kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage

Introduction

More than half of U.S. children have health insurance through their parents' employment, and over a quarter are covered by Medicaid and the State Children's Health Insurance Program (SCHIP), the nation's safety-net health insurance programs. Still, in 2007, nearly 9 million children – most of them, low-income children – were uninsured. Eroding job-based insurance, the deepening economic crisis, the collapse of comprehensive SCHIP reauthorization in 2007, and rising health care costs all jeopardize children's access to coverage further, and without action, the number of children who lack health insurance is certain to grow.

Expanding coverage for uninsured children is a high priority on the nation's health policy agenda. Many states have launched initiatives to achieve universal coverage of children. The issue also gained attention in the Presidential campaign, as now-President Obama proposed requiring coverage for children as part of his larger health reform plan. Finally, increased federal funds for states to support increased Medicaid enrollment during the downturn and the reauthorization of SCHIP are among the priorities being taken up by the new Congress early this year. As decision-makers consider the options for covering uninsured children, data on the circumstances of these children and their families can help to frame their policy choices.

This brief provides findings from the 2007 Kaiser Survey of Children's Health Coverage, a telephone survey of parents that was conducted to learn more about children's access to coverage and care and the health care cost-related pressures facing their families. The survey examined how uninsured, privately insured, and publicly insured children and their families fare on a core set of measures. To help inform the policy debate about how far up the income ladder to expand children's eligibility for public coverage, the survey gathered information from middle-income as well as low-income households. In addition, it probed the reasons why children who are eligible for public coverage are not enrolled, a question central to designing efforts to reach the millions of children in this status.

The key findings from the survey are as follows:

- Uninsured children in both low-income and middle-income families lack access to private coverage or cannot afford it.
- Low-income and middle-income parents with an uninsured child report significant and similar access deficits and financial barriers to care for their child.
- Medicaid and SCHIP are viewed favorably by low-income families with an uninsured child, but gaps in awareness and understanding of the programs and burdensome enrollment procedures remain obstacles to participation by children likely to qualify.
- Diversified outreach, simplified enrollment and renewal processes, and linkages with other public programs offer potential to boost participation in Medicaid and SCHIP.
- Most low-income parents with an uninsured child are uninsured themselves and would like to enroll in public coverage along with their child.

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The finding that private insurance does not reach most low- and middle-income families with an uninsured child indicates, as previous research has, that the most promising approach to covering uninsured children may be to broaden eligibility for the nation's public coverage programs, Medicaid and SCHIP. Moreover, parents appear likely to embrace public coverage for their uninsured children, and public coverage has been quite successful in connecting children with care. The survey results highlight opportunities to improve Medicaid and SCHIP outreach and lower barriers to enrollment and renewal so that these public programs might more fully achieve their potential to provide health coverage and access for uninsured children.

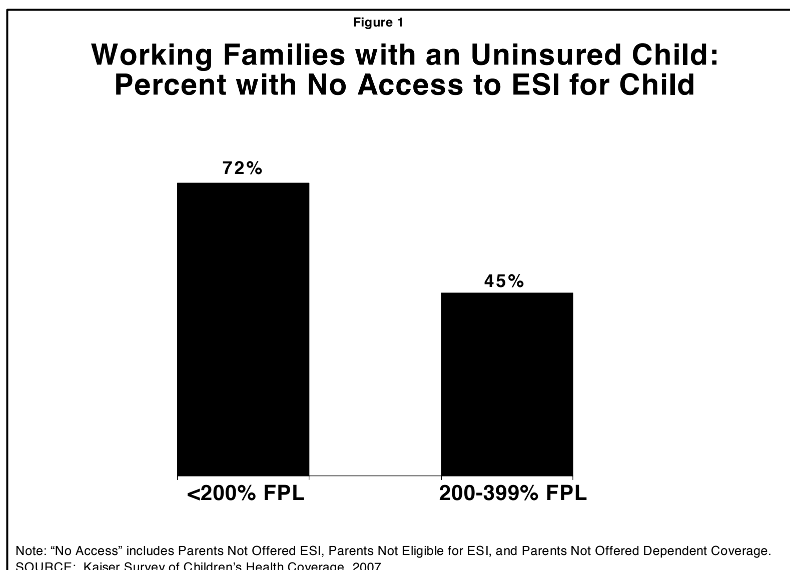
Data and Methods

The 2007 Kaiser Survey of Children's Health Coverage was designed and analyzed by researchers at the Kaiser Family Foundation. ICR/International Communications Research collaborated with Kaiser researchers on sample design and weighting and conducted the fieldwork. The survey is a nationally representative telephone survey of 2,073 parents or caregivers of a child age 18 or younger. Both low-income (<200% of the federal poverty level (FPL) and middle-income (200-399%FPL)) parents were sampled, and interviews were conducted in both English and Spanish. The survey was fielded between October 18 and December 23, 2007. The data and methods are described more fully in Appendix 1. The demographic characteristics of the survey sample are shown in Appendix 2.

