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The Scientific Evidence for Child Health Insurance

Peter G. Szilagyi, MD MPH*,

Department of Pediatrics, Strong Memorial Hospital, Rochester, NY

Mark A. Schuster, MD PhD, and

Division of General Pediatrics, Department of Medicine, Children's Hospital, Boston, MA, Harvard Medical School, Boston, MA, RAND, Santa Monica, CA

Tina L. Cheng, MD MPH

Division of General Pediatrics & Adolescent Medicine, Johns Hopkins University, Baltimore, MD

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As President-Elect Obama and the 111th US Congress assume leadership, we hope that they will work together to put children's health issues, and in particular, health insurance for children, on the national agenda. The new leadership will likely address two critical policy options related to child health insurance: reauthorization and potential expansion of the State Children's Health Insurance Program (SCHIP), and expansion of health insurance to all children. We hope that policy-makers keep in mind the substantial body of scientific evidence about SCHIP and child health insurance.[1] This commentary reviews the scientific evidence for child health insurance and also highlights areas in which more evidence is needed.

A growing body of evidence supports the value of paying increased attention to children's health issues, especially for children who are vulnerable because of chronic conditions or social circumstances. Research has demonstrated the profound and potentially lifelong influence of positive and negative childhood experiences. Nobel Laureate economist James J. Heckman emphasizes that early investment in the education and well being of disadvantaged children leads to enduring benefits throughout the lifespan. A focus on children and children's health promises to pay off with substantial downstream benefits.[1-3] An important component of child health involves health insurance.

The Obama proposal for healthcare reform, as presented during the campaign, included a Medicare-like health plan for uninsured individuals of all ages.[4] The proposal emphasized a choice of insurance options, so that uninsured families or small businesses could opt into the plan. Although it did not mandate health insurance coverage for adults, it included a mandate for health insurance coverage for children, through either private or public insurance options.

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* Corresponding author peter_szilagyi@urmc.rochester.edu.

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Several lessons have been learned from over thirty years of studies of health insurance for children.[5-7] First, a large body of evidence demonstrates that lack of health insurance among children and adolescents is associated with delays in needed healthcare; foregone care; lack of receipt of preventive, acute, or chronic services; lower quality of care; and in many cases suboptimal health outcomes.[7, 8] Although not all uninsured children suffer such adverse consequences, the lack of insurance for medical or dental care increases their risk of poor health outcomes. Second, many studies have demonstrated that lack of health insurance among children with special healthcare needs represents a particularly risky situation[6,7] because such children often require substantial care from primary, specialty, and ancillary services to address their chronic health problems. [9-11]

Multiple studies have evaluated the impact of providing health insurance to children. During the 1980s, the RAND Health Insurance Experiment demonstrated that children who had health insurance received better quality of care for many measures such as preventive services.[5] Studies during the 1980s and 1990s demonstrated that provision of Medicaid to uninsured children living in poverty improved their receipt of ambulatory care. During the 1990s, studies in Florida,[12] New York,[13, 14] and Pennsylvania,[15] found that enrollees in state prototype programs that offered health insurance for low-income children who did not qualify for Medicaid showed measurable improvements in access, utilization, and quality measures.

This body of evidence was helpful in the passage of SCHIP, which was enacted in 1997 as Title XXI of the Social Security Act and authorized for ten years to provide health insurance to low-income children who were not eligible for Medicaid. States provided SCHIP through private programs, Medicaid expansions, or a combination, and within several years SCHIP covered more than 4 million children per year, with families paying premiums on a sliding scale matched to their income levels. Studies evaluating SCHIP have found that children who enroll in SCHIP experience improved access to care, more appropriate use of health care (e.g., better continuity of primary care), and enhanced quality of care.[16-21] Studies also show improved outcomes among children with asthma[18] and other children with special healthcare needs,[22] and among specific age groups such as adolescents.[23] One study even noted reductions in pre-existing healthcare disparities following enrollment in SCHIP.[20] Findings from these studies add critical evidence to the debate on SCHIP reauthorization.

Despite the relatively large body of evidence of the benefit of SCHIP, its reauthorization in 2007 stalled.[24] Two fundamental questions were hotly debated.[25] The first was reauthorization of SCHIP for the currently eligible child population, which varies by state, but generally consists of children living in families whose income is above the Medicaid eligibility level but below 200% of the federal poverty level (FPL), which amounts to $42,400 in 2008 for a family of four in the 48 contiguous United States. The second question involved potential expansion of eligibility to 300% or even 400% of the FPL. Both proposals were vetoed by the Bush administration, and SCHIP was temporarily extended with its prior design and eligibility in place. The Obama administration and the 111th Congress are expected to consider SCHIP reauthorization and expansion, as well as the issue of child health insurance for all children.

