronic health conditions (such as asthma) that require frequent, consistent preventive monitoring by health care providers.[29] In 2015, 8 percent of children were uninsured for at least part of the previous 12 months, and 2 percent were uninsured for more than a year.[30]

3. Reduce barriers to essential services.

States should act to reduce barriers to essential children's health services. While rates of insurance coverage for children are at an all-time high, these data can be misleading, for they ignore that significant barriers inhibit access to care even when children have insurance. One recent comprehensive report notes that 50 years after the creation of Medicaid, and approximately 2 decades since the start of CHIP, nearly 30 percent of U.S. children still lack full access to essential health services. These include children who are uninsured or incompletely insured (lacking coverage for some portion of the year), as well as some who have insurance.[31]

Children may have insurance but their families may still have great difficulty accessing essential subspecialty services (for example, dentistry, pediatric cardiology, or endocrinology), particularly in rural areas or other federally designated Health Professional Shortage Areas.[32] States could enact policies that increase access to subspecialty providers, particularly in rural and other underserved areas.

Children who are insured might also miss primary care visits due to challenges of affordability, an insufficient number of providers, transportation problems, parents' work schedules, and cultural and language barriers.[33]

4. Address issues of affordability.

The determination of out-of-pocket costs for families should be fair and consistent across states, so that children have equitable access to essential health care regardless of where they live.

Although many states have streamlined eligibility determination and enrollment systems for children, 30 states charge premiums or enrollment fees to families whose children receive

Medicaid or CHIP coverage, and 25 states require some form of cost-sharing. For example, in Utah, which imposes the greatest cost burden, the poorest families (with incomes below 150 percent of the poverty level) pay premiums and enrollment fees of $300 annually, and cost-sharing of $25 for a routine office visit for a child's sick care.[34]

A related provision of the ACA that should be addressed is known as the "family glitch"; it denies participation in the health insurance marketplace if parents have employer-sponsored health coverage that is "affordable." The problem arises because affordability is determined by the cost of employee-only coverage, not by the cost of a family plan, leaving some moderate-income families with no financially viable option. In addition to its impact on parents, the "family glitch" is estimated to affect nearly half a million U.S. children.[35]

5. Address gaps in health insurance coverage for parents.

Ensuring more parents have adequate health insurance is a logical strategy for improving child well-being. Children's well-being is closely tied to the well-being of their parents.[36] When parents are physically or mentally ill or suffer from substance abuse, or when they experience severe financial strain, children are affected—sometimes to the point of developing chronic symptoms associated with toxic stress.[37] Parents facing these conditions may be unable to focus on getting their children needed care.

In addition, when health coverage eligibility is expanded and more parents gain insurance, they tend to insure their children as well.[38] The ACA offers incentives to states that expand Medicaid eligibility to cover poor uninsured adults (including those who are parents). However, as of January, 2017, 19 states had still not done so, claiming it would jeopardize future state budgets. In these states, low-income parents are not likely to qualify for Medicaid, nor are they likely to be able to afford insurance in the private marketplace. It is estimated that a quarter-million uninsured children have parents in this situation. Extending coverage to these children will likely continue to be more difficult as long as their parents are ineligible.[39] States that are reluctant to take on a broader Medicaid expansion should be encouraged to at least extend coverage to low-income adults with minor children.

6. Increase outreach to underserved groups.

Specialized outreach efforts may be necessary for underserved groups. Efforts might include innovative mobile phone applications,[d,40] expanded availability of culturally-responsive health navigators,[e,41] and continued efforts to reduce structural and interpersonal racism and other forms of bias within the health care system.[42]

Such efforts would help address disparities in health insurance coverage for Latinos, for example. Rates of coverage for Hispanic children continue to lag behind those of black and white children.[43] Recent research suggests there are multiple reasons for this disparity. A 2015 analysis of Hispanic families found that, even among those with low incomes, 1 in 4 reported they were not aware they could apply for public assistance, including Medicaid.[44] A similar proportion of those families who already receive one or more forms of assistance were not aware they could apply for additional assistance. Many Hispanic immigrant parents, even those with legal permanent resident status, erroneously believe their immigration status makes them ineligible for public assistance. Additional barriers likely include language, literacy, and cultural factors related to seeking care.[45]

Other groups for which rates of insurance are disproportionately low are children in single-parent families[46] and U.S.-citizen children of noncitizen parents.[47]

d Mobile health interventions ("apps") use a variety of strategies (prompts, activity trackers, and so on) to increase awareness of health-related issues and encourage behavior change.

e Health navigators assist individuals or families with eligibility determination, enrollment, identifying health care providers, and coordinating complex care needs, among other things.

7. Strengthen state data systems for health services.

We recommend that states make investments to strengthen their data systems so they can answer basic questions pertaining to equity of access to children's health services as well as the quality of the outcomes associated with that care. One challenge to understanding whether and how children access the care they need is the lack of consistent data within and across public and private insurance payers, as well as across states. The 2009 Children's Health Insurance Program Reauthorization Act created a set of child health measures states could report voluntarily. While most states report at least one measure, reporting is inconsistent.[48]

Evidence shows that, particularly for low-income children, having health insurance is associated with a broad array of positive outcomes. Insurance, by providing an anchor within the health care system, gives children access to vital preventive services, helps protect families' economic security, and pays dividends that last into adulthood.

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We'd love to hear your thoughts on this publication. Has it helped you or your organization? Email us at feedback@childtrends.org

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APPENDIX

Health insurance status of children (birth to age 17), 2015: U.S., and by state

	Private source	Medicaid & other public source	Uninsured
United States	52%	43%	5%
Alabama	47%	49%	3%
Alaska	40%	49%	11%
Arizona	50%	42%	8%
Arkansas	40%	55%	5%
California	49%	48%	3%
Colorado	55%	41%	4%
Connecticut	62%	35%	3%
Delaware	56%	41%	3%
District of Columbia	47%	52%	2%
Florida	45%	48%	7%
Georgia	47%	46%	7%
Hawaii	51%	48%	2%
Idaho	54%	40%	6%
Illinois	56%	41%	3%
Indiana	57%	37%	7%
Iowa	59%	38%	4%
Kansas	58%	37%	5%
Kentucky	49%	46%	4%
Louisiana	44%	53%	4%
Maine	54%	40%	6%
Maryland	57%	39%	4%
Massachusetts	62%	37%	1%
Michigan	55%	42%	3%
Minnesota	64%	33%	3%
Mississippi	37%	58%	4%
Missouri	58%	36%	6%
Montana	53%	40%	8%
Nebraska	61%	33%	5%

Notes: Rates refer to current coverage. "Medicaid & other public source" includes Medicaid, CHIP, Medicare, TriCare, VA, and those with 2 or more types of coverage (which could include private coverage).

	Private source	Medicaid & other public source	Uninsured
Nevada	53%	39%	8%
New Hampshire	66%	32%	3%
New Jersey	62%	34%	4%
New Mexico	35%	60%	4%
New York	53%	45%	2%
North Carolina	47%	49%	4%
North Dakota	68%	24%	8%
Ohio	56%	40%	4%
Oklahoma	45%	47%	7%
Oregon	51%	46%	4%
Pennsylvania	57%	38%	4%
Rhode Island	57%	39%	3%
South Carolina	48%	48%	4%
South Dakota	55%	38%	7%
Tennessee	50%	46%	4%
Texas	46%	44%	9%
Utah	70%	23%	7%
Vermont	49%	50%	1%
Virginia	57%	38%	5%
Washington	53%	44%	3%
West Virginia	48%	49%	3%
Wisconsin	61%	35%	4%
Wyoming	61%	31%	8%

Source: 2015 American Community Survey. Percentages calculated by Georgetown University Health Policy Institute.

Notes: Rates refer to current coverage. "Medicaid & other public source" includes Medicaid, CHIP, Medicare, TriCare, VA, and those with 2 or more types of coverage (which could include private coverage).

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