Health Insurance and Children’s Well-Being

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What Do We Know?

What Do We Need to Know?
The Percentage of Children with No Health Insurance: 1997-2009 (NHIS)

Private

Public
What was the Health Impact of this Increase in Public Coverage?
Health Insurance and Health

• Many studies show that having health insurance increases utilization and expenditure

• Does health insurance improve health?
  – RAND HIE: little health benefit
  – Some studies find a health benefit of having insurance (e.g., Doyle 2005, Card et al., 2008)
Medicaid and Child Health

• Mixed evidence
  – Currie and Gruber (1996) find improvements in prenatal care and infant mortality, but only for expansions targeted towards poor populations
  – Other studies find no improvements in health (Piper et al., 1990; Kaester et al. 1999; Dubay et al, 2000)
Trends in child health

Percentage of Live Births with No Prenatal Care

Percentage of Women who Smoke During Pregnancy

Percentage of Live Births that are Low Birth Weight

Infant Deaths / 1000 Live Births
Wisconsin’s Recent Experience: BadgerCare Plus
All Kids Eligible are for Coverage in Wisconsin

Health insurance for all kids
Enrollment: Children
# Child Enrollment by FPL

<table>
<thead>
<tr>
<th></th>
<th>Dec-07</th>
<th>Sep-08</th>
<th>Change</th>
<th>% of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>287,496</td>
<td>379,819</td>
<td>92,323</td>
<td>100%</td>
</tr>
<tr>
<td>&lt; 150</td>
<td>270,000</td>
<td>327,372</td>
<td>57,372</td>
<td>62%</td>
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<tr>
<td>150-200</td>
<td>17,400</td>
<td>37,447</td>
<td>20,047</td>
<td>22%</td>
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<tr>
<td>200-300</td>
<td>75</td>
<td>12,480</td>
<td>12,405</td>
<td>13%</td>
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<tr>
<td>300+</td>
<td>21</td>
<td>2,520</td>
<td>2,499</td>
<td>3%</td>
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What Do We Need To Know?
How can we enroll more eligible children?

- Many eligible children do not enroll
- Early enrollment may improve health (Aizer, 2007)
- How can we enroll eligible children?
  - Information and administrative costs are barriers to enrollment
  - WI experience shows that automatic enrollment procedures can be effective and target efficient
How can we improve access to care?

• Access to care under Medicaid
  – comparable to low-income privately insured (Coughlin et al., 2005)
  – concerns for dental and specialty care
• Reimbursement rates can be low
  – About 50% of private rates (Holahan, 1991)
• Increased fees may improve access and health (Currie et al., 1995)
Can We Reduced the Burden of “Underinsured” Children?

- Even children with “good” private insurance can face gaps in coverage
  - Medicaid may provide better coverage than private insurance for many children with disabilities or chronic illness (Kaiser, 2010)
The graph illustrates the relationship between OOP (out-of-pocket) spending and total spending. The X-axis represents total spending, and the Y-axis represents OOP spending. Two lines are shown:

- **Line A**: This line has a slope of 0.20 and reaches an OOP Max at 5000. It starts at a deductible of 250 and shows a gradual increase until it reaches OOP Max.

- **Line B**: This line has a slope of 0.15 and maintains a consistent OOP spending level after reaching a deductible of 500.

The graph highlights how different slopes affect the total OOP spending at various points.
Insurance curves illustrate significantly higher OOP spending among chronic relative to non-chronic for total spending amounts in excess of $8000 per year.
Financial Well-Being

• How well does Medicaid protect families against financial difficulties?
  – Families with disabled children

• Medicaid Home and Community-Based Services Waivers (for children with disabilities or high medical needs)
  – Waives the family income test
  – Low enrollment caps (long waiting lists)
Current Policy Issues

• Should we be increasing coverage?
  – ACA spend lots of money subsidizing the “healthy” uninsured to buy insurance

• Should we spend money in a more targeted fashion?
  – Increase enrollment and improve access to care for poor children
  – Provide services to a greater number of disabled children