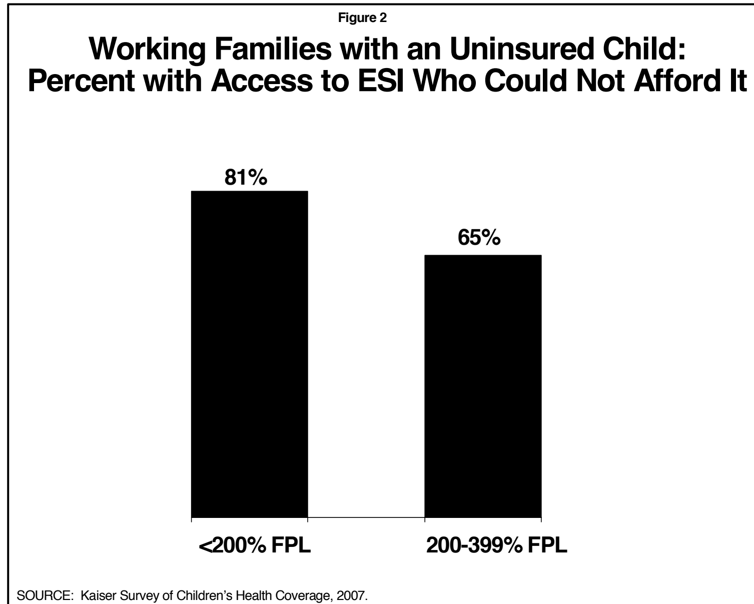
Findings

Uninsured children in both low-income and middle-income families lack access to private coverage or cannot afford it.

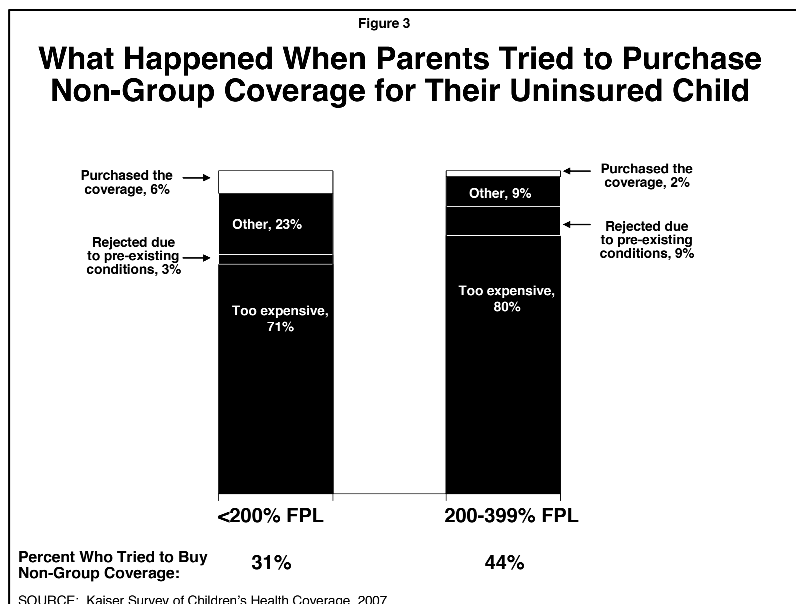
The vast majority of low-income working families with an uninsured child lack access to employer-sponsored insurance (ESI) for the child, and ESI access among middle-income working families is also limited (Figure 1). Nearly three-quarters (72%) of low-income working families with an uninsured child had no access to ESI for the child. Among middle-income working families with an uninsured child, almost half (45%) lacked ESI access. Few parents in either income group reported that their child was uninsured because coverage was not needed or they were not interested.



Most working families with uninsured child who do have access to ESI cannot afford it, whether they are low-income or middle-income (Figure 2). Of the minority of low-income families with an uninsured child who did have access to ESI for the child, 81% could not afford the premium. The cost of coverage was also a barrier for most middle-income families with an uninsured child: almost two-thirds of those with access to ESI for the child could not afford it.

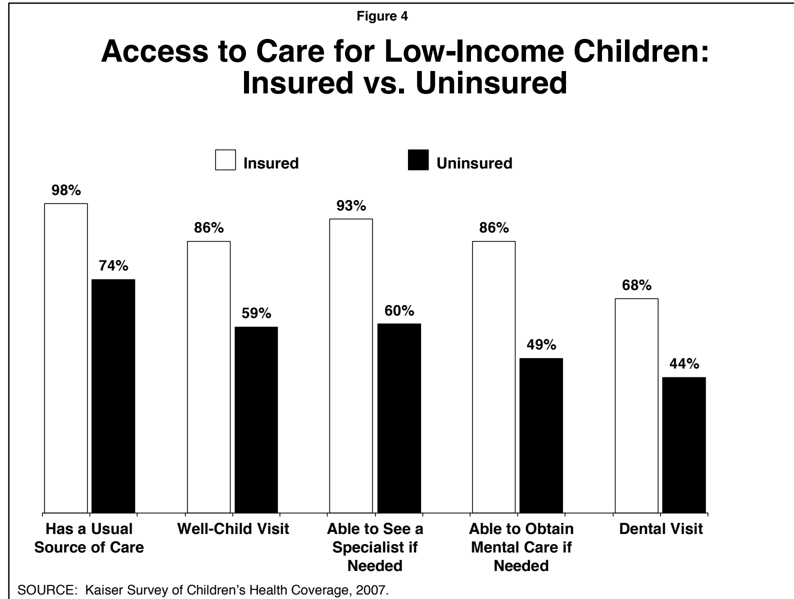


Few parents who try to purchase non-group insurance for their uninsured child succeed (Figure 3). Nearly a third (31%) of low-income and 44% of middle-income parents had attempted to purchase non-group coverage for their uninsured child, but only a tiny fraction ever succeeded. The vast majority could not afford it and medical underwriting excluded others.



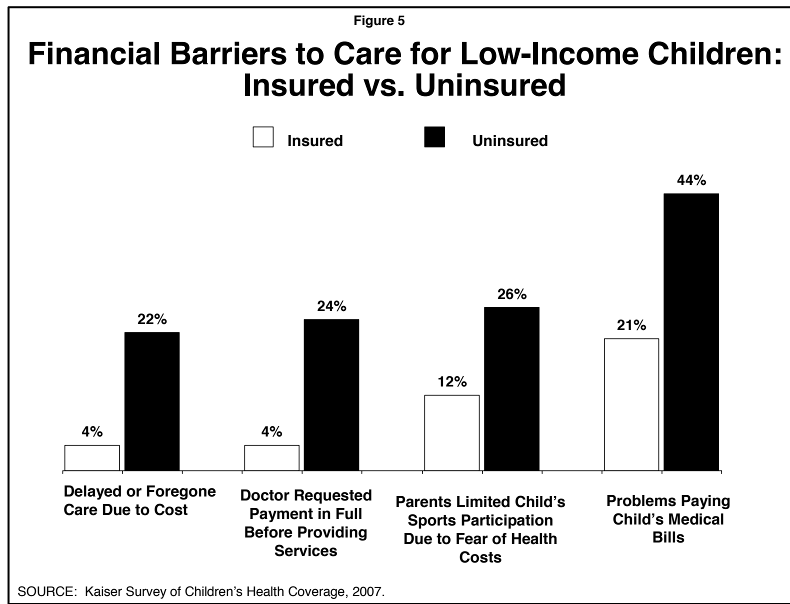
Uninsured children have reduced access to care and increased financial barriers.

Uninsured low-income children have much less access to care than their insured counterparts. Consistently across key measures of access, low-income children who were uninsured fared worse than low-income children who had either private or public insurance. Uninsured children were significantly less likely to have had a usual source of a care, a well-child visit, access to needed specialist or mental health care, and a dental visit in the past year (Figure 4).

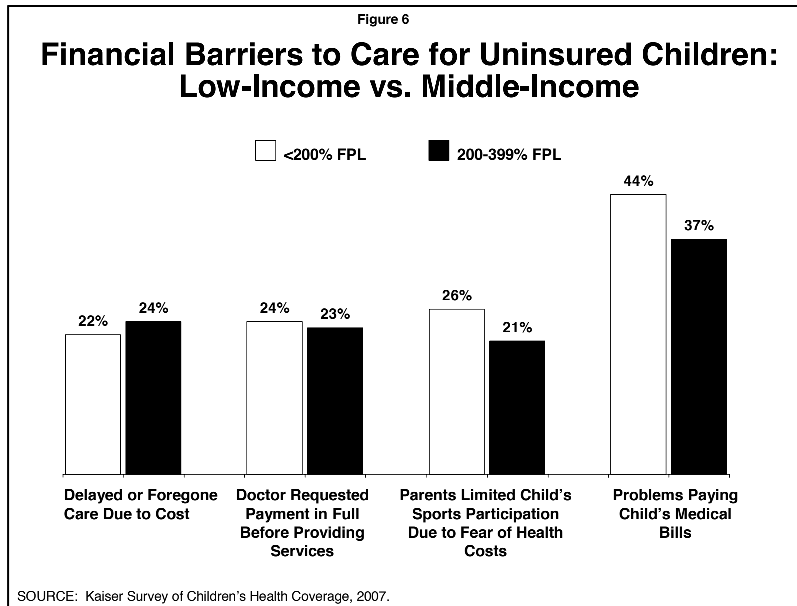


Being uninsured is generally not a short-term problem. More than half the uninsured children covered by the survey had gone without coverage for a year or more. Fully a quarter of those age 1 or older had been uninsured their entire lives. These findings imply that many uninsured children experience lengthy and potentially cumulative gaps in access to needed care.

Low-income families with an uninsured child face substantial financial barriers to obtaining care for their child. Low-income parents with an uninsured child were far more likely than low-income parents with an insured child to have delayed or foregone care for their child due to costs (Figure 5). This result may be explained, at least in part, by the finding that nearly one-quarter of the parents with an uninsured child reported that they had been required to pay in full before receiving services for their child. Close to half (44%) of low-income families with an uninsured child had problems paying their child's medical bills, and one in four limited their child's participation in sports due to fear of health costs. Consistently, these financial barriers and pressures were significantly less likely to be reported by low-income families with an insured child.



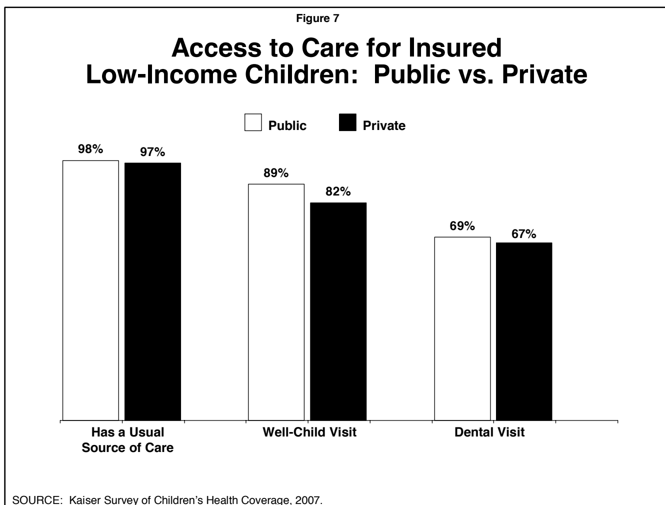
Middle-income uninsured children don't fare much better than low-income uninsured children. Middle-income uninsured children generally had somewhat better access to care than low-income uninsured children, but the gaps in access between uninsured and insured children were similar in both income groups. Financial barriers to care were just about as common among middle-income families with an uninsured child as among low-income families with an uninsured child (Figure 6). One-quarter had delayed or foregone care for their uninsured child due to cost, and similar shares had been required to pay in full before receiving services and had limited their child's sports participation because of health cost worries. Despite higher earnings, over a third (37%) of middle-income parents still had problems paying their uninsured child's medical bills.

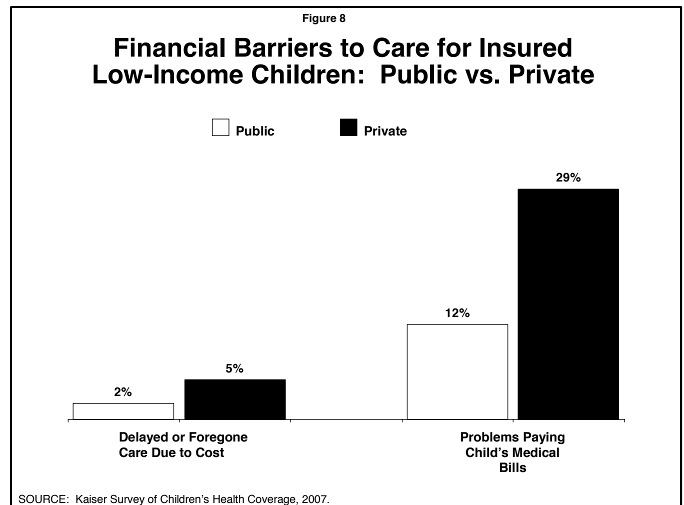


Public and private coverage provide similar access to care for children.

Publicly and privately insured low-income children have similar rates of access to care. On key measures of access to care, publicly insured low-income children fared as well as privately insured low-income children (Figure 7).

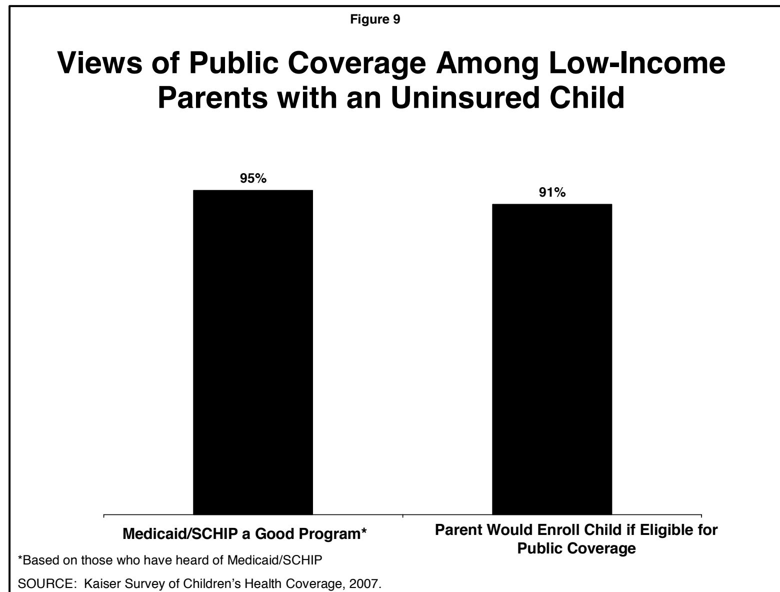
But public coverage eases out-of-pocket burdens more than private coverage. The percentage of low-income parents who had delayed or foregone care for their child due to cost was small, whether their child's coverage was public or private (Figure 8). However, low-income parents with a publicly insured child were much less likely than those with a privately insured child to report problems paying their child's medical bills (12% vs. 29%).



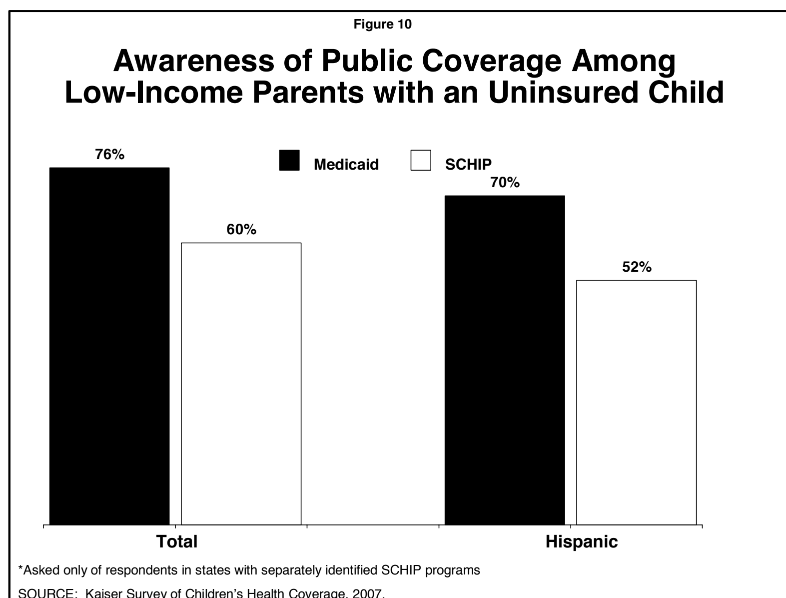


Parents view public coverage programs favorably, but barriers depress participation.

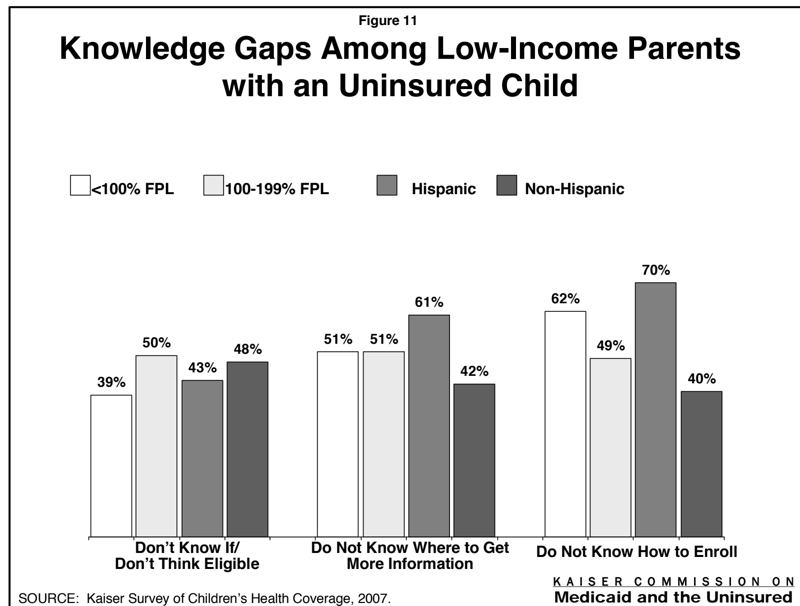
Low-income parents with an uninsured child have positive perceptions of Medicaid and SCHIP (Figure 9). Nearly all low-income parents with an uninsured child who had heard of Medicaid and/or SCHIP thought that they were good programs, and 9 out of 10 said they would enroll their uninsured child if the child was eligible.



However, gaps in awareness of Medicaid and SCHIP persist, especially among Hispanic parents. Three-quarters of all low-income parents with an uninsured child had heard of Medicaid and 60% had heard of SCHIP (Figure 10). Awareness of Medicaid and SCHIP was significantly lower among Hispanic parents (70% and 52%, respectively) compared to non-Hispanic parents (82% and 68%, respectively; data not shown).

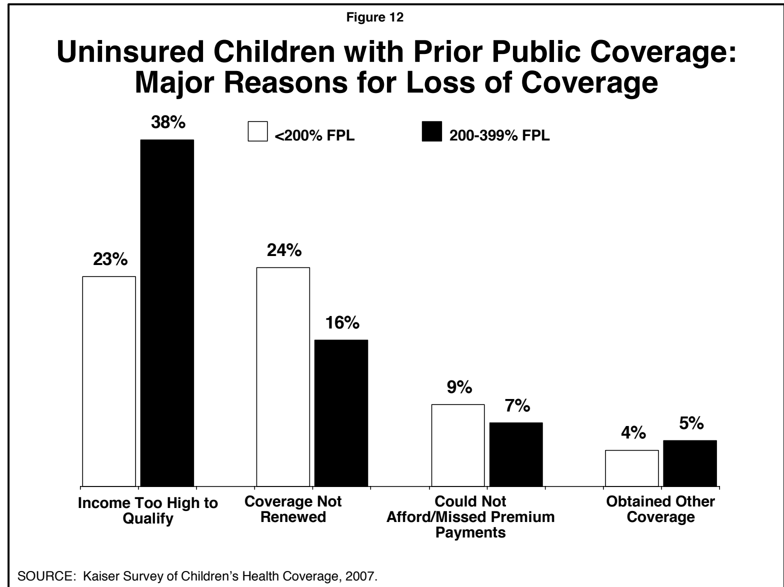


Confusion about program eligibility and how to enroll are large barriers to participation in public coverage, especially among Hispanic parents (Figure 11). Even though nearly all low-income children are eligible for Medicaid or SCHIP, their parents often do not realize their children are eligible, or they are uncertain. Many low-income parents have misperceptions about specific issues, believing, for example, that a child cannot qualify for coverage if the parent works or has a car or a savings account. Of particular concern given the high uninsured rate among Hispanic children, especially large shares of Hispanic parents report not knowing where to get information about public coverage programs (61%) or how to enroll their child (70%).



Families seeking to obtain or keep Medicaid for their children often find the enrollment and renewal processes onerous and discouraging. Consistent with what other studies have shown, many families reported problems with the enrollment process. About half of low-income families with an uninsured child found the Medicaid process difficult; a smaller but still considerable share of parents considered the SCHIP enrollment process to be difficult (data not shown). Under requirements introduced by the Deficit Reduction Act of 2005, parents must now document their child's citizenship and identity as part of the initial Medicaid enrollment or renewal process, often by presenting an original birth certificate. The majority of low-income parents had a birth certificate for their uninsured child, but more than half of them said that they were not willing to put these original documents in the mail.

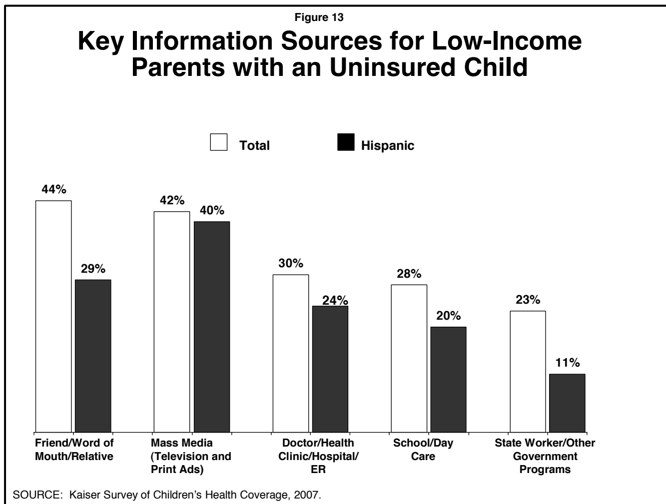
Most children who lose public coverage become uninsured. About half of low-income and middle-income parents with an uninsured child reported that the child was previously enrolled in public coverage. The reasons given most frequently for why the child was no longer enrolled were having family income too high to qualify and coverage not renewed (Figure 12). Only about 4% of parents said that the reason the child was no longer enrolled was that he or she had obtained other health coverage.

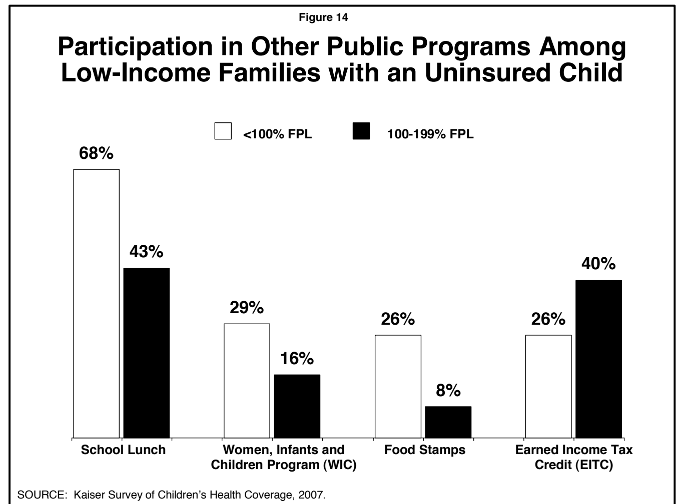


Families get information from diverse sources and prefer diverse enrollment methods.

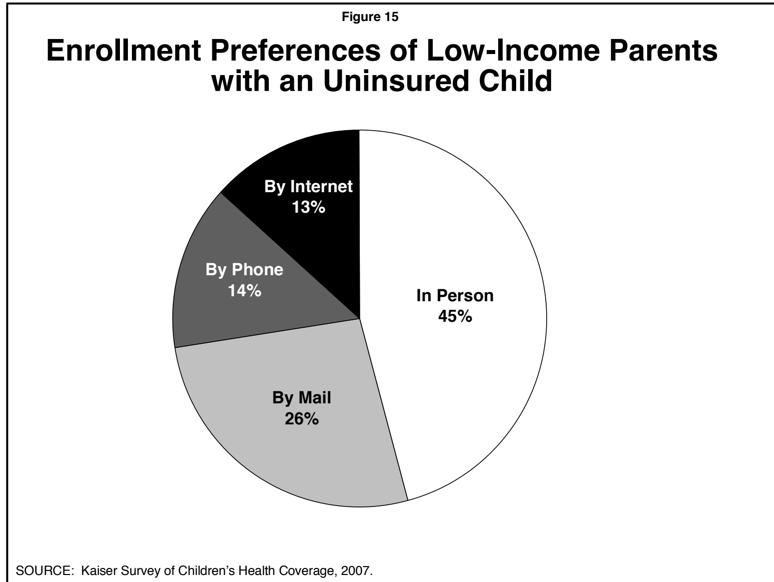
Low-income families with an uninsured child rely on a variety of sources for information about assistance programs for their child. The information sources parents relied on most often were word of mouth, mass media, and health care providers (Figure 13). Notably, compared with all low-income parents with an uninsured child, Hispanic parents used all the information sources at lower rates.

Low-income families participate in a variety of public assistance programs. Two-thirds of poor parents with an uninsured child reported that their family participated in the school lunch program, and more than one-quarter participated in WIC, Food Stamps, and the Earned Income Tax Credit (EITC) program (Figure 14). These assistance programs also reached a smaller share of families between 100% and 200% FPL – except for the EITC program, which reached 40% of these families.



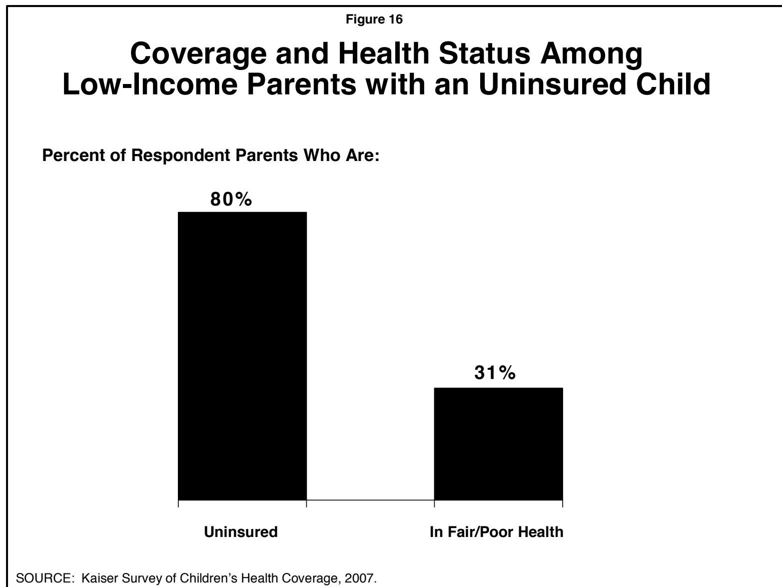


Low-income parents with an uninsured child have diverse preferences regarding modes of enrollment and renewal (Figure 15). Filing applications in person and applying by mail, by phone, and by internet are all favored by substantial shares of parents. No single method is preferred by a vast majority of parents. Compared with parents overall, Hispanic parents had different preferences, favoring enrollment in person more, and enrollment by internet less.

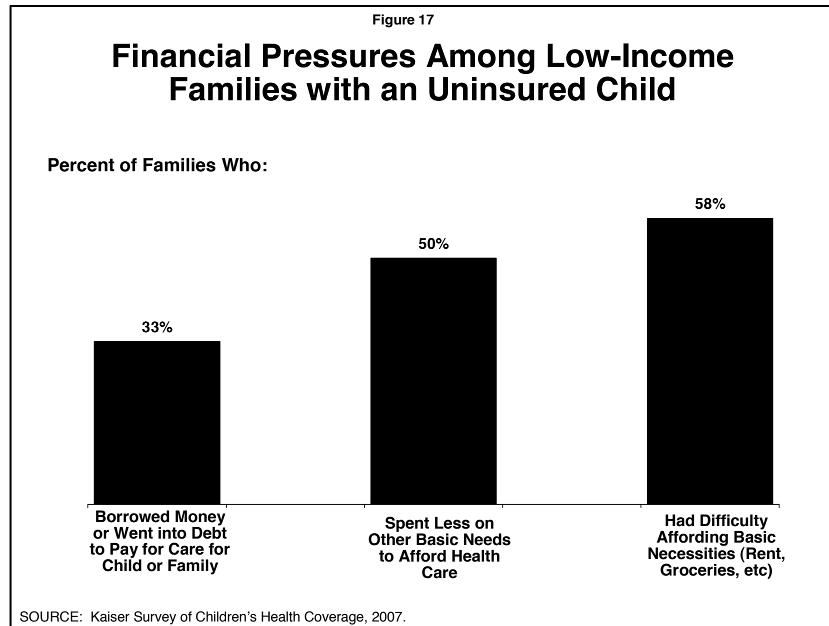


Most low-income parents with an uninsured child are uninsured themselves and would like to enroll in public coverage along with their child.

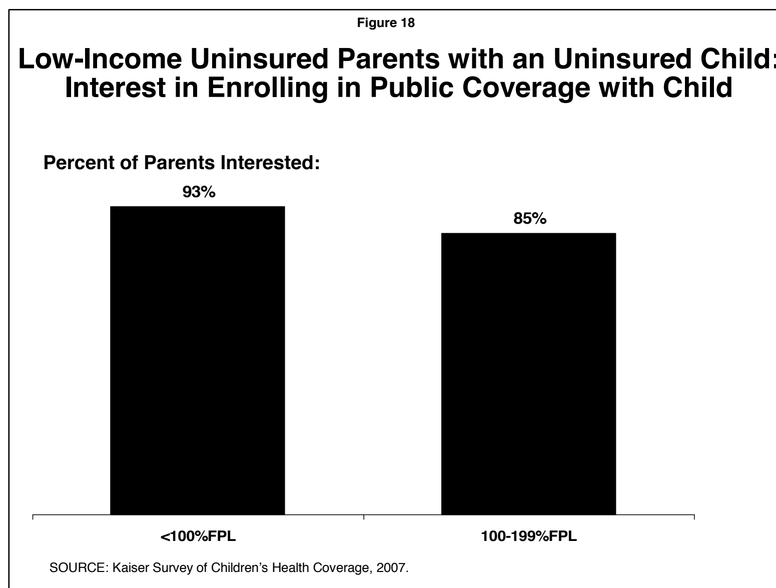
Low-income parents with an uninsured child are very likely to be uninsured themselves and to report family budget pressures related to health care costs. More than three-quarters of parents with an uninsured child were uninsured themselves, and almost one-third were in fair or poor health (Figure 16). A third of low-income parents had borrowed money or gone into debt to pay



for care for their uninsured child or other family member (Figure 17). About half reported spending less on other basic needs to afford health care and having difficulty affording basic necessities.



The vast majority of low-income uninsured parents with an uninsured child are interested in enrolling in public coverage along with their child. Nearly all poor uninsured parents with an uninsured child (93%) said they would be interested in enrolling in public coverage along with the child. Among parents with income 100-199% FPL, 85% said they would be interested in doing so.



Discussion

The survey findings reported here add to the large body of evidence that most low-income uninsured children lack access to both job-based health insurance and non-group coverage. Furthermore, the survey reveals that middle-income uninsured children confront similar circumstances – most lack access to private coverage or face affordability barriers, and their parents report comparable access deficits and financial barriers to care for them. The evidence that private insurance does not reach most uninsured children in low- and middle-income families suggests that the most practical approach to expanding coverage for these children may be to broaden eligibility for the nation's public health insurance programs.

The positive view of Medicaid and SCHIP held by the vast majority of low- and middle-income parents with an uninsured child indicates that these programs are likely to be well-accepted as a source of coverage for their children. Also, the results show that on key measures of access, public coverage does as well as private insurance at connecting low-income children with care and provides their families with greater protection against health care cost-related pressures. Taken together, these findings suggest that the Medicaid and SCHIP programs provide a sound platform for expanding coverage for low- and middle-income uninsured children.

While pointing to the potential of Medicaid and SCHIP as coverage mechanisms, the survey also highlights gaps in awareness of the programs, confusion about who is eligible, and a widespread perception among families with an uninsured child that the enrollment procedure is difficult. Barriers to renewing public coverage are implied by the substantial share of uninsured children who previously had public coverage and the very small share who obtained other coverage. It is difficult not to draw the conclusion that these factors impede participation and help to explain why 6 million low-income children who are potentially eligible for Medicaid or SCHIP are uninsured. The information that parents provided suggests that multi-pronged outreach and coordination with other public assistance programs could help more families find Medicaid and SCHIP, and help the programs find more eligible children. Lowering enrollment and renewal barriers – for example, by providing many ways to enroll, simplifying the process, lengthening eligibility periods, and broadening income eligibility to reduce disruptions in coverage due to small fluctuations in earnings – would all serve to maximize and stabilize children's participation in Medicaid and SCHIP.

Finally, the high uninsured rate among low-income parents with an uninsured child, and uninsured parents' high level of interest in enrolling with their child, indicate additional coverage potential that could be tapped. Research on family-based eligibility for public coverage shows not only increased coverage of low-income parents, but also increased rates of participation among low-income children. Moving in this direction would confer the important benefits of health coverage on many uninsured families, improving their access to care and easing the difficult trade-offs they must often make now to afford it.

This brief was prepared by Julia Paradise, Caryn Marks, Karyn Schwartz, and Barbara Lyons, all of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Appendix 1: Data and Methods

The sample was drawn primarily from previous ICR surveys that identified households with a child under age 19. The sample was stratified by income and state of residence, which were available from the prior surveys. Respondents who refused to answer questions about income were also included in the sample and assigned to different income strata, as described later. The study over-sampled low-income households. Also, in order to survey a sufficient number of parents with an uninsured child, households in states with higher uninsured rates for children were over-sampled. ICR's prior surveys were conducted only in English. To obtain a Spanish-speaking sample, respondents who were screened out as Spanish-only households in the previous ICR surveys were included. Parents with more than one child were asked to respond to the survey based on one child. If only one child in the family was uninsured, parents responded based on that child. Otherwise, parents were asked to respond based on the child with the most recent birthday.

The dataset was weighted to be representative of the population of parents in the U.S. as determined by 2007 U.S. Census CPS data, and the weighting corrects for our over-sampling of certain insurance and income groups. The first step of the weighting process categorized the sample into groups based on the number and gender of adults in the household and the insurance status of the child. Then, each observation was assigned to one of nine groups based on household type (one adult male, one adult female, more than one adult) and the child's insurance status (private, public, uninsured). Within each of those groups, the respondents were weighted by the Census distributions for income relative to the federal poverty level, age of adults, age of children, and race of children. Data were analyzed in SUDAAN and statistical testing accounts for the complex sampling methodology.

Key variables and data analysis. Family income relative to the poverty level was a central analytic variable. Low-income households were defined as households with income below 200% of the Federal Poverty Level (FPL), and middle-income households were defined as those with income of 200%-399% FPL. ICR imputed data for the approximately 10% of the sample (212 respondents) who had refused to provide their income to ICR. Using an algorithm to assess likely income based on other characteristics, respondents were assigned to one of the following classes: 0-44% FPL, 50-99% FPL, 100-149% FPL, 150-199% FPL, 200-249% FPL, 250-299% FPL, 300-399% FPL, or 400% FPL and above.

Health insurance for both the focal child and the parent were reported by the respondent. The survey instrument used state-specific program names for Medicaid, SCHIP, and other state programs when asking parents about insurance coverage. Those with Medicaid, SCHIP, or other state coverage were categorized as having public coverage. Those with employer-sponsored insurance (including military coverage) or non-group insurance were categorized as having private coverage. The 8% of publicly insured respondents who also had private coverage were included in the publicly insured group. Those with only Indian Health Service coverage were categorized as uninsured. Of the 2,073 respondents, 974 had an uninsured child, 495 had a child with public coverage, and 604 had a child with private coverage.

The child's coverage status refers to his or her coverage at the time of the interview. However, the access and utilization variables that were analyzed refer to experiences during the 12 months before the interview. This discrepancy may have introduced some measurement error.

Appendix 2: Demographic Characteristics of Survey Sample

		Characteristics of Respondents	
		Number of Respondents (Unweighted)	Percent of Respondents (Weighted)
Gender of Child			
	Male	1112	**51%**
	Female	956	**49**
Insurance Status of Child			
	Public	495	**16**
	Private	604	**71**
	Uninsured	974	**14**
Age of Child			
	Less than one year	75	**3**
	One year old	88	**6**
	Age 2-5	428	**22**
	Age 6-18	1465	**69**
Family Poverty Level			
	Under 100%	761	**16**
	100-199%	718	**23**
	200-299%	367	**23**
	300-399%	121	**19**
	400%+	106	**20**
Household Type			
	Married	1422	**71**
	Living with a Partner	203	**6**
	Unmarried	443	**23**
Family Work Status			
	2 Full-Time Workers	391	**31**
	1 Full-Time Worker	1122	**53**
	Part-Time only Workers	267	**6**
	No Workers	272	**10**
Race/Ethnicity of Child			
	White only (non-Hispanic)	1032	**60**
	Black only (non-Hispanic)	113	**13**
	Hispanic	739	**19**
	Other (non-Hispanic)	166	**8**
Health Status of Child			
	Excellent/Very Good/Good	1865	**94**
	Fair/Poor	204	**6**
Citizenship of Child			
	U.S. Citizen	1873	**98**
	Non-Citizen	183	**2**

SOURCE: Kaiser Survey of Children's Health Coverage, 2007.

NOTE: Total number of responses to individual questions is not always the same because not all respondents answered all questions.

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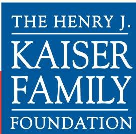

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