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Regarding the possibility of SCHIP expansion to cover children with families with higher income, there is little direct evidence because studies have rarely evaluated the impact of health insurance on children who are between 200% and 400% of the FPL. However, research has shed light on two issues related to SCHIP expansion. A recent study found that uninsured children living in families between 200-400% of FPL were twice as likely as insured children in the same income levels to lack medical visits or prescriptions during a year, and substantially more likely than insured children to lack preventive care. These uninsured children between 200-400% FPL resembled uninsured children below 200% FPL in their level of foregone care.[26] This finding suggests that expansion of SCHIP to cover children between 200-400% FPL has the potential to significantly improve their health care as well, and supports expansion of SCHIP to at least 400% of the federal poverty level.

The second issue related to SCHIP expansion is that parents of children who would find themselves newly in the SCHIP income eligibility range might drop (or might be encouraged by employers to drop) private insurance in order to enroll in SCHIP—a phenomenon known as "crowd-out." Indeed, employers might be more likely to stop sponsoring insurance if they knew that a larger percentage of their workforce could qualify for SCHIP. This concern was raised when SCHIP was originally authorized, and some states instituted provisions to prevent crowd-out. However a recent study found that in New York State, the incidence of crowd-out was extremely low,[27] and other studies[28] have suggested that few SCHIP enrollees switch directly from private insurance to SCHIP. Although some crowd-out does exist, it may also result in improved coverage for the children who move to SCHIP coverage. It turns out that the majority of families who enroll in Medicaid or SCHIP have either had a major life event (e.g., job loss or divorce) that reduced their income and made private insurance unavailable, or are working families unable to afford private insurance. These studies counter arguments that children do not benefit from SCHIP, and that SCHIP expansion will threaten private insurance.

The above-mentioned studies provide strong evidence for the benefit of health insurance for children below 200% FPL, and also provide some evidence for the potential benefit of SCHIP expansion to children up to 400% of the FPL. We hope this body of evidence will be used in the likely upcoming debate about SCHIP reauthorization and expansion.

The second major policy option regarding child health insurance involves the Obama proposal during the 2008 Presidential campaign to provide health insurance to all children. It is reasonable to ask how far this policy option would extend beyond an SCHIP expansion to 400% FPL. This question has to do with two groups of children: those living in families above 400% FPL, and those children who are currently eligible for public health insurance who remain uninsured.

Regarding the potential benefit of health insurance to children above 400% FPL, few studies have addressed this population specifically. This group of children makes up only 9% of all uninsured children since 91% of uninsured children are from families below 400% FPL.[29] Their level of foregone care is lower than among children below 400% FPL.[27] However, uninsured children above 400% FPL are nonetheless twice as likely to lack any healthcare visits or prescriptions compared to insured children above 400% FPL.

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Altogether, 88% of all children in the US are already covered by private health insurance or public health insurance,[30] leaving 12% of children (11 million children) without health insurance Multiple studies have demonstrated that about two-thirds of these uninsured children are already eligible for either Medicaid or SCHIP.[29] The reasons for their lack of enrollment include administrative barriers, family issues, attitudes about insurance, and inability to maneuver through the complicated healthcare system to complete enrollment.[31] A child health insurance program that covered all children would need to ensure that these barriers are overcome.

The new administration and Congress will certainly be looking at the potential cost of insuring the 11 million uninsured children. Studies demonstrate that the healthcare costs of children are about one-tenth the healthcare costs of adults.[32, 33] Nevertheless there would certainly be costs associated with either SCHIP expansion or of provision of health insurance to all children. The costs of the latter would be influenced by associated incentives/penalties to limit a substantial decline in the number of children who receive private insurance through their parents' employers. It will be important for future research to assess both the costs and the gains of expanding child health insurance.

Finally, it is important to point out that scientific evidence has also demonstrated the *limits to health insurance*. Studies have demonstrated that health insurance does not guarantee receipt of high-quality care.[34] Provision of health insurance to children will not, by itself, be enough to optimize their health outcomes. Indeed, a series of steps is necessary to achieve optimal health outcomes in any population.[35, 36] Health insurance is a critical first step, but by itself is not sufficient.[2] Further refinements are needed in each step from improved access, to optimal and efficient utilization of health care, to optimal receipt of health and related services, to combining effective health care with healthy behaviors and child-oriented environmental, community, and public health improvements.

We hope that the Obama administration and the 111th Congress, working together with state and local leaders, will make children a focal point. The evidence is compelling with respect to health insurance for children. Uninsured children experience greater risk for multiple adverse consequences during childhood and later in life. Provision of health insurance improves children's health care and health outcomes. SCHIP has been extremely beneficial to children, and expansion of SCHIP is likely to reap similar benefits. Provision of health insurance for all children would improve the health of millions of uninsured children, most of whom are already eligible for existing public health insurance programs. A renewed focus on children and families in the United States can start with reauthorization of SCHIP, progress to expansion of SCHIP, and finally move on to a guarantee of health insurance for all children.